BIG TALK:
AN EXPLORATION OF SELDOM HEARD DISCOURSES OF BODY SHAPE AND SIZE FROM AFRICAN CARIBBEAN WOMEN IN THE CONTEXT OF PRIMARY CARE

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A thesis submitted to

The University of Birmingham

For the degree of DOCTOR OF PHILOSOPHY

Institute of Applied Health Research

College of Medical and Dental Sciences

The University of Birmingham

April 2017

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Abstract

African Caribbean women in the United Kingdom are more likely to be biomedically defined as overweight or obese than the general population and have an increased risk of developing obesity related chronic illnesses. For healthcare professionals to engage in meaningful discussion about weight management and; for the development of targeted intervention, it is important to have an understanding of alternative discourses of health and wellbeing that may be held by women of this ethnic group.

This qualitative research explores the discursive construction of health and wellbeing with regard to body shape and size for African Caribbean women. To address issues of under representation in applied health research, a novel research method was developed.

Thematic analysis was used to identify the contours of the discourse and themes from the data were explored within the wider social contexts from which they emerge. The importance of post memory; trust of healthcare systems and; meanings of wellness are central concepts for understanding health beliefs and behaviours of African Caribbean women. Findings demonstrate the importance for research design take into account the dynamics of seldom heard communities to encourage participation and elicit rich data that is useful for healthcare practice.

Acknowledgements

There are many people without whom I may not have completed this thesis, and to them I will always be grateful. It has often been the smallest acts of kindness or the quietest whispers of motivation that have kept me going throughout this PhD journey. Thank you.

In particular, I would like to thank my academic supervisors Professor Sheila Greenfield, Dr Sabi Redwood and Dr Will Drever. They have each shared their knowledge, guidance and expertise with me in abundance throughout this process. It has been an honour to work with you.

Many thanks to the National Coordinating Centre for Research Capacity Development for funding this study. Also, thank you to my fabulous colleagues at University of Birmingham and Newman University for all their encouragement.

Special thanks to my beautiful family who are always unwavering in their support. Without them, many things would not be possible. Especial thanks to my husband Kehinde whose love, encouragement and endless belief in me has been a constant source of strength.

Finally, many thanks to all of those contributed to this study as research participants or assisted in gaining access to the research sites. I truly appreciate you all.

Table of Contents

Introduction 1

Clarification of the use of terms 3

Biomedical 3

Ethnicity 3

Discourse 4

Discursive Construction 7

Understanding discourse and discursive construction for health research 8

Discursive construction and African Caribbean women 10

Research aims and objectives 11

Thesis structure 13

Chapter One Research Background 16

Introduction 16

The surgery space as a social space 17

Raising the issue of weight management in the clinic 18

The weighty issue 23

Discursive constructions of health and wellbeing 25

The changing face of illness in the 21st century 27

Policy response to obesity 30

Policy: contradictions and tensions 33

Modern medicine: contradictions and tensions 36

The research context 38
Locating research ideas 41

Chapter Two Literature Review 43
Introduction 43
Search strategy and selection of literature 45
Historical discourses of health and health care 49
The ancient context 49
The African experience 53
An alternative discourse of health 58
Health in the UK: The African Caribbean experience 65
Understanding health inequalities for minority ethnic communities 68
Artefact 69
Migration 70
Socioeconomics 72
Cultural beliefs and behaviours 73
Racism 75
Biology 81
Accessing healthcare services 83
The changing nature of weight 84
The history of fat 86
The politics of fat 87
Fat studies 92

Black oppositional gaze 93
Weight management and African Caribbean women 95
Conclusion 105

Chapter Three Methodological Approach 108
Introduction 108
The need for research 109
Hard to reach vs seldom heard 114
Methodological framework 116
The liminal space 121
Researcher Positionality 122
Conclusion 126

Chapter Four Research Design 128
Introduction 128
Geographical location of the research 131
Learning from the liminal: Phases one and two 131
Talk Radio as a liminal space 132
Community groups as a liminal space 135
Hairdressing Salons as a liminal space 137
First Cycle Data Analysis 141
Probing the knowledge: Phase three 142
Second Cycle Data Analysis 143

Summary 144

Chapter Five Research Method 146

Introduction 146

Participants 148

Phase one: Talk radio 148

Phase two: Community women's groups and hairdressing salons 148

Phase three: Focus groups 149

Recruitment 149

Phase one: Talk radio 149

Phase two a: Community women's groups. 149

Phase two b: Hairdressing salons 151

Phase 3: Focus groups 152

Ethical Considerations 157

Consent 157

Participant withdrawal 159

Confidentiality 161

Storage, analysis, access and disposal of data 162

Risks 162

Methods of data analysis 163

First cycle data analysis 163

Second cycle data analysis 174

Summary 180

Chapter Six Thematic Findings 181
Introduction 181
Themes of the discourse 185
Biomedical/alternative discourses: 185
Keeping 'healthy': 191
NHS healthcare: 199
Weight management and excess weight: 203
Diasporic influence 205
Experiences of illness 210
Interpretive themes of the discourse 224
Ethnicity 224
Femininity 227
Gender and sexuality 230
Socio-politics 233
Summary 236

Chapter Seven Conducting Community Based Research in Liminal Spaces 237
Introduction 237
Research phase one 239
Talk Radio 239
Research phase two 251
Hairdressing salons 251
Community women's groups 258

Research phase three 263
Focus groups 264
Conclusion 266

Chapter Eight Post Memory and Health in African Caribbean Communities 267
Introduction 267
The importance of culture in alternative discourse 267
Health as remembering: culture, behaviours and preserving the past 271
Conclusion 280

Chapter Nine Rethinking Trust and Healthcare Services 281
Introduction 281
Understanding alternative discourses of health 281
Engaging in healthcare services 283
Wellness versus illness 285
Relationships with healthcare professionals 290
Conclusion 293

Chapter Ten Discussion 294
Introduction 294
Research findings in context 297
Limitations of the study 299
Recommendations 300

Raising the issue in Primary Care 301

Further research 305

Conclusion 306

Appendices 366

Appendix One: Verbal Consent 366

Appendix Two: Participant information 372

Appendix Three: Recruitment material 381

List of Tables

Table one	Literature search key terms and keywords	46
Table two	Clinical databases searched	47
Table three	Social science databases searched	48
Table four	Description of traditional herbal treatments used by African Caribbean people	63
Table five	Description of traditional foods eaten by African Caribbean people	100-101
Table six	Recommendations for the prevention of type 2 diabetes in high risk populations	110
Table seven	Gaps in research evidence	111
Table eight	Recommendations for research based in the gaps in evidence	112
Table nine a	Framework matrix of phase one data collection sites and the themes emerging from first cycle data analysis	165
Table nine b	Framework matrix of phase one data collection sites and the themes emerging from first cycle data analysis, continued	166
Table nine c	Framework matrix of phase two data collection sites and the themes emerging from first cycle data analysis	167
Table nine d	Framework matrix of phase two data collection sites and the themes emerging from first cycle data analysis, continued	168
Table ten a	Themes and codes emerging from the first cycle data analysis	169
Table ten b	Themes and codes emerging from the first cycle data analysis, continued	170
Table ten c	Themes and codes emerging from the first cycle data analysis, continued	171
Table ten d	Themes and codes emerging from the first cycle data analysis, continued	172

Table ten e	Themes and codes emerging from the first cycle data analysis, continued	173
Table eleven a	Themes and codes tables with additional codes emerging from second cycle data analysis	175
Table eleven b	Themes and codes tables with additional codes emerging from second cycle data analysis, continued	176
Table eleven c	Themes and codes tables with additional codes emerging from second cycle data analysis, continued	177
Table eleven d	Themes and codes tables with additional codes emerging from second cycle data analysis, continued	178
Table eleven e	Themes and codes tables with additional codes emerging from second cycle data analysis, continued	179
Table twelve a	Six main themes that construct the discourse of health for African women	182
Table twelve b	Six main themes that construct the discourse of health for African women	183

List of Figures

Figure one	GP Ten Top Tips: raising the topic of weight	21
Figure two	The Big Talk project: research design	130
Figure three	The Voice Newspaper headline	139
Figure four	The Big Talk project: research method	147
Figure five	Focus group slides	154
Figure six	Focus group schedule	155-156
Figure seven	Intersectionality paradigm	184

Introduction

This thesis presents the qualitative research conducted into the study of discourses of health in African Caribbean communities in the United Kingdom (UK). It has a particular focus on women's body shape and size. Rooted in a sociological perspective, the purpose of the study is to gain understanding of how cultural constructions of health and wellbeing within this community may influence relationships with healthcare professionals and responses to public health messages with regard to weight management. The rationale for the direction of study comes from both personal and professional standpoints which have shaped how this project was conceived and conducted.

The National Health Service (NHS) has a central role in history of African Caribbean migration to the UK as a major employer of Caribbean women post World War 2 (Fryer, 1984). Thus, the NHS has a particularly close relationship with this ethnic group, a legacy that continues in to the present (Kramer and Bernard, 2006). As a second generation, African Caribbean woman, born in the UK to a Jamaican father and Bajan mother, I know many women who have worked, are working for or are training to work as healthcare professionals in the NHS in a range of roles. In my own family, both my Mother and Grandmother were both healthcare professionals and it is a career that I too considered. My interest in health research care comes from observing that there is a wealth of healthcare professionals in the African Caribbean community, yet we are always hearing news of ill health in the community. Exploring the complexities of health disparities can be difficult enough, but when you can put many names and faces of people in your own neighbourhood to the figures of mortality and morbidity, it is genuinely painful. Such circumstances force you to consider the issues that result in this reality.

This process of humanising the figures relating to health disparities was further developed during two years I spent working a small charity in the West Midlands that offers social and emotional support to people living with or affected by HIV/AIDS. In working closely with service users and their families, this allowed me insight into the lives of those marginalised by society due to their health status. In this work, I developed a deep passion for health related social justice and the need for society to listen to and act upon the voices of those who need support.

It is in these perspectives that this PhD is rooted. This investigation seeks to interrogate issues of health disparities by placing the names, faces and voices of affected communities at the centre of the knowledge process. This work seeks to lift the curtain on taken for granted understandings of health that assume that a shared language translates to shared perspectives. Through the aim of developing novel health research methods that reflect the communities concerned, it is anticipated that the often unheard health understandings can be articulated to academia and reflected into practice. I am driven by this possibility and the opportunity that this research gives me to add to the legacy of African Caribbean's women's contribution to developing healthcare services in the UK.

Clarification of the use of terms

It is appreciated that there is much complexity with regard to the terms and labels that are used within health research texts. For the purpose of clarity, terminology that will be used frequently in this research thesis will be outlined.

Biomedical

The terms 'biomedical' and 'biomedicine' will be used in the manner proposed by Keating and Cambrosio (2002) who point to the fact that 'recent work in the history and sociology of biomedicine has emphasized the *novelty* of the biomedical enterprise as a distinctive institutional, material, and epistemological configuration [which has] witnessed a realignment of the modalities and conventions linking the normal to the pathological. Biology and medicine are now such tightly intertwined research enterprises' (Keating and Cambrosio, 2002, p. 300). As such, the prefix of *bio* before medicine refers to the 'transformation of both the human and nonhuman made possible by such technoscientific innovations such as molecular biology, biotechnologies, genomization, transplant medicine and new medical technologies' (Clarke at al, 2003, p. 169).

Ethnicity

When denoting ethnicity, this work will refer to the glossary of terms and principles outlined by Bhopal (2004) and Agyemang et al (2005). The term 'Black' will refer to people of African ancestry; 'White' will refer to people of European descent. Use of the term Black is important for this discussion as it is

drawing on discourse and experiences of people of African descent in the West. Understanding Black populations in the West cannot be done in isolation as they must be rooted in an exploration of the Black Atlantic (Walvin, 2000a). As such, the wealth of African American research conducted with Black communities will be referenced, seeking to give context to Black British experiences that may be shared with others of the African diaspora in the West. In this research, the concept of ethnicity is understood as a multi-faceted, fluid quality referring to 'the group to which people belong, and/or are perceived to belong, as a result of certain shared characteristics, including geographical and ancestral origins, but particularly cultural traditions and languages' (Bhopal, 2004, p. 441). Ethnicity will be denoted conventionally i.e. African American, White British. The term African Caribbean is used to refer to Black British citizens with Caribbean heritage.

Discourse

Definition of the term discourse as offered by Oxford Dictionary denotes that as a noun, discourse refers to 'written or spoken communication' and; as a verb means to 'speak or write authoritatively on a topic or subject' (Oxford English Dictionary, 2016). However, for the purpose of this investigation, the use term 'discourse' is used in an analytical Foucauldian sense rather than in a linguistic sense.

Foucault uses discourse as a term to describe 'the general domain of all statements, and sometimes as an individualized group of statements, and sometimes as a regulated practice that accounts for a number of statements' (Foucault, 1972, p. 80). Foucault also uses the term discourse to describe the 'regulated practices that account for a number of statements (Foucault, 1972, p. 80)' which constitute

the unwritten rules and norms that certain statements produce and maintain knowledge and understandings as regimes of truth:

‘Each society has its regime of truth, its “general politics” of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true’ (Foucault, 1980, p. 131).

In his work on the relationship between power and knowledge, Foucault (1980) explains that societal structures enable discourses which reflect a particular ideology to become dominant, which in turn shapes what becomes accepted as common-sense epistemology by society. As a result, alternative discourses become marginalised and discredited. However, the relationship between the dominant and subordinate discourses is not static, and it is suggested that:

> Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowances for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it (Foucault, 1978/ 1981, pp. 100-101).

This quote suggests that while discourse can exist as a means of oppression, it can also be a site of resistance. Therefore discourse must be understood as more than just the translation of reality into language but the scaffolding which structures perceptions of reality. From this position, analysis of discourse is not a quest for truth, rather it is an exploration of how knowledge that may be accepted as correct or rejected as false are part of wider social, political and economic ideologies that intersect with in society, i.e. geography, race, ethnicity, gender, sexuality, class and so on. In fact, Foucault suggests that alternative views that question the power of the biomedical view of health are inevitable as the power to define knowledge about the body and health is not absolute and that 'in power relations there is necessarily the possibility of resistance because if there were no possibility of resistance [...], there would be no power relations at all' (Foucault, 1984/1997, p. 292). Thus, Foucault calls for attention to be paid to the 'microphysics of power' (Foucault and Sheridan, 1977): 'the dispersal of power throughout the cracks and crevices of the social system; the omnipresence of resistance at every site; and the propagation of knowledge, practices, meanings, and identities out of the deployment of power' (Epstein, 1996, p. 4).

It is important to note that taking this position is not to propose an idealistic view that privileges resistance and subjugated knowledge. Rather, this positioning of discourse allows for the space to interrogate articulations of understanding from above and below as ontologies that exist symbiotically within the contestation of power/ knowledge. This contestation manifests as 'reverse discourse' (Foucault, 1978/ 1981, p. 101) which offers alternative interpretations of expert, top down knowledge to shape alternative discourses within society.

In applying understanding of reverse discourse to understanding of health, hooks (1992) suggests that the existence of alternative perspectives of the 'healthy' body seek to empower the individual and inform an 'oppositional gaze'. This resistance to the authority of the medical gaze to define 'health' relates to the agency that individuals possess over their own bodies and the meanings that they may ascribe to it.

Discursive Construction

In further exploring the reality of discourse and how it frames understanding especially in contemporary diverse Western societies, it is important to acknowledge that it is often not a singular discourse that underpins understanding. Rather, it is a myriad of discourses that merge and intertwine to produce knowledge and concepts of truth that in turn influence cultural practices and behaviours. This process of building perspectives from wide ranging sources is termed discursive construction (Jette and Rail, 2014). As a theoretical approach from feminist post structural thought, discursive construction posits that constructed reality through socio-cultural discourse which reflects social power relations is not static. Rather it is shifting and adaptable and can be transformed through individual agency to negotiate or resist dominant discourses (Jette and Rail, 2014). From this perspective, rather than being an antagonistic relationship between dominant and alternative discourses, there is a more fluid and nuanced reality which shapes the lived experience.

As such, this research study that seeks to explore how discursive construction may influence understandings of health, must be rooted in the understandings of subjective, contextual, individual or group contexts. It is important that the research methodology, design and analysis accommodate this dynamic so that the elements influencing discourse can be identified and explored. Woolhouse et al (2012) suggest the following components are essential for understanding the discursive construction of any given knowledge. The first component is discursive resources which refer to the different sources of knowledge that individuals are able to drawn upon. The second component is referred to as discursive strategies, which point to which understandings are drawn upon in different situations. Third, discursive patterns describe the regularity of where, when and with whom certain knowledges are drawn upon.

Understanding discourse and discursive construction for health research

When conducting research that explores how issues of health, wellness and the body are perceived and how these perceptions may influence health behaviours and responses to health promotion material, understanding the role of discourse and discursive construction is important for a number of reasons. Firstly, through acknowledging and having some understanding of how knowledge is constructed and maintained within communities gives insight into health practices which may or may not reflect guidance offered by healthcare professionals and health promotion initiatives organisations. Second, understanding that the knowledge process is contextual and fluid depending on a range of factors, taken for granted assumptions of individuals and communities are encouraged to be questioned. Third, the importance of qualitative research within health studies is exemplified whereby non tangible elements

of understanding, that may not appear important to some, can be identified as pivotal points to improve healthcare and health outcomes.

Due to the significant shift in the way that ill health is experienced in developed countries, from infectious acute illness to chronic illness, there has been a change in the way that medical sociology attempts to understand how health is encountered by individuals, both lay and professional (Thomas, 2012). In moving from a Parsonian perspective, that purports ill health as from of social deviance and healthcare professionals as representatives of social control (Parsons, 1951), contemporary healthcare must concern itself with understanding how society conceives health and the ways that this may influence lifestyle choices. Such a shift is reflected in the models of consultation that General Practitioners (GPs) are encouraged to consider when working with patients to develop an effective consultation style. Approaches that place 'doctor-centred and 'patient-centred' approaches on an axis with 'task' and 'behaviour' orientated models enable the consultation to be tailored to meet the needs of individual patients, having the potential to be more effective than a single approach for consulting which may allow for improved relationships with patients (Neighbour, 2005).

Further, it is during consultation where the relationship between dominant and alternative discourses of health is of especial importance where both forms of knowledge meet and converse in both tangible and non-tangible form. As suggested by C. W Mills (1959), the sociological imagination is the lens through which personal and social issues can be understood as related and 'while 'medical encounters that involve "micro-level" interactions between individuals, these interpersonal processes occur in the

context shaped by "macro-level" structures in society' (Waitzkin, 1989, p. 220). This dynamic is of particular importance when considering that African Caribbean communities experience poorer health outcomes of chronic obesity related illness than the general population (Smith et al, 2000). Research must explore and explain how both dominant and subjugated knowledges influence and shape health realities of African Caribbean communities,

Discursive construction and African Caribbean women

For this research, the concept of discursive construction is a useful one due to the intersectional nature of the experiences of African Caribbean women in the UK. Understandings which emerge from biomedical, mainstream and wider socio-political discourses are interlinked with knowledges that come from historical, geographical, cultural, racial and ethnic, gender and class perspectives that make understanding the mechanisms of health perspectives and behaviours a complex process, but one that can be explored through this lens.

Research aims and objectives

This research is primarily concerned with discursive analysis of understandings of health in African Caribbean communities and developing a research method that encourages the participation of the target group, enabling for rich data to be gathered.

I. To set out the strands of understanding that contribute to the discursive construction of health and wellness with regard to body shape and size in African Caribbean communities.

This will be achieved through a process of data collection and analysis conducted over two distinct data analysis phases.

II. To develop a research method that engages with target participants and elicits in-depth and meaningful discussion about the research topic.

This will be achieved through the design and implementation of a novel qualitative community research method. Although rooted in medical sociology, the method will be informed through a multi-disciplinary approach.

III. To embed within research practice a way in which data collected can enable the finely grained intricacies of understandings to surface.

The research method is to be facilitated over a number of data collection and data analysis phases. The final data collection phase will be focus groups which will add further insight when drawing final

conclusions from the data to address the research questions that may not have been captured elsewhere in the research process.

IV. To show how discursive constructions of health and wellness in African Caribbean communities with regard to body shape and size relate to biomedical and mainstream discourses.

The dynamics of alternative constructions of health and wellness from the African Caribbean community will be explored with regard to interaction with Primary Care healthcare professionals and public health messages.

V. To make recommendations for research practice and further investigation in this particular field of research study.

The recommendations from this study will be presented in ways that will give direction for research practice and further investigation involving the development and evaluation of culturally appropriate weight management intervention.

Thesis structure

This qualitative study is concerned with lifting the curtain on subjugated health discourses that are not widely known outside of African Caribbean communities. This thesis is presented in a manner that offers a coherent and rigorous telling of the theoretical foundations of the study; processes of conducting novel health research; its findings and recommendations. The thesis is structured over ten subsequent chapters. Chapter one presents the background to the study. Chapters two to five present the theoretical scaffolding and practical basis to the study and how they proceeded to shape the dynamics of investigation. Chapter five presents the thematic findings from the study. Chapters six to nine offer a critical discussion of the method and the findings of this study and in these chapters, particularly insightful participant quotes are included, often at full length, so that depth and clarity can be conveyed. The final chapter offers recommendations based on the work undertaken. A brief synopsises of each chapter is given below.

Chapter one: Background

This introductory chapter offers a broad context to the study presented in the thesis. It details current issues with regard to levels of excess weight and the complexities of addressing increasing rates of obesity related chronic illnesses.

Chapter two: Literature review

This literature review chapter presents and critically engages with existing research evidence to identity what is already known in the area of study and informs the direction of this study. Literature from

biomedical and social sciences sources is examined in the context of understanding health for African Caribbean communities in the UK.

Chapter three: Methodological approach

This chapter sets out the theoretical direction that the data collection and analysis will follow. The multidisciplinary approach to developing the methodology allows for the construction of a novel method that will encourage participation and elicit in depth responses from African Caribbean women.

Chapter four: Research design

The application of theory into practice is explored in this chapter, giving detail of how Black feminist thought can be articulated in applied health research to engage with African Caribbean women.

Chapter five: Research method

The process of conducting the research across the three data collection phases and two data analysis cycles is presented in detail in this chapter. Research phases one and two were conducted in African Caribbean community locations using talk radio, hairdressing salons and community groups. Research phase three employed the use of focus groups facilitated in community venues familiar to local African Caribbean communities. Issues pertaining to the practical implications of this investigation and the ethical considerations of this research are discussed.

Chapter six: Thematic findings

This chapter presents the themes that emerged through the data analysis process. Each theme is outlined and illuminated with participant quotes.

Chapter seven: Conducting community based research in liminal spaces

This chapter gives an evaluation of the novel method that was developed and applied in this research investigation.

Chapter eight: Post memory and health in African Caribbean communities

The theoretical concept of post memory is used in this chapter to gain insight into the data gathered. This perspective enables the importance of alternative discourses of health for African Caribbean communities to be located within cultural and historical contexts.

Chapter nine: Rethinking trust and healthcare services

This chapter details how discourses of health that may be held by African Caribbean women can shape trust relationships with healthcare professionals and public health messages, with regard to improving health outcomes.

Chapter ten: Discussion

This concluding chapter reviews what has been undertaken as part of this investigation, establishing how the findings are relevant to the aims and objectives of the research. The ways in which the issues raised in this research relate to health policy are offered and relevance to the clinical context and research development is given.

Chapter One

Research Background

Introduction

This first chapter will outline the broad context for the thesis, offering direction as to the rationale and relevance of the study. It will focus on perspectives of health about weight and weight management for African Caribbean women and; how this may shape discussions with healthcare professionals in NHS Primary Care. The chapter starts by giving insight into the importance of studying health interaction in the GP surgery setting due to the role that this space occupies and represents within healthcare. It then moves on to introduce the complexity of raising the issue of weight and weight management with patients in this setting due to social frames of understanding that give meaning to particular body shapes and sizes. The importance of such conversations is then explored within the wider context of evolving understandings of health and wellbeing and society. The chapter then details into how understandings of health and wellbeing regarding obesity are framed within biomedical discursive constructions. The chapter then outlines how health policy and practice are influenced by biomedical discourse and the tensions and contradictions that subsequently arise when such positions are located within social contexts within mainstream discourses of health.

This will be followed by the context of researching health with African Caribbean communities through discussion of central concepts for this investigation: seldom heard groups; cultural

understandings of health and the body and; researcher reflexivity. The final section of this background chapter then presents the research questions, aims and objectives.

The surgery space as a social space

GP surgeries in the UK exist as particularly important and interesting spaces within the NHS and the country more broadly. This unique place within Primary Care gives GP surgeries a multifaceted role with the capability to diagnose, prescribe and refer patients for further care within the NHS. Located in local communities where patients live also enables for GP surgery staff to have real insight into the wider social issues that may influence the health of the local population and give a context to the healthcare strategies that could be implemented to improve their patient outcomes. GP surgeries are also important in preventative healthcare; encouraging patients to adopt lifestyle changes that could reduce rates of morbidity and mortality (Harris, 2008) . The need to reduce incidence of preventable health conditions is a highly charged political issue, very much rooted in the management dynamics of the UK social welfare system of which the NHS is a central element (Peckham et al, 2011).

As such, there an eclectic framework of knowledge that is adopted by healthcare professionals working within Primary Care that straddles biomedical understandings and professional guidelines; wider social perspectives of health; the varying dynamics of difference between patients and; the political thrusts that shape the delivery of healthcare (Fisher and Owen, 2008). It is this exceptional circumstance within Primary Care that leads to the acknowledgement that ‘among inter-personal relationships, the doctor-patient relation is one of the most complex’ (Ong et al, 1995, p. 903). An exemplar of this multi-layered reality to delivering effective healthcare to ethnically diverse patient groups in Primary Care is

about the prevention of obesity related chronic health conditions and how this shapes interaction between patient and professional in the clinic.

Raising the issue of weight management in the clinic

In attempt to curb the increase in chronic illnesses partly attributed to lifestyle, the NHS has proposed guidelines that call on healthcare professionals to 'make every contact count':

> use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, in particular targeting the four main lifestyle risk factors: diet, physical activity, alcohol and tobacco – whatever their specialty or the purpose of the contact (Soni and Bailey, 2012, p. 11).

The basis of this initiative is to use each available opportunity to initiate discussion about health with patients regardless of point of contact e.g. at a GP surgery; dental practice; or podiatrist surgery. The need for effective discussion between healthcare professional and patient is heightened in Primary Care for the prevention and management of chronic illness. A central element of facilitating good discussion with patients that will encourage them to act upon advice given is the ability for the healthcare professional to foster a positive relationship with patients: 'medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-physician relationship' (Jones and Newburn, 2001, p. 18). In his book entitled 'The Inner Consultation: how to develop an effective and intuitive consulting style', Neighbour (2002) suggests that subtlety is the extra

quality of practice to make a general practice consultation skilful rather than adequate for exploring potentially sensitive topics with patients. However, the clinic does not exist in a vacuum and societal discourses of health that circulate outside of the consultation do influence the manner in which the consultation is conducted. It is acknowledged that the medical encounter is 'a microcosm for the complex division of labour [between the patient and healthcare professional] and its interactional consequences in modern society' (Atkinson, 1995, p. 31).

While topic guidance for discussing weight management is based on biomedical evidence (Edge and MacKian, 2010), in practice the matter exploring health issues with patients is 'emotionally laden and, requires close co-operation' (Ong et al., 1995: 903). This is especially pronounced when a discussion of excess weight can also be construed as a judgment of individual morality and self-worth due to the unfavourable imagery ascribed to the larger body by mainstream discourse. The negative stereotypes that pervade society have been found to influence views of overweight and obese patients held by some healthcare professionals (Foster et al., 2003; Malterud and Ulriksen, 2011; Teachman and Brownell, 2001).

Research finds that GPs and practice nurses are genuinely apprehensive about introducing and discussing weight management with patients who are overweight or obese (Blackburn et al, 2015; Michie, 2007; Mold and Forbes, 2011). Pryke et al (2015) discuss the complexities of initiating such discussions for GPs. This research cites that fears of causing upset to the patient are also accompanied by concerns that such a topic could result in lengthy discussion about diet but with no confidence that there will be any behaviour change. Uncertainty about the value of such conversations and the limited success of GP lead weight management support (Jebb et al., 2011; Jolly et al., 2011) contribute to such

apprehension. Such are these issues for GPs and other Primary Care healthcare professionals and an observed dearth in training on this topic, the Royal College of GPs Nutrition Group has developed a range of tools that can be used to support GPs to raise the issue. One such resource being a leaflet titled 'GP Ten Top Tips: Raising the topic of weight' (RCGP, 2015); see figure one.

Figure one: GP Top Ten Tips

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Safe phrases for raising the subject of weight in a consultation

How do you feel about your weight?

Do you keep an eye on your weight?

We know weight can affect the safety of doing an operation - has anyone talked to you about this?

When did you last weigh yourself?

Has your weight changed much over the past few years?

Dr Rachel Pryke, RCGP Clinical Champion for Nutruition for Health

For further information about the RCGP clinical priority programme, please visit: www.rcgp.org.uk/clinical-and-research/clinical-priorities.aspx or alternatively, contact the CIRC team at circ@rcgp.org.uk

Royal College of General Practitioners

GP Ten Top Tips:

Raising the Topic of Weight

Safe ways to introduce weight into a consultation without causing upset

RCGP 60 YEARS

The Opener

1. Always consider whether your patient's weight may be relevant both to future health and to the presenting complaint, and if he/she would benefit from active management. (1)
2. Start with asking "How do you feel about your weight?", or " Do you keep an eye on your weight?". This avoids casting a judgement and gives the patient the opportunity to join the conversation if they wish without being defensive. You might be surprised that the patient has already lost some weight - if so, give encouragement. Follow this with "Is it something you would like to discuss further or get some (more) support with?" (2)
3. Acknowledge the difficulties in changing weight. Explore what steps the patient may have tried already. What helped? What didn't? Emphasise the benefits of long term lifestyle improvement over short term 'dieting'. Physical activity will help weight maintenance but weight loss will require dietary management too. (3)
4. Check whether weight management is a priority for the patient right now. Would they gain more health benefit from stopping smoking perhaps? Should any mental health aspects be addressed first?

Putting weight into context

5. What goal is the patient heading towards? "What are you hoping to achieve?" Distinguish between health aspects and cosmetic concerns. Reign in unrealistic weight loss targets, particularly if there has been a pattern of yo-yo dieting. Reinforce the health benefits of relatively small amounts of weight loss.
6. For patients that are not ready to aim for weight reduction explain that taking active steps to avoid further weight gain is a worthwhile goal in itself. Regulary weighing helps with keeping weight stable. (4)
7. Broaden awareness of the wide variety of health gains from improving lifestyle. Avoid focusing solely on BMI change. Improving fitness and dietary quality is valuable even if weight does not change significantly. (5) Explore the current barriers that stop the patient being more active.

Signpost patients to further support

8. Consider the effect of changed eating and activity patterns on other family members, especially children. Maternal dieting can have a negative effect on daughters. Encourage long-term healthly lifestyle changes that apply to all the family.
9. Refer non-complex patients to a local community-based weight-management service, as their first option, (6, 7, 8), using Public Health funding mechanisms if available. Signpost patients to reliable, evidence-based resources for general nutritional information, such as NHS Choices website, British Heart Foundation and World Cancer Research Fund leaflets. Refer complex patients via local bariatric pathway.
10. Consider screening for eating disorder if you suspect underlying psychological problems relating to body image or eating behaviours. "Have you felt that your weight or eating has dominated your life?" (9) Offer to listen and consider psychological support/referral if deeper issues emerge.

- NHS Choices website www.nhs.uk/LiveWell/loseweight/Pages/Loseweighthome.aspx
- British Heart Foundation www.bhf.org.uk/heart-health/prevention/healthy-eating.aspx
- World Cancer Research Fund leaflets www.wcrf-uk.org/

Further complexities arise when working with patients from diverse communities, where it is important for healthcare professionals to have an appreciation of alternative discourses of health that may complement or contradict biomedical and mainstream understanding. For instance, for African Caribbean women issues relating to health, body shape and size are bound in the intersections of race, ethnicity and gender, which may be underpinned by the histories of the African diaspora and shaped by contemporary social conditions. Indeed, to 'make every contact count', healthcare professionals need an understanding of the explanatory model of health their patients refer to in understanding their health status (Kleinman, 1988) and the health belief that they may hold (Becker and Maiman, 1975). Gaps in understandings between patients and healthcare professionals, mediated and shaped by societal discourse, mean that new paradigms of practice are needed to effectively address weight management issues in the clinic successfully.

Often as the first contact that a patient has with the NHS, Primary Care healthcare professionals have distinct opportunities to weigh 'economy of performance' consisting of public policy and management requirements with 'ecologies of practice', consisting of knowledge and understandings that are derived from personal understandings and experience (Fisher and Owen, 2008) for the benefit of patients and health outcomes. In addition to the guidance provided by RCGPs, healthcare professionals should be encouraged to actively engage in a process of reflection, broadly understood as a process which questions the epistemology of the healthcare professional and how this knowledge serves the patient, practitioner and society (Kinsella, 2010). Part of such reflection is to engage with the varying frames of understanding that 'diagnose, evaluate and prescribe' (Entman, 1993, p. 52) courses of action for improving health; some of which may confer or contradict information. The inter relationship between biomedical, mainstream and cultural perspectives of weight and health shape the narratives ascribed to

the large body which become embedded as taken for granted knowledge within communities (Atanasova and Koteyko, 2016). It is essential to explore these frameworks as they relate to obesity for the direction of this research and the lens through which issues of overweight and obesity are understood.

The weighty issue

In the UK, as in much of the developed world, the rates of excess body weight among its population continue to increase. Statistics indicate that 24% of the population is obese and 36% are overweight. When exploring gender, trends show that men are more likely to be overweight, but women are more likely to be obese. When accounting for race, Black adults are more likely to be obese that any other ethnic group (Baker and Bate, 2015). Regarding ethnicity and gender, the prevalence of excess weight among African Caribbean women is 65% compared to 58% of White British women (Gatineau and Mathrani, 2011). The outcome of steady yearly increase in the number of those categorised as having an unhealthy weight can be understood in relation to the increase in obesity related chronic illnesses such as type 2 diabetes, hypertension and stroke. For instance, between 2012 and 2013, the number of people diagnosed with type 2 diabetes rose by 137,000 to a total of 2.7 million people, 6% of the total UK population (Gatineau and Mathrani, 2011). For those of minority ethnic backgrounds, such figures are especially stark given the increased susceptibility to developing obesity related chronic health conditions (Forouhi et al., 2006; Tillin et al., 2013) and reports that people of minority ethnic backgrounds experience worse health outcomes than the general population post diagnosis of conditions such as type 2 diabetes (Smith et al, 2000). Thus need to explore ways to support weight

management for African Caribbean women to reduce the likelihood of developing obesity related chronic illness is of especial importance.

Obesity as defined by the World Health Organisation is the 'abnormal or excessive fat accumulation that may impair health' (World Health Organisation, 2013). Biomedical understandings of excess weight hold that for the most part, overweight and obesity are the result of total energy into the body (food and drink), exceeding total energy expenditure, resulting in unused energy to be stored as fat in the body (Royal College of Physicians, 2004). From this standpoint, the remedy for losing weight is then to reduce energy intake and to increase exercise. There is research that looks at the dietary habits and physical activity of African Caribbean communities, that has informed the development of culturally relevant dietary information (Scott and Rajan, 2000a, 200b; Sharma and Cruickshank, 2001). However, this approach to addressing what has been dubbed a 'global obesity pandemic' (Swinburn et al., 2011) has not been wholly successful when considering the continued increase in rates of excess weight and diagnosis of obesity related chronic illnesses, especially in younger people. For instance, African Caribbean girls are more likely to be overweight or obese than their White British counterparts; a situation that has serious implications for future health outcomes (Gatineau and Mathrani, 2011; Saxena et al, 2004). This current situation does show that whilst the medical gaze upon the body which shapes the biomedical gaze is powerful, it is not powerful in isolation. Rather, attention must be paid to the ways that this discourse relates to social mainstream understandings of the body, health and wellness and; relationship to weight to develop successful interventions.

Discursive constructions of health and wellbeing

Whilst it is possible to identify particular discourses and the knowledge that they circulate, it is important to understand how they relate to and exchange with other discourses. Research that seeks to explore the realities of discourse must engage with the various discursive repertoires. This would allow for understanding of how knowledge from different discourses merge and interlink with each other to shape understanding and give meaning to health, wellness and the body in the realities of the social world. Through the theoretical lens of discursive construction, focus is directed upon the ways that individuals and collectives draw upon ranges of knowledge resources to shape and understand their reality, which in turn influences behaviours and interaction. From this view, it becomes possible to identify where and how biomedical discourses cascade into social discourses and become infused with ranges of perspectives to form the basis of 'common sense' everyday epistemologies that shape health beliefs and behaviours. Understanding the dynamics of health perspectives is of especial importance when developing policy and effective health intervention 'at a time when greater conceptual clarity is crucial [as] there are more stakeholders in 'health', each with a potentially different perspective and understanding of what 'health' is' (Cameron et al, 2008, p. 225).

When exploring where biomedical understandings of excess weight and related obesity related health conditions intertwine with social understandings that shape mainstream discourse, we see body shape and size, rather than just weight, becoming markers of health and illness and indicators of risk for developing obesity related health conditions. This social translation also gives meaning to character, attractiveness and desirability of the individual which vary depending on the numerous strands of understanding that are discursively constructed against the backdrop of variables such as gender,

ethnicity, sexuality, class, location, age and so on. As such, whilst there may be a mainstream approach to health and wellness that may define conventional understandings of the body, there also exist other ways of understandings that may complement or contradict biomedical and mainstream approaches. Research findings report that there is a cultural normalising of the larger body within Black communities and that Black women are more likely to connect health with a larger body shape and size than White women (Shoneye et al, 2011). Where mainstream discourse socially constructs the overweight individual as immoral and socially deviant for making the 'wrong' choices (Campos, 2004; Gard, 2005; LeBesco, 2011; Meleo-Erwin, 2011; Mold and Forbes, 2011; Rich, 2005), research has found that within Black communities a particular respect is afforded to the lager-bodied Black woman (Gilkes, 2001).

These findings that indicate that Black communities ascribe a different meaning to the larger female body show the importance of acknowledging that there are alternative ways of interpreting the body. Thus, it cannot be assumed that all communities will construct understandings of health and the body in the same way which may have implications for health behaviours; in this case, weight management. In addition to reporting a cultural normalising of the larger female body, Shoneye at al (2011) also found that African Caribbean women are less likely that their White British counterparts to be engaged in any form of weight management programme and the authors suggests that a one size fits all approach to addressing weight management in diverse communities will be limited in its success.

The changing face of illness in the 21st century

In the high income nations of the world, the last century has witnessed a marked shift in the nature of illnesses that affect populations that reside there. Due to robust immunisation programmes, improved social conditions and access to medical care, the ways in which illness is understood and experienced in the global north has been redefined (Lopez et al, 2006). However, in place of illnesses that have a sudden onset and short intense duration, they have been replaced with health conditions that develop slowly over a longer period of time during the life course. The rise of chronic illnesses, particularly those that had previously been associated with old age, have been attributed to changes in human lifestyle such as food choices and activity levels (Yach et al, 2004). Thus, illness has 'became conceptualised in the twentieth century as a social no less than a biological phenomenon to be understood statistically, psychology –and politically' (Porter, 2002, p. 158).

The rising trend of overweight and obesity has been identified as one of the driving factors for this fundamental societal change in health of populations and is often referred to as a 'global pandemic'. (Swinburn et al., 2011). As such, local approaches that seek to address issues of excess weight locally, must be understand the global nature of this circumstance. The framing of obesity as a pandemic is an interesting one. This term has traditionally referred to infectious diseases of previous eras such as smallpox and implies that obesity develops, but is curable and can be stopped. The dilemma for public health bodies worldwide is that unlike infectious diseases like tuberculosis and preventable illnesses linked to lifestyle such as lung cancer and tobacco use, investment into challenging obesity has not stalled the rising trend making this truly a pandemic of the 21st century.

The socio-economic politics of health regarding obesity has also changed in recent decades. During previous times in the West, excess weight was associated with wealth and was a signifier of abundance and was celebrated as a symbol of personal wealth (Gilman, 2008). Yet, investigation into overweight and obesity indicates that excess weight has indeed 'spread' to those lower in the socioeconomics strata and this is reflected globally, nationally and locally where deprivation is an environmental factor in overweight and obesity. From a global perspective, Mexico has recently overtaken the United States (US) as the world's most obese nation where 32.8% of the population are defined as obese yet 46.2% of the population live in poverty (Food and Agriculture Organization of the United Nations, 2013). In the UK, research has found correlations between rates of obesity in children and socioeconomic position at both regional and household levels; the lower the socioeconomic position, there is an increased likelihood of excess body weight (El-Sayed et al, 2011). Focusing on Birmingham, the city where this project is based, the Ladywood constituency serves as an illustrative example. In this particular area, the levels of deprivation are found to be disproportionally high in comparison to the rest of the country. In this area of the city, 'over half the population lives in the 5% most deprived neighbourhoods in England [and] the entire constituency population lives in the 40% most deprived areas of the country' (Economic Research and Policy Economy Directorate, 2015). It is also found that in Ladywood there are higher than average levels of overweight and obesity in this area with research finding that 23.9% of primary school year 6 pupils are obese compared to the city average of 22% (Browne, 2012).

In addition to the individual effects of economics and health, there are also consequences for the State. The economic implications of health issues associated with excess weight is calculated that 5-6% of the NHS total budget is spent on treating patients with obesity related illnesses (Department of Health,

2011). Financial modelling has indicated that the treatment of obesity related illnesses was £4.2bn in 2007 and forecast to increase to £9.7bn by 2050 (Morgan and Dent, 2010). Figures also indicate that increases in obesity has had an impact on the economic growth of the UK and to the life chances of individuals; calculations from 2011 suggest that lost earnings related to obesity amount to £2.35bn-£2.6bn a year, including premature mortality and sick leave (Department of Health, 2011).

Whilst the biomedical remedy for reducing excess weight is to make changes to energy intake and expenditure (Royal College of Physicians, 2004), the issues relating to obesity are multifarious. The link between social deprivation and obesity is one element of this complex issue that requires more than a biological perspective to improve health outcomes. It is important to pay attention to the other contributing factors to excess weight and obesity related illnesses such as biology, genetics and social issues.

When surveying excess weight, the differences *between* and *within* populations influences physiological responses to body fat and its storage is a central consideration (Gatineau and Mathrani, 2011).There are documented differences between males and females in how they gain and store fat in the body (Santosa and Jensen, 2008) and the influences these differences have on the development and progression of obesity related chronic illnesses (Power and Schulkin, 2008). A difference in fat accumulation and influence on illness progression is also found between ethnic groups. For instance, South Asian populations are more likely to experience obesity related illnesses at lower Body Mass Index (BMI) than White populations (Raji et al, 2001). Differences within groups refer to the individual genetic differences that influence health outcomes where some may be more predisposed to

the onset of obesity related chronic illness than others; 'all obese people are not made equal' (Reaven, 2005).

To understand and challenge the characteristics of present society that enable this shift in health, the environmental factors that enable obesity must also be explored. The term 'obesogenic' refers to the linked to increased urbanisation and the globalisation of food and food production especially in developed countries. City dwelling is typically associated with lower physical demands than rural living and advancements in technologies encourage less energy exertion in work, transport and entertainment (Chaput et al, 2011). Where sedentary lifestyles are coupled with the consumption of foods that are cheap, energy dense and easily obtained, the outcome confirms the biomedical view (Caballero, 2007). Acknowledgement that levels of excess weight are shaped by 'global drivers and local environments' (Swinburn et al, 2011) enables the multifaceted nature of this issue to be examined with the intention challenging this trend (Gortmaker et al., 2011; K. D. Hall et al., 2011; Swinburn et al., 2011; Wang et al, 2011).

Policy response to obesity

Due to the multifaceted nature of obesity, there is debate regarding where responsibility should be placed for improving population health by reducing obesity levels. In the UK, discussion about who is responsible for addressing obesity is played out in politics, media and the living rooms of people across the country. As such, it then becomes important to explore the complexities when addressing this health issue by focusing on the stakeholders involved, from the national to the individual level and the tensions between them.

In viewing obesity as a policy issue, there are three key reports that have influenced government responses to the challenges posed by excess weight in the UK. In 2001, the 'Tackling Obesity in England' report (Bourn, 2001) was the first document to provide detail of the social and financial implications of the increase in obesity in the UK. Written by the head of the National Audit Office (NAO), the report offered key recommendations for the management of obesity in the NHS and for government initiatives to that seek prevent obesity. The report makes clear that successful intervention must reflect the nature of obesity and be multidimensional in nature:

> a high priority must be given to implementing the nutrition initiatives included in the NHS Plan to improve the balance of the diet; the Department of Health should lead the development of a cross-government strategy, including the Department for Culture, Media and Sport, to promote the health benefits of physical activity (in particular sport and active forms of travel, such as walking and cycling); the Department for Education and Employment should continue to reinforce the importance of physical activity and encourage more physical activity in schools; and there should be strengthened guidance to schools to help them weigh up the advantages and disadvantages of participating in commercial sponsorship schemes that might promote behaviors contrary to key messages on healthy eating (National Audit Office, 2001) .

In 2004, the House of Commons Health Committee published a report that further continued to highlight the increasing levels of obesity. It acknowledged that solutions to this complex issue must be 'designed to bring about long-tern, sustainable change, rather than promising overnight results […] which demands truly joined up policy making' (House of Commons Health Committee, 2004, p. 3) for the prevention and treatment of obesity. The role of food manufacturers was included in this report,

with particular focus on the need for increased control in the advertising of particular foods to children and; to reduce the levels of salt and energy density of food products. The report also highlighted the need to encourage people to become more active in collaboration with the Department of Transport and Department of Education. NHS provision of support for overweight and obese patients was also reviewed and it was found that access to specialist weight management support services was compromised by funding restrictions, a problem felt acutely in Primary Care (House of Commons Health Committee, 2004, p. 3).

The Foresight Report (Butland et al., 2007) examined seven intersecting themes that have directly influenced the health of the population. By identifying biology, environment, physical activity, social influences, individual psychology, food environment and food consumption as related factors, this report highlighted the necessity for any intervention that seeks to address obesity must reflect the complex nature of this health phenomenon.

Published in 2011, the government policy paper 'Healthy Lives, Healthy People: A call to action on obesity in England' (Department of Health, 2011) was based on the findings of the previous reports, with a focus on the Foresight Report. It proposed the need to mobilise new approaches to meet the government targets for 'a sustained downward trend in the level of excess weight in children by 2020 [and]; a sustained downward trend in the level of excess weight averaged across all adults by 2020'(Department of Health, 2011, p. 6). The suggested elements of a successful strategy must empower individuals by placing them at the centre of any approach, through education and information, encouragement and individualised weight management support. Strategy must also encourage partners, such as food and drink companies, to reassess and improve the nutritional value of

their products; support local governments to work with local partners and organisations to provide specific support for local populations and; improve the evidence base of the effectiveness and cost-effectiveness of obesity reduction interventions.

The implementation of this guidance is evident in the development of the national 'Change 4 Life' campaign, whose mantra is 'eat well, move more, live longer' (Department of Health, 2009, p. 1). The presence of this campaign, in its numerous forms, spans mass media and in national and local institutions such as schools, leisure centres and libraries as well as medical spaces such as surgeries and hospitals and supported by the major UK supermarket stores. In fact, the Change 4 Life campaign has been dubbed the 'most ambitious to launch anywhere in the world' (Department of Health, 2009, p. 3) to reduce obesity and cost £1.4 million to launch. To evaluate this innovative campaign, Crocker et al (2012) conducted a cluster randomised trial with parents of primary school aged children. While they found that there was a high awareness of the campaign among participants, they also found that 'there were few positive effects on attitudes or behaviour' (Croker et al., 2012, p. 8) towards lifestyle choices that would reduce excess weight for their families. These disappointing findings reflect the contradictory nature of understanding obesity and the tensions that exist in subsequent attempts to address this issue.

Policy: contradictions and tensions

To increase awareness of the nutritional value of food purchased and consumed, the governmental department, the Food Standards Agency has recently introduced proposals regarding consistent front of package food labelling system. The new labelling details information such as the amount of fat, sugar

and salt and use colour-codes to highlight percentages of daily intake amounts contained within (Department of Health, 2013). Whilst this can be hailed as a positive step forward which encourages individuals to be more aware of the food choices that they make before they buy the produce, at present it is not compulsory. As such, the gains that may be yielded by such a move is compromised by the fact that only 60% of food will be covered by the system and many of the large multi-national companies such as Coca-Cola and Cadbury-Schweppes have declined to take part (Triggle, 2013). Further, the suggestion that a 'fat tax' could be an effective way to address obesity in the UK has also been explored, with proposals that include: taxing food based on its nutritional content, such as high salt or fat or; extending the Value Added Tax (VAT) inclusion brackets to include foods that have high fat content (Leicester and Windmeijer, 2004). As part of the strategy to address childhood obesity, the UK will shortly be introducing a tax on sugary drinks (HM Treasury, 2016); a move hailed by health campaigners but denounced by soft drink manufacturers who refer to the negative economic impact such a strategy would have on other areas of society and forecast negative economic outcomes such as rises in unemployment and food prices (FTFCTT, 2016).

These tensions between improving the health of the nation and satisfying the food and drink industry is a real issue for national and local governments who have to negotiate these competing agendas. In many cases, this tension results in contradictory outcomes and one such example can be identified in Birmingham, regarding local government policy. In the last decade, attempts to increase levels of physical activity in the city, especially in more deprived areas which have higher levels of overweight and obesity have been especially spirited. Since 2009, schemes such as 'Be Active' and 'Exercise on Prescription' have offered communities the opportunity to use gym and pool facilities free of charge. These initiatives currently have approximately 300,000 members from the city, which equates to

around 1 in 3 of the entire city population (Birmingham City Council, 2013). However, such efforts from the council are then juxtaposed with the plethora of fast food takeaway establishments that exist in the city, 'particularly in deprived areas [where there are] nearly four times the number of hot food takeaways than in the more affluent locations' (Ordinance Survey, 2013a).

Interestingly, research conducted by Birmingham Public Health using Ordinance Survey geographic information found that '71% of all primary and secondary schools in the city have a hot-food takeaway such as a kebab shop, fish and chip shop, pizza shop or Chinese takeaway within 400 m; some have as many as 19 within this distance'(Ordinance Survey, 2013b). City planning and licensing regulations that have allowed such food establishments to populate areas close to schools pose a direct challenge to the work undertaken by the Change 4 Life campaign and other health promotion interventions. Addressing childhood obesity and encouraging healthy lifestyle choices is also a responsibility bestowed upon schools; however there is continuing concern about the nutritional value of food available in academy and free schools (Vasagar, 2012) and opportunities to include regular physical activity within the curriculum (OFSTED, 2013). Thus, from this brief exploration into the complexities of health policy and its contradictions with other government dynamics, addressing levels of excess weight is complex.

For policy makers, issues of obesity are made more intricate by some views that understand obesity as a personal rather than a public concern. In neoliberal societies such as the UK, people are encouraged to make their own choices about themselves and their health and; as such the government is cautious of 'accusations of "nanny statism"' (House of Commons Health Committee, 2004, p. 7). In fact, research suggests that people are 'tired of being told what to eat' (Watson and Wyness, 2013, p. 29) and are

sceptical of government and food manufacturer recommendations (O'Key and Hugh-Jones, 2010). Such findings shed light into why levels of obesity continue to increase in the face of huge investment. Although issues of health are of huge political and public interest, for individuals this is a highly personal matter, especially regarding obesity. While individuals and may challenge and/ or resist information from government and food manufacturers, this does not mean that they are immune from societal discourse of obesity and its subsequent social effects.

Modern medicine: contradictions and tensions

The biomedical understanding of obesity: an imbalance of energy intake and energy expenditure, while objective in nature becomes subjective when understood within dominant societal understandings. The objective large body in the biomedical discourse becomes the overweight or obese person within mainstream discourse, based on a stereotypical view views overweight people as lazy and subsequent obesity related health conditions are self-inflicted and that obesity has a selfish impact on society (Puhl and Brownell, 2001). When such views are reported in mass media headlines such as 'Obesity bankrupting the NHS' (Donnelley, 2013), the portrayal of obesity as social deviance becomes embedded in the discourse (Puhl and Brownell, 2001). As a result of this discourse, terms to describe excess weight such as fat, obese and overweight become emotionally loaded with negative social connotations that may upset and offend patients when used in by health professionals (Mold and Forbes, 2011). Such is the powerful influence of social construction of the overweight individual that it can re-define and give meaning to biomedical terms that had traditionally sought to separate the body from the individual. This important shift in dynamic is also evident in close analysis of the Change 4 Life campaign conducted by Piggin and Lee (2011). They observe that the campaign purposely does

not use the term obesity or use any visual imagery of overweight bodies in spite of the focus on obesity in the research, policy and strategy that influenced the campaign (Piggin and Lee, 2011). Interestingly, the role of modern medicine in addressing and treating obesity and related illnesses reflects these contradictions. Where there is an expectation for modern biomedicine to be able to provide 'cures' for the health ailments of society, with regard to obesity this is juxtaposed with notions of personal morality and character and responsibility for one's own health which is reflected in both professional prescribed and consumer medicine

An invasive biomedical intervention to address obesity is bariatric surgery, the generic term to describe weight loss surgery which has been shown to be an effective way of reducing body weight and related health risks. The level of NHS commissioned bariatric surgery continues to rise: 'between 2000/01 and 2005/06 there was a year on year increase in the number of hospital episodes involving bariatric surgery, from 261 to 1,038. In 2011-12 this had risen to 8,794 hospital episodes, with women accounting for the majority of these' (Gatineau et al., 2014, pp. 24-25). It has also been observed that there is an increasing number of young people having such surgery, as a preventative measure to reduce the likelihood of continuing to be overweight into adulthood and developing obesity related chronic illnesses (Health and Social Care Information Centre, 2014). Updated National Institute for Health and Care Excellence (NICE) guidelines for weight loss surgery outline that obese patients recently diagnosed with type 2 diabetes should be assessed and considered for such surgery which it is suggested will make future savings for the health service (NICE, 2014).

However, against the successes of such treatment there exists an alternative social perspective that questions the allocation of NHS resources to such interventions that have an estimated cost of £85

million per year (NHS Choices, 2012). Tabloid newspaper headlines that scream 'TWO MILLION *(sic)* obese brits to receive gastric bands' (Gregory, 2014) and go on to outline the costs of such treatments and the implications of obesity and related health conditions for the cash strapped NHS. Such views embedded within the same societal discourse that constructs the overweight individual as the failed citizen. With regard to obesity, biomedicine is then excused from having to provide the cure for this health condition and onus is placed on personal accountability.

The realities of such contradictory and contentious positions to addressing excess weight and obesity are indicative of the varied way that understandings of health and the body are not separate from wider societal values and expectations as well as biomedical understandings and political perspectives.

The research context

Whilst there have been significant established African Caribbean communities in the UK post World War 2, there are gaps in knowledge about how health and wellness are constructed in this community and this has been attributed to underrepresentation of these groups as participants in health research investigations (Redwood and Gill, 2013). Often referred to as a 'hard to reach' population group, along with other minority ethnic groups (Bonevski et al, 2013; Shaghaghi et al, 2011), this label implies that the onus is on the marginalised community to engage with research and implicitly negates responsibility from the research community to develop research methods that encourage participation. Rather, this research takes the position that seldom heard is a more apt way of understanding underrepresentation in health research. It posits that it is the task of researchers to develop methods of enquiry that are sensitive to the cultural dynamics and knowledge creation and validation processes of

participant communities. In taking such an approach, it would seek encourage participation and yield in depth data that may push the boundaries of conventional qualitative research practice. As an African Caribbean woman conducting this research, it is important to reflect upon myself with regard to the communities and people involved in this investigation and how this has shaped the rationale for and direction of this study. The process of exploring researcher positionality from a first person perspective allows for the voice of researcher subjectivity to be earnestly acknowledged (Milner, 2007). For many, myself included, there is a strong familial history of women working in the NHS and a strong sense of affiliation and pride to this important institution and the work it does for the population of the UK. Yet at the same time, such feelings exist against the realities of continued health inequalities for African Caribbean communities and the continued battle against institutional racism that has shaped the lives of many African Caribbean NHS employees and patients. This makes any research that seeks to explore relationships between African Caribbean communities and healthcare systems a task that requires a good knowledge of the backgrounds from which knowledges emerge and the contexts in which they are situated which can often evoke very personal and sensitive responses which may not have been expected by a researcher who does not appreciate or expect this.

While statistics illustrate the disproportionate rates of type 2 diabetes, hypertension and stroke in African Caribbean communities (Laird et al, 2007), the lived realities of this disparity gives names and faces to the figures; family, friends, neighbours. Thus, where there may be issues concerning relations with healthcare services and underrepresentation in research, this should never be understood as apathy from the African Caribbean community, or indeed any other minority ethnic group. Such a position would be to assume that people do not want better outcomes for themselves, their families and communities which would be unfair and untrue. Rather, the approach taken by researchers, irrespective

of ethnicity, gender, sexuality and so forth, should be one that seeks to give voice to communities using whichever method best suits the communities rather than the researcher.

With regard to the focus of the research investigation around body shape and body size, as an African Caribbean woman, the suggestion that there is a cultural normalising of the larger Black female body (Baptiste-Roberts et al, 2006; Gilliard et al, 2007; Schuler et al, 2008) is of no surprise to me, However, it is important to explore this cultural normalising from an from a perspective that considers how this Black woman's body aesthetic becomes culturally removed from discussions of health and wellness.

This background chapter has presented examples which illustrate the tensions between biomedical and mainstream discourses that may shape perceptions of health, wellness and the body and how they may influence the ways in which health messages are pitched to patients and the wider population. Whilst understandings of mainstream discourse are extremely useful in developing mainstream services to address issues relating to excess weight, when developing targeted intervention it is essential to understand that such perspectives may not reflect the dynamics of alternative discursive constructions of health, wellness and the body held by different groups in society. Having an understanding of nuances in perspectives of health would be central in developing effective interventions and it is important for research, such as this, to develop such knowledge that enhances and pushes boundaries of understanding for improved health outcomes for communities. As such, the research questions to be addressed by this investigation are:

What are the discursive constructions of health, wellness and the body that exist for African Caribbean women?

How do these discursive constructions influence the ways in which African Caribbean women relate to healthcare professionals and receive public health promotion messages with regard to body weight and weight management programmes?

Locating research ideas

As previously mentioned, due to the continued increase in overweight and obesity in the UK and globally, it is the role of health research to continue to explore the issues of obesity from alternative perspectives framework with the aim of improving health outcomes for all. It is essential to consider what is it about the current ways of addressing this health issue that are not working? What can be done to develop meaningful ways of exploring weight management and to establish successful interventions to prevent obesity related illness?

As such, this research will be positioned in the *social*. It is not the intention of this research to critique the biomedical discourse of overweight and obesity but rather to critically engage with it. When developing health research to be conducted in complex and diverse societies like the UK, it is important to acknowledge that the differences between and within individuals and groups in society must influence how the investigation is conducted. It cannot be assumed that a 'one size fits all' approach to research would encompass the ranging dynamics present in the population and yield findings that reflect such diversity. It is the aim of this project to focus on one particular ethnic group.

This approach to developing targeted research reflects the government position that ‘each community has different characteristics and what works best for one will not necessarily work well for another’ (Department of Health, 2011, p. 4) The government also affirm that it is vital to develop and support efforts to collate high quality data that can inform the development of appropriate services that are ‘locally tailored […] to meet the needs of their communities’ (Department of Health, 2011, p. 2

Chapter Two

Literature Review

Introduction

This literature review identifies and explores the different strands that make up the discourse. In doing so, will create the contexts for which the research can investigate how these elements of knowledge work together to constitute understandings of health, body shape and body size. In undertaking the task of exploring and explaining discourses of health, this research will take a multi-disciplinary approach which is reflected in the literature presented in this review. Rationale for doing so is that while much dominant biomedical discourse becomes mainstream and validated through Western science, subjugated health knowledge often exists and is affirmed in other academic arenas. Therefore, whilst this research is rooted in Medical Sociology, conducted in a Medical School, it will incorporate perspectives using an interdisciplinary approach.

The search strategy and selection of literature is presented first and grounds the review by offering detail of the criteria and types of information that will be drawn upon in this literature review and where the information was sourced. The review then moves on to present strands of understanding that may influence how health knowledges in African Caribbean communities are constructed.

The first strand explored is the historical discourse of Western understandings of health and how the work of ancient physicians continues to influence modern biomedical practice and mainstream

understandings of health. Such an overview is important to present as it enables an alternative historical discourse of Western medicine based on the experiences of Africans in the diaspora to be placed in context and how such histories continue to shape thought in African Caribbean communities in contemporary UK society.

The complex nature of health inequalities in the UK will then be surveyed as a strand of understanding. Matters relating to different explanations for disparities in health will be discussed and Bourdieu's theory of capital (Bourdieu and Johnson, 1993) will be applied to further understanding. Through this, it will be shown that rather than exist as discrete positions, the different explanations exist in relation to each other.

The third stand of understanding to be presented explores the ever changing connotations of 'fat'. The individualisation of health through a neoliberal ideological lens will be used to understand the basis of stigma faced by those who are overweight and obese (LeBesco, 2011). 'Fat studies', the academic response to the mainstream discourse of the 'war on obesity' will be outlined and alternative responses to the large body formed in Black communities are expressed.

The final strand will examine the research which informs the current approaches of addressing issues of excess weight in African Caribbean communities that largely focusses on food preparation and consumption habits and how dynamics of this approach may shape perspectives of health.

Theoretical ideas presented in this literature review chapter have been developed and published as a journal article in July 2015. The paper, entitled 'Strong, Female and Black: Stereotypes of African

Caribbean women's body shape and their effects on clinical encounters' (Andrews at al, 2015) and was written collaboratively between the researcher and the supervisory team. The article explores how stereotypical images of Black femininity may influence relationships between African Caribbean female patients and GPs in the clinic, with particular focus on discussions of weight management.

Search strategy and selection of literature

Whilst this research is rooted in the social and is founded upon sociological and health and medical sciences literature, this work draws upon understandings developed in other areas of study in an approach that is interdisciplinary. Positions from disciplines such as psychology, anthropology, Black studies, gender studies, cultural studies, postcolonial studies, media studies, and fat studies are used to inform the direction of this investigation through the literature review and the development of the research methodology, method and analysis. It is important to appreciate that 'the aim of the literature search is not to retrieve everything. It is to retrieve everything of *relevance*, while leaving behind the irrelevant' (Petticrew and Roberts, 2006, p. 81). Between disciplines are differences in the approaches that can be taken to achieve this end. Such variances in method to searching for relevant materials from within this range of source types is indicative of the wider tensions that can sometimes exist between traditional approaches to health inquiry conducted within an established medical school and; medical sociological inquiry, which often takes a more nuanced approach to investigation. Due to the nature of this study, effort has been made to satisfy the expectations of each. Table one shows the search terms and keywords that were used to search the literature.

Table one: Literature search key terms and keywords

Text words and keywords	
African Caribbean	Black
Black British	Chronic illness
Ethnic minorit* / minority ethnic	Healthcare Professionals
Hypertension	Inequalit*
National Health Service/ NHS	Obesity
Stroke	Type 2 diabetes
Weight	Weight management
Wellbeing	Women

Within health and medical studies, the expected approach to searching for literature is one that is sensitive, so that important information is not missed. It is specific, so that only literature relevant to specific criteria is returned. It is also systematic, so that the process can be repeated if necessary. As such, when searching research databases, the search strategy involved a combination of text words in the title and abstract and searching keywords that are used to index the literature (Kate Gerrish and Lacey, 2010). From the literature retrieved from the searches, the abstracts were reviewed and those which were relevant were then read and explored in further detail. Tables two and three details the clinical and social science literature databases that were searched:

Table two: Clinical databases searched

Clinical databases searched	
Cochrane Library	research that promotes evidence-based healthcare decision making;
Global health	research focussed on public health investigation and practice;
Google Scholar	broad search of literature;
Pubmed	research related to health, medical and life sciences via MEDLINE and additional journal sources
PyscINFO	research literature in areas of behavioural science and mental health;
Science Direct	access to a range of scientific, technical and medical content and;
Scopus	a broad access to global, interdisciplinary scientific information
Web of Knowledge	a range of medical and social science research

Table three: Social sciences databases searched

Social Science databases searched	
Google Scholar	broad search of literature;
Jstor	contains multidisciplinary research
Science Direct	access to a range of scientific, technical and medical content and;
SocIndex	contains high quality sociology research
Social Science Research network	contains a research from across social science disciplines
Scopus	a broad access to global, interdisciplinary scientific information
Web of Knowledge	a range of medical and social science research

In searching for relevant social science literature, a second process using a more dynamic and iterative process that follows signposts from the literature to build upon the range of sources included. As such, a broader range of relevant multidisciplinary research and theory can be drawn upon as directed to by the literature in more fluid manner. To embed the literature review in relevant policy, searches were also conducted of governmental department websites and signposts were followed from the sourced literature.

Historical discourses of health and health care

In order to place contemporary constructions of health into context, it is legitimate to explore the historical contexts from which they emerge and how the past may influence present discourse. Such consideration also enables understanding of how particular understandings of health became the dominant approach to health and the body and how others became subjugated forms of knowledge. For African Caribbean communities, history as a discursive strand illustrates how the legacies of the past continue to shape cultural health practices in contemporary UK. It shows how historical experiences and culture are infused as a construction for providing understanding and how this may influence health outcomes.

The ancient context

The history of modern Western healthcare in its most recognisable form can be traced back to ancient Greek medical practice, which has been described as providing the 'prototype of modern primary care' (Bynum, 2008, p. 7). Based on Ancient Egyptian thought, the medical practise employed by Ancient Greek physicians was based on the premise that for optimal health, the humours of the human body must be kept balanced. For Hippocrates:

> The bile of a man body has in itself blood, phlegm, yellow bile and black bile. These constitute the nature of his body, and through these he feels pain or enjoys health. Now he is particularly

> healthy when these constituents are in due proportion to one another with regard to blending, power and quantity, and when they are perfectly mixed. Pain is experienced whenever one of these constituents is deficient or in excess or is isolated in the body and is not blended with all the others (Hipprocrates (c.500BC) cited in Torrance, 1998, p. 343)'.

Thus, physicians of the time took the view that humour imbalance and subsequent ill-health was caused by more than just biological factors. For treating patients, they had to concern themselves with how the 'social, economic, and familial circumstances were, how he lived, what he usually ate and drank, whether he travelled or not, whether he was a slave or free, and what his tendencies to disease were' (Bynum, 2008, p. 7). This position of placing the individual and, importantly their circumstances at the centre of healthcare equates that the condition could not be divorced from the patient. This would have been especially important as the nature of illness at this time was acute and it would have been necessary for doctors to glean as much information about the patient as soon as possible as often the window of life and death was very narrow. It may then be possible to claim that this influenced the nature of the doctor-patient relationship as a reciprocal one as both were required to share information with each other with the aim of improving health outcomes quickly.

The personal nature of healthcare in Ancient Greece also lead to what may be referred to in contemporary times as professional codes of conduct and; the Hippocratic Oath where by physicians must pledge to practice medicine honestly. Creating a union between medical knowledge and the experience of ill health was a central tenant to medicine in Ancient Greece to foster trust. Conversely,

the notion of an equal relationship was contradicted in practice. In opposition to the oath that bears his name, Hippocrates encouraged doctors to conceal information about patient's conditions from them and suggested that they should 'promise to cure what is curable and to cure what is incurable' (Hipprocrates (c.500BC) cited in Katz, 1984, p. 6). Also, further historical enquiry into Ancient Greek medical practice does confirm that the individual and the illness are not separated, but in fact are further fused by social stratification. The experience of illness and healthcare by those enslaved or free poor citizens in Ancient Greece was of a different nature. The enslaved were given quick treatment to get them back to work and; the free poor could not be 'trusted' to follow doctor's instructions but should be given an 'emetic or a purge or cautery or the knife' (Hipprocrates (c.500BC) cited in Katz, 1984, p. 4) as soon as possible.

Interestingly, the face of such polarising views of how healthcare and treatment should be offered to different patients in Ancient Greece, an alternative approach to doctor-patient relationships surfaced. This standpoint purported that a communal relationship is not best practice and that ill health can be objectively studied without relation to the individual. Jori (1997) explains how an alternative epistemology of conducting healthcare in the fifth and fourth centuries places all authority with the medical doctor, who with the knowledge of science, does not have to exchange information with the patient but rather conveys instruction. It is this model of the doctor patient relationship that prevailed into modernity and remained a part of Ancient Greek legacy that helped to shape the history and contemporary status of Western medicine. It is this separation of the person from the body that Foucault (1973) refers to as the 'clinical gaze' which enables the classification and treatment of disease from a position of authority. It is this clinical gaze that shapes and maintains the production of

knowledge about the body within biomedical and mainstream societal discourse and marginalises other forms of understanding (Foucault, 1973, 1980).

Historical evidence of medical practise in Europe show that from the Roman period into the Medieval age, understandings of health and illness became infused with the politics of religion and the treatment of ill health also became the treatment of morality (Porter, 2002). Through the Renaissance into the period of enlightenment in the seventeenth and eighteenth century, the emergence of modern medicine as practiced in its current from can be witnessed (Foucault, 1973). This period of modernity, as understood in the sociological sense, was partly characterised by the pursuit of positivist science for technological and medical advance that supposed facts of nature and society should be observable and quantifiable. This perspective reflects the ideology of the time that rejected the superstition, ritual and notions of divinity from a Judeo-Christian religious and affirmed the findings of the emerging fields of science (Hall and Gieben, 1992). It was in the generation of knowledge in exclusionary spaces and institutions such as the Royal Society (established in 1660) and Royal Society of Medicine (established in 1805), were membership was only extended to elite, White , formally educated males meaning that the knowledge produced reflected their epistemologies of health, healthcare and the healthy body. Foucault explains the relationship that exists between those who develop and maintain knowledge production and the power that they exhibit to influence dominant epistemologies of understanding the body (Foucault, 1973, 1980). Thereby, a few define what constitutes health for the many and subjugate knowledge that exists to over alternative perspectives to the dominant framework. The legacy of subjugation of non-Western, non-traditional scientific medical intervention is still evident in contemporary healthcare. Until very recently, the value of treatments such as some homeopathic have

been accepted and used within mainstream medical practice, yet is labelled as 'alternative' or 'complementary' or 'integrative' medicine. In fact, such titles afforded to non-Western medicine 'refer to an extraordinarily diverse set of therapeutic modalities, most of which have little in common other than the fact that they differ from conventional Western biomedicine (Barrett et al, 2003, p. 938)'.

In exploring understandings and experiences of healthcare, it is imperative to investigate the influence of Western biomedicine and its epistemologies on non-European populations. As it exemplified by the example of 'alternative' medicine, there is much diversity in perceptions of and experiences of health and healthcare across populations and communities. Therefore, it is important to interrogate these differences as they may influence healthcare in contemporary UK, especially for Black communities.

The African experience

During the period of Enlightenment in Europe, when positivist science was being used to create and develop biomedical understanding, the same *science* was being used to justify the enslavement, colonial expansion and imperial dominance in the New World. Scientific findings of the time suggested that peoples outside of the *civilised* West were inferior and as such, European thought should be placed at the centre of understanding (Hall and Gieben, 1992). Porter (2002, p. 53) writes that 'the body is pregnant with symbolic meanings, deep, intensely charged' and meaning shaped by racial discourse of the time that equated Black skin of African people to sub-humanity. It is this view that facilitated for the enforced removal and enslavement of Africans to the Caribbean, North and South America for over

four hundred years. Within this same discourse, the Black body also became a site that could be used as medical abuse in the guise of experimentation. This discourse of Black sub-humanity was so embedded and normalised to the point where Washington (2006, p. 73) questions whether 'we can judge eighteen century doctors for experimenting on Blacks?' In her chronological account of the 'dark history of medical experimentation on Black Americans from colonial times to the present', Washington (2006) gives in depth accounts of the biomedical exploitation on unwilling and unwitting participants who were subjected to painful and often prolonged surgical abuse.

The legacy of Dr James Marian Sims (1813-1883) as the 'father of modern gynaecology' is illustrative of the ways that discourse of Western science and understandings of race and ethnicity produced a dualism of experiences of health and healthcare. During the nineteenth century, a common complication of childbirth was vesicovaginal fistula, a condition where a tract develops between the bladder and the vagina that causes continuous leakage (NHS, 2014b). In addition to the medical implications of this condition, there are also effects on the individual's psychological wellbeing. Dr Sims developed and perfected a surgical treatment for this condition which before was untreatable. Revered as a benefactor of women, who established the first women's hospital, Dr Sims carried out excruciatingly painful and humiliating experiments without anesthesia, pain relief or consent on a number of enslaved African women for four years between 1845 and 1849 (Washington, 2006). From his published papers, notes and disclosure to others, it was clear that Dr Sims viewed Black women and their bodies as ideal test subjects that were available in abundance. Much controversy and debate existed and still exists, around the ethics of Dr Sims' use of powerless Black women and girls to use as human guinea pigs to develop a treatment that was not going to be available for Black women who had

no or very limited access to healthcare (Kenny, 2007; Ojanuga, 1993; Spettel and White, 2011; Wall, 2006)[1].

Whilst much of the science from the Enlightenment period that advocated Black inferiority was debunked in the mid to late twentieth century, the ethical abuses of Black communities as part of medical research continued. In most cases, issues relating to consent, or indeed lack of consent and exploitation form the basis of such ethical abuses. The most famous and widely cited abuse is that of the Tuskegee syphilis clinical study, conducted by the US Public Health Service. The study commenced in 1932 and surveyed the natural course of untreated syphilis in 400 untreated Black males. The initial report of the study was published in 1936 with further papers between every four and six years. Those taking part in the study had been told that they were receiving free healthcare. In the early 1950s, when penicillin was routinely prescribed as treatment for syphilis, the men did not receive treatment; rather the US Public Health Service actively sought to prevent treatment. This research was only halted when the ethical abuses were uncovered by investigative journalists in 1972 (Brandt, 1978). Later in 2010, Professor Reverby, a medical historian, unearthed information that indicated that a US researcher who was involved with the Tuskegee study was also involved in a study that deliberately

[1] Similar to nineteenth century society, in contemporary society the majority of women affected by vesicovaginal fistula are those who have limited or no access to healthcare especially pre and postnatal care and live in developing countries such those in Sub-Saharan Africa, South America and Asia (Wall, 2006).

infected 1500 Guatemalan men and women with syphilis and gonorrhea in the late 1940's. An apology was issued to the Government of Guatemala by President Obama in the same year (Smith, 2010).

Similar to the exposure of the Tuskegee study by journalists, is the story of Henrietta Lacks. In 1951, who during the course of unconsented experimental treatment for cancer, had cells removed. These cells were developed in culture and are commonly known as He-La cells and were used in the discovery of many medical breakthroughs in recent history such as the polio vaccine, gene mapping and in vitro fertilisation. The He-La cells have been bought and sold for millions of dollars, yet she and her family received no financial gain and her family continues to live in relative poverty in the US (Skloot, 2010). 'The Immortal Life of Henrietta Lacks' (Skloot, 2010) is soon to be made into a film starring Oprah Winfrey.

The thousands of instances of forced sterilisations of minority ethnic women in the US are also testament of the ethical abuses as medical care that has shaped experiences of health care. The famous civil rights activist, Fannie Lou Hamer (1917- 1977) used the phrase 'Mississippi appendectomy' (Kluchin, 2009, p. 177) in reference to the involuntary sterilisation that she and other poor Black women had experienced when seeking medical assistance for other health matters[2]. In a study entitled 'Sterilized in the name of public health', Stern (2005) explored the history of involuntary sterilisations

[2] Interestingly, the tombstone of Fanny Lou Hamer reads "I'm sick and tired of being sick and tired" (Mills, 2007). Hamer's phrase later became synonymous with the Black Women's health movement (Davis, 1989).

in Los Angeles, US between 1909 and 1979. It was found that approximately 20,000 operations had been conducted in *one* state funded institution without consent from the female patients. It also transpired in the research process that women predominantly abused were African American, Mexican, Puerto Rican and Native American women. The legacies of eugenic thinking are evident in public health literature of the 1950s that refers to forced, compulsory sterilisations as a 'strategy that could breed out the undesirable defects from the populace and fortify the state as a whole' (Stern, 2005, p. 1130)[3].

In light of such instances of abuse of Black communities in the name of health research and healthcare, it is hardly surprising that there is a historical distrust of biomedical health interventions. Washington (2006) explains how during enslavement, the Africans would try to hide signs of ill health of themselves and their children to avoid being 'treated' by a doctor. In his influential social study of the city, 'The Philadelphia Negro', DuBois (1899/1996) focused on the African American population in all areas of life through statistics, interviews and observation and states 'many a Negro would rather die than trust himself to a hospital' (Dubois, 1899/1996, p. 162). A plethora of contemporary research with African American communities finds a continued mistrust of biomedical health care and healthcare professionals. Issues such as the late presentation of symptoms (Kashef, 2001); lack of adherence to medication and advice (Villarosa, 2003); resistance to blood and/or organ donation (Fett, 2002) and;

[3]In 2013, the Israeli health ministry was investigating allegations that Ethiopian immigrant women are unknowingly being given contraceptives that can effect long term fertility (Greenwood, 2013).

screening (Sanchez et al, 2007) have been linked to cynicism of healthcare systems and contribute to the pervading health inequalities faced by these communities.

Of this deeply rooted mistrust of Western biomedicine, healthcare and its subsequent discourses, Washington (2006) explains that there must be a careful approach to understanding this suspicion and that the suggestion that Black communities are *paranoid* suggests that there is a fear of something that is said not to exist. Using language of the originators of Western bio-medicine, she proposes that:

> not only is *paranoid* a misnomer but is also symbolic of a dangerous misunderstanding. That is why I refer to [Black] fears of medical professionals and institutions as iatrophobia, coined from the Greek words *iatros* ("healer") and *phobia* ("fear"). Black iatrophobia is the fear of medicine (Washington, 2006, p. 21).

An alternative discourse of health

Positions presented thus far have referred mainly to the African American experience of healthcare. Thus, it can be questioned as to how far such understandings can be extrapolated to African Caribbean communities in the UK, where the dynamics of ethnicity, society and health diversity differ (Liu et al, 2012). This is a particularly important point as in the UK, the NHS exists as a system that is free at the point of contact to all in comparison to the American system that is based on a paid health insurance accessed care (Braunstein, 2013). Unlike in the US, there are no well-known cases of medical abuse

particularly directed to African Caribbean communities in the UK, yet research conducted in the UK with these communities also finds that issues relating to mistrust of biomedicine impact on health outcomes. Also, investigations into type 2 diabetes management (Brown et al, 2007) and mental health (McCloud and Ebron, 2003) find that wariness of healthcare systems can result in patients seeking support for symptoms late.

Whilst migration to the UK from the Caribbean started post 1945, there has only been a significant African Caribbean population since the 1960s (Fryer, 1984), unlike in the US where the African American community has roots in enslavement for approximately 400 years. Whilst Britain was centrally involved in enslavement, this took place outside of the country, in the Caribbean, North and South America and through colonialism in Africa and there are very few explicit details of medical abuses taking place in British colonies or plantations (Walvin, 2000b) . However, this is not to suggest that they did not happen, rather they were not documented or have been documented and not yet in the public domain[4]. For instance, for many years the British government denied claims of abuse against the Kenyan Mau Mau during the 1950s yet the recent declassification of files show that there was an orchestrated cover up by the British government following a number of massacres against the Mau Mau (Wright, 2011). Although this abuse is not of a biomedical nature, it serves to fuel the distrust and highlight the influence of diaspora in contextualising the experiences of Black communities.

[4] An interesting and important research project could involve collecting the oral health experience histories of African Caribbean elders, documenting youth in the Caribbean, migration and growing older in the UK.

Whilst, it is essential to understand that whilst there may be mistrust in the discourse and practice of biomedicine, this does not mean that Black communities are passive with regard to health care and health practices. Rather there is a strong history of particular understandings of health in Black communities across the diaspora that are rooted in traditional African healthcare. Oral history and document research into the health and healing on plantations in the US and Caribbean find that unlike Western medicine, based on physiology, African-centered healing used by those enslaved involved strong physiological, spiritual and social elements. Understood as a 'relational vision of health' (Fett, 2002, p. 93), this view of health is truly a holistic one that encompassed the whole community and the natural world in which they shared. From this alternative perspective of understanding, emerges an alternative discourse of empowerment though health and health practices which affirms different beliefs about the causes and cures of ill health (Weaver, 2006).

The spiritual component of African-centered discourse of health highlights the importance of appealing to God, moral preparedness and the intercession of ancestors, which explains why death rituals were and continue to be of extreme importance for Black communities. This understanding of the culture also offers explanation of the horror that was experienced when the enslaved realised that Western medicine used dead bodies for dissection and display (Washington, 2006). In contemporary society, this may also go some way to explain why African Caribbean communities in the UK are less likely to donate organs after death (Davis and Randhawa, 2006). Western discourse placed African holistic medicine outside the realm of 'medicine', subjugating and delegitimising its claims to knowledge. Literature of the time decried and ridiculed this alternative view of health as ignorance, old wives tales, superstition and dark force voodoo (Washington, 2006).

However, there can be no domination over scientific knowledge. Within the African tradition of health is an in depth knowledge of herbs, plants and roots and natural elements for healing. In enslaved communities, there would often be a wise men or women, known as herbalists, who held this encyclopedic knowledge and would treat patients and pass knowledge to the next generation. Of the influence of the herbalists on plantations, Washington writes:

> Despite their characterization as primitive, African healers first employed citrus juice for scurvy and inoculation for smallpox and other viral diseases; midwives used African techniques, herbs and medicines so successfully - without dangerous tools of the day, such as forceps- that many White women called them to attend births (Washington, 2006, p. 49).

In many Caribbean countries, there are still community herbalists that are consulted for their knowledge of natural treatment for ailments; in the UK there are also traditional herbalists who offer alternative health and well-being services. Research into the use of African centered health within contemporary communities finds that prayer and spirituality are still widely used as part of health practice (Dessio et al., 2004; Gillum and Griffith, 2010) and that alternative treatments that lie outside conventional biomedicine are sought after by Black communities (Cappuccio, et al, 2001; Shippee et al, 2012). There also exists a plethora of Black self-health books, predominantly aimed at Black women, that offer guidance on how to maintain health, physically and spiritually, rooted in an holistic approach with titles such as ‘Like a Natural Woman: The Black woman’s guide to alternative healing and disease prevention (Kashef, 2001)’; ‘A Healthy Foods and Spiritual Nutrition Handbook’ (Wright,

2011); ‘Blessed Health: The African-American woman’s guide to physical and spiritual well-being’ (McCloud and Ebron, 2003); Heart Health for Black Women: A natural approach to healing and preventing heart disease (Yates, 2000)’ and ‘Body and Soul: The Black woman’s guide to physical health and emotional wellbeing (Villarosa, 2003)’.

This emphasis on natural approaches to health also influences self-treatment of illness or for general health. Higginbottom and Mathers (2006) present findings of a qualitative study that focused in the use of herbal remedies by African Caribbean hypertensive patients. During the process it transpired that some participants only gave information about their use of herbal medicine when it became apparent that the primary researcher had an understanding of Caribbean herbalism. Once this understanding was established, participants spoke more freely about what remedies they used for health and some expressed that they were not compliant with their hypertension medication, favoring traditional treatments. The data gathered was grouped into four overarching themes: ‘the use of herbal remedies and how this was learned from family members; specific herbal remedies for hypertension; the need for caution in using herbal remedies; and where herbal remedies were obtained (Higginbottom and Mathers, 2006, p. 99)’ The information about the herbal treatments that were discussed by participants are presented in table four.

Table four: Description of traditional herbal treatments used by African Caribbean people

Remedy	Used for
Aloe vera	High blood pressure, healing of wounds
Bissy	Stomach upset
Bread fruit plant leaves as an infusion	High blood pressure
Cerasee (cerrasee, serasee)	General health, blood cleanser
Cho-cho	High blood pressure
Coconut water, lime and lemon	High blood pressure
Fever grass as an infusion	High blood pressure
Hawthorn	High blood pressure
Lime juice, garlic	High blood pressure
Marijuana as an infusion	Asthma
Scorn the earth	High blood pressure
Singer bible (single bible or *semper viva*)	High blood pressure
Tuna	High blood pressure
Any bitters	To lower blood pressure
	(Higginbottom and Mathers, 2006, p. 104)

These findings presented by Higginbottom and Mathers (2006) highlights the effects of subjugating alternative health discourses, which can have serious impacts for health. They also note that almost all participants choose not to disclose their use of herbal medication to their GP, citing fear of retribution. Higginbottom and Mathers suggest that if healthcare professionals acknowledged other forms of treatments, patients may disclose their herbal use. Findings that also report that prevalence of used of herbal medication by African Caribbean's living with type 2 diabetes were published by Brown et al (2007) and Scott (2001). Aarons (1999) proposes that biomedicine must seek to engage with alternative medicine of the Caribbean to genuinely improve the health of Caribbean communities, especially for those with chronic conditions.

Crucially, it must be understood that the contemporary relationship between Black communities and biomedicine is not one of outright rejection but a contextual one. Whilst the content of the self-health books referenced earlier are rooted in an alternative discourse of health, they regularly refer to the importance of taking symptoms of ill health to the biomedical healthcare professionals (e.g. changes in breast tissue) and the authors of the books are often biomedical health professionals. Whilst this literature review has drawn upon the wealth of African American investigative findings to locate and understand the discourses of health and historical experiences of healthcare in the diaspora, it is imperative to acknowledge that that the healthcare landscape in the UK is fundamentally different from the US and as such shapes contemporary experiences of health differently. Issues pertaining to health inequities based on lack of health insurance are not relevant in the UK in the same vein, so access to biomedical treatment is not restrictive to those who require care.

Health in the UK: The African Caribbean experience

In the UK it can be claimed that there is also more trust in health service from Black communities than in the US for a number of reasons. Up until mass migration to Britain after the Second World War, African Caribbeans were colonial subjects, rather than second class citizens *within* the British nation. Britain was therefore seen as the 'mother country' and there was, and remains, a reverence to the nation and its institutions. When the call to rebuild Britain went out to the Caribbean, people willing migrated and expected to be treated as equals in the country (James and Harris, 1993). It is important to understand that the African Caribbean population of Britain is mainly made up of economic migrants, and their descendants, who chose to come to work in the country for a better life (Phillips and Phillips, 1998). This mitigates some of the more virulent distrust that exists for the African American population.

There is also a particular history of healthcare services in the Caribbean that took inspiration from the British system (Golding, 1994). There has long existed a tradition in the Caribbean of people paying for private health care if it could be afforded or geographically accessed, i.e. living in a town (Higginbottom, 2006). Further to this, though discrimination was vicious against those who settled in Britain, the NHS presented as a relatively open institution. Free care was dispensed irrespective of colour and the nursing was one of the few professional careers open to African Caribbean women. Discrimination certainly existed in the NHS, and continues to do so, but as a major employer of African Caribbean women there is a strong relationship between the health service and community (Kramer and Bernard, 2006). In terms of *treating* ill health, the dynamic of mistrust that exists in the

US is not the same as those that may be present in the UK as the social histories of Black communities in each place differ greatly.

As such, this shows that there is a particular need to interrogate the understandings and experiences of African Caribbean communities in the UK, as the lay discourse of health operates *between* biomedical and alternative perspectives of health as a result of the history of British colonies and the relationship to healthcare access in the Caribbean and in the UK. With this perspective the typology of lay health beliefs, as set out by Kleinmann (1980), can be applied to the African Caribbean context to unpack the complexities of relations with contemporary healthcare systems and its professionals.

In his seminal text entitled 'Patients and Healers in the Context of Culture', Kleinman (1980) refers to the wider healthcare system as 'a cultural system composed of three overlapping parts: the popular, the professional, and folk sectors' (1980, p. 50). In this it is proposed that where the popular sector refers to the self-treatment of ill health by the lay public who may utilise social networks to diagnose and choose treatment, the professional sector comprises of organised healing professionals sanctioned as legitimate by the culture. The term 'folk' which refers to non-professional healers including those that practice sacred, secular and herbalist treatments. As such, it is important to understand that patients from ethnically diverse communities may refer to a wide range of culturally influenced explanatory models for health that may at times complement or contradict biomedicine.

From the context of the African Caribbean experience, it is illustrative that the complex relationship between the popular health knowledge circulated within communities by means of network resources and the widely available self-health literature, especially that aimed at women. Also, the professional sector in which historically there has been a strong presence of African Caribbean women within the NHS and there continues to be a significant number of African Caribbean women working in healthcare services[5] whilst there continues to be an embracing of traditional African and Caribbean approaches to health and medical treatments. There are examples of where these discrete sectors as suggested by Kleinman actually converge and exist as community healthcare services. There is such as example in Birmingham within the African Caribbean community that embraces popular, professional and secular approaches, which rearticulates mainstream, biomedical and cultural health perspectives into a redemptive approach to address inequality. Pattigift CIC offers African-centred psychotherapy and counselling and exists as an alternative to the mental health services provided by the NHS (Pattigift, 2014). Founded and run by accredited Black psychotherapists, this successful service is based within the community and takes many of its referrals from within local networks and offers arrange of conventional and holistic treatments. Existing outside of mainstream health services, Pattigift attempts to address the disparities in mental health diagnosis and issues relating to mistrust and dissatisfaction of NHS mental health services offering a different representation of health and mental wellbeing from NHS services.

[5] The NHS is currently the largest employer of minority ethnic staff in the UK, of whom make up 14% of the workforce (Archibong and Darr, 2010).

This complex web of differing perspectives rooted in varied cultures, each claiming to offer correct representation of health, illness and treatment can be seen to exemplify what Bordieu (Bourdieu and Johnson, 1993) refers to as the struggle for cultural production; the pursuit of validation within dominant culture by subjugated forms of culture which reflect wider struggles as a result of societal stratification.

Within the context of understanding health inequalities, the dominance of Western biomedicine marginalised alternative forms of knowledge and this metaphorical tussle has tangible implications for health and health information seeking behaviour.

Understanding health inequalities for minority ethnic communities

The ways in which health inequalities are understood is also an important discourse to explore as the explanations given for disparities in health outcomes does contribute to how communities and healthcare professionals and health researchers understand health, healthcare services and the roles of healthcare professionals. For minority ethnic groups in the UK, this is especial importance as 'in many instances [they] experience a higher burden of disease, but have paradoxically been marginalised from preventative behaviour change interventions which tend to originate from a Eurocentric perspective' (Davidson et al, 2014, p. 508). For the process of truly understanding of health inequalities and allowing for the development of valuable and effective healthcare intervention, Smaje (1996) and Nazroo (1998) both point to the need for health research to theorise ethnicity and health effectively; a call that has been heeded in more recent investigation. Both scholars suggest an approach that

acknowledges both the structural and identity politics that interplay in the health of communities. Narrow perspectives that focus solely on structural or material explanations cannot offer a depth of knowledge that emerges with the interrogation of contexts in which health is socially constructed and experienced by patients. In contemporary society, the complex relationship between social; economic; environmental; structural and; cultural issues intersect across the life course contributing to health inequalities. As such, a number of competing and complementary explanatory models have proposed to unpack this. Whilst it cannot be claimed that one model offers more understanding than another, they each make a contribution to observed patterns of health in minority ethnic communities in the UK. These models of health inequality have been 'developed and refined over many years' (Smith et al, 2000, p. 393) and in this thesis will be specifically applied to understanding the health of African Caribbean communities, in particular women using the framework offered by Smith et al (2000). This exploration will attempt to show how the differing positions used to explore health inequalities are not discrete positions, rather they exist with each other.

Artefact

This approach to understanding health inequalities suggests that disparities in health outcomes are due to the construction of the measurement practice (Blane, 1985; Bloor et al, 1987). From this perspective, it is in the recording and analysis of data pertaining to the health of minority ethnic groups that may be problematic. For instance, use of encompassing terms for analysis such as 'South Asian' to include a range of diverse communities ignores the huge cultural variations that exists within and between different communities and subsequent health issues that may arise and how best to address them

(Nazroo, 1998). Also, the method by which with health is measured may also differ between ethnicities which calls into question the validity of using self-reported health as an accurate data collection method. Whilst there is research evidence which suggests a single item measure of self-reported health is valid for use with different ethnic groups (Chandola and Jenkinson, 2000), there are also findings that contradict this. Older research findings presented by Nazroo (1997) through analysis of data collated in the Fourth National Survey of Ethnic Minorities, finds that African Caribbean participants had reportedly less tiredness, sleep issues, anxiety and chronic illness than the general White British population. However, indices of general health as reported by health investigation finds that African Caribbean communities are more likely to experience poorer health than the general population. Interestingly, Curtis and Lawson (2000) in their research found that there are also gender differences in the self-reporting of health; African Caribbean women are more likely to report ill health than African Caribbean men.

Additionally when exploring artefact health approaches to health inequalities, the influence of ethnicity on the diagnosis of particular health conditions is also important. A plethora of evidence exists that race and ethnicity are factors in the over or under diagnosis of ill health, especially with regard to mental health for African Caribbean communities (Lewis et al, 1990; McNeil, 1995). The intricacies of this issue will be discussed in more detail in a later section of this literature review.

Migration

The history of migration to the UK is an essential area of study when attempting to understand and address health inequalities for minority ethnic groups in the UK from an artefact perspective. Although African Caribbean communities in the UK, like those from India and Pakistan, are deemed to be more 'settled' than more recently arrived communities from places such as Eastern Europe and Eastern Africa, issues pertaining to migration are still important. Currently, the majority of the first wave of migrants from the Caribbean are of retirement age and a number have chosen to return home to the Caribbean. This desire to return to one's birthplace is termed the 'salmon bias' (Abraido-Lanza et al, 1999) which could artificially decrease the mortality rate for this ethnic group and yield inaccurate data (Smith et al., 2000).

Exploring how migration may influence health inequalities for minority ethnic groups recognises of how the stress associated with leaving a home country and adapting to life in the UK[6] may impact on health outcomes. However, it is expected that the stress experienced during adaptation to a new environment would reduce over time. This is especially so if new migrants live in geographical locations where there are other members of the same ethnic group. Findings of studies that have explored the effects of 'group density' on health indicate that people of minority ethnic groups who live in areas where there are higher proportion of their own ethnic group tend to experience better health outcomes (Pickett and Wilkinson, 2008). Drawing upon the work of Bourdieu (1986) and his

[6] This stress may be especially pronounced for those migrants to the UK who may be seeking asylum or refugees (Carswell, Blackburn, and Barker, 2011; Papadopoulos, Lees, Lay, and Gebrehiwot, 2004; Quinn, 2014; Warfa et al., 2012).

suggestion of the importance of social capital of establishing and maintaining interpersonal support networks that may be useful for personal health, it is not surprising that this may be the case. Yet interestingly, when using self-reported health as a measure, responses from participants contradict the suggestion of a positive health impact due to ethnic density (Karlsen et al, 2002), also reflected in the health disparities of minority ethnic groups in parts of cities where there are significant and established communities of minority ethnic groups. Research which has mapped race and rates of poverty in Birmingham found that there is a 'geography of health disadvantage' that can be mapped across the city (Cangiano, 2004, p. 10) with regard to race and ethnicity and health outcomes.

Socioeconomics

In the process of examining ethnic density, it is imperative to consider the socioeconomic factors that typically shape the environmental, social and economic determinants of health for minority ethnic groups in the UK. This position places deprivation at the core of understanding and echoes sentiments of Bourdieu (1986) understands that access to resources through economic capital as a central principle to understanding social stratification and its effects for society. Economic capital is linked with other forms of capital that have their own influence, in this case, on health outcomes. Issues such as poor housing (Garvie, 2004), food poverty and insecurity (Dowler and O'Connor, 2012) and fuel poverty (Lorenc et al, 2013) have become especially pronounced in recent years. Investigation by Bernard and Turner (2011) find that minority ethnic groups in the UK are more likely to experience these economic hardships compared to the general population. However, it is important to explore the nuances between ethnicities, and indeed gender within the examination of socioeconomic influence on health for African

Caribbean women. For instance, whilst it is found that people from minority ethnic groups are less likely to enter employment, the rates of full time employment for African Caribbean women is similar to the White British population. In fact, figures from 2011 census show that 57% of African Caribbean women aged 25-49 were engaged in full time employment, compared to 51% of White British women (Nazroo and Kapadia, 2013)[7]. However, to place this figure into wider context, 65% of African Caribbean children are raised in lone parent families, the majority by their mother (Platt, 2011) and may experience deprivation and lack of social support can accompany this situation (Edge, 2011). Being aware of this situation could offer partial explanation for the late presentation of symptoms of illness that can influence health outcomes, thus shaping experiences of health and illness.

Cultural beliefs and behaviours

An additional influence of how health is experienced is rooted in the culture/s in which in the patient is immersed and is important to investigate when developing appropriate healthcare systems (Kleinman et al, 1978). Culture is not genetic in nature and cannot exist in isolation, rather it is shared by members of communities (Hall, 1976). Thus, culture has been understood as 'the collective programming of the mind which distinguishes the members of one group from another (Hofstede, 1980, pp. 21-23)' that which is arbitrary in nature as it changes form as it is passed from generation to generation. These shared understandings exist as common sense, taken for granted knowledge and are assumed to be

[7] Census data also indicates that the rate for full time employment for African Caribbean men is 61% (Nazroo and Kapadia, 2013)

correct as it is often the first, and sometimes, only cultural perspective to be learnt. In the context of health, culture is understood as distinctive shared norms, values, beliefs and practices that are directly and indirectly associated with health-related behaviours (Napier et al, 2014). In the contemporary West, the dominant cultural understandings of health are underpinned by discourses that emerge from a biomedical perspective and influence mainstream cultural constructions of health in terms of wellness, illness and the body. However, there are alternative epistemologies that also exist which shape how health is perceived and for minority ethnic groups are typically rooted in traditions from home countries and merge into and out of mainstream perspective.

Patterns of diet are often an exemplar of the interplay of mainstream and minority ethnic cultures as food eaten in many contemporary minority ethnic homes includes traditional and Western dishes and cooking styles. However, issues relating to dietary and portion control have been found to be contributing factors to the levels of overweight and obesity and related chronic illness in minority ethnic groups, particularly those of South Asian and Black backgrounds. The cultural symbolism of food preparation and feeding one's family, roles usually performed by the women of the family has been understood as a moral ethnic of caring; the physical enactment of moral duty to one's family. To feed one's family well, often with limited access to the best food has become a symbol of Black femininity and 'successful' mothering (Williams-Forson, 2006) and could offer explanation for the excess calorie intake at meal times in African Caribbean families.

When exploring culture and health inequalities, language use has long been considered central for communities for whom English is often not the first language and the need for translators and multi-

lingual literature is essential, especially when attempting to provide access to Primary Care (Ahmad, 2000; Gerrish et al, 2004; Pharoah, 1995). However, there is real need for understanding of language issues for African Caribbean communities for whom English is a first language but may face issues as a result of accents, colloquial language use, speed, pitch, volume, stress, rhythm and tone of speech (Atkin and Rollings, 1992; Scott, 1998). Non-verbal communication is a fundamental element of Caribbean patois or dialect; eye contact, physical gesture and body language are important cultural aspects of conveying meaning and if not understood could result in misunderstandings and misdiagnosis. For instance, Evers et al (1989) highlight the case of an elder African Caribbean man who was misdiagnosed with a speech impediment after a stroke when in actuality he had a strong Caribbean accent.

It is important to place the misunderstanding of non-Western culture within an additional framework that does not simply refer to the cultural difference of minority ethnic cultures when exploring health inequalities, but of wider issues of racialisation.

Racism

The manifestation of racism, prejudice and discrimination has been found to have direct impact on the health outcomes of ethnic minority groups. Research conducted in both the US and the UK shows that negative racial and ethnic stereotyping has an adverse effect on individuals. For

Bourdieu, the symbolic violence that occurs as a result of conscious and unconscious affirming of cultural and social imagery of misrepresentation that reinforces social stratification is as powerful as physical violence (Bourdieu, 1979 / 2010).

The historical portrayal of Black femininity in the West has been founded upon well documented stereotypes. The earliest of such stereotypes is that of the Black 'mammy', an image which emerged in the Southern states of the US during the civil war at a time when enslavement was existed in the US, South America and the Caribbean (Collins, 2000) and it is suggested that this is the most classical, famous and enduring image of Black femininity that has contributed much to societal discourses about Black women and their bodies in both mainstream and Black understanding (Wallace-Sanders, 2008). Depictions of the mammy place Black women as 'fat and dark, with "nappy" hair and a booming voice. She is ever-nurturing, though virtually sexless' (Williamson, 1998, p. 66). Interestingly, it is this image of Black femininity that juxtaposes it with White femininity where White women are defined as carriers of beauty in terms of slenderness and delicateness that resides in a body unsuited for physical work, while the Black female body is big and strong, best suited for low status physical work and subservience, without the dominance and power afforded to masculinity. During enslavement plantation society, the role of the Black mammy was to be 'the maid of all work, caring for the children, washing, ironing, cooking, cleaning and helping in the fields as well' (Parkhurst, 1938, p. 351). Popular culture of the first half of the 20th century contains many examples of the portrayal of Black women in this way, the most notable including: Hattie McDaniel's character 'Mammy' in the film Gone with the Wind; the recurring housekeeper character 'Mammy Two Shoes' in the MGM Tom and Jerry cartoons; and Aunt Jemima, the trademark logo image featured on 'Quaker Oats Company' food products which was developed from a minstrel show. However, it was the emergence of the Black Power movement of the 1960s that started in the US and had a considerable influence for Black

communities across the Diaspora in challenging this negative portrayal of Blackness and the Black feminine aesthetic. It was during this era that the slogan 'Black is Beautiful' (Mercer, 1994, p. 98) gained prominence and encouraged Black women to reject notions that beauty could only be ascribed to Whiteness, rather they should celebrate their natural attributes that can be just as beautiful as those of White women. As such, the embracing of larger body shapes and sizes, African facial features and the fashion aesthetic became popular; the most recognisable embrace was that of African hair texture and the afro hair style become synonymous with the movement as a challenge to racism.

However, it has been purported that the image of the mammy has not been consigned to history; rather this image of Black femininity continues to pervade society in the form of 'modern mammies' (Collins, 2004, p. 138). Critical Black feminist studies refer to images in media that reflect such an image and of those suggested, the most recognisable figure is that of Oprah Winfrey, the African American talk show hostess, actress and business woman (Collins, 2004; Hagg, 1993; Stanley, 2007). This label of modern mammy is not to diminish or discredit her success, but is to critically engage with her persona as a 'cultural icon for the neoliberal era' (Peck, 2008). It is suggested that in the form of the modern mammy, the image of Oprah is that she is a strong, hardworking and caring confidante who is always sympathetic to the needs of those she serves: her guests and her audience (Stanley, 2007). In an article in her magazine, Oprah describes how after years of struggling with her own weight, she has found her own *strength*:

> I did a head-to-toe assessment, and though there was plenty of room for improvement, I no longer hated any part of myself, including the cellulite. I thought, this is the body you've been

> given—love what you've got [...] In that moment, as I stood before the mirror, I had my own "spiritual transformation / a root revival of love," which Carolyn M. Rodgers writes of in one of my favourite poems, "Some Me of Beauty." What I know for sure is that the struggle is over. I've finally made peace with my body (Winfrey, 2002).

Examination of the mammy stereotype in both its historical and contemporary forms indicates that there is an essence of strength that is linked representation of the large Black female body. Body size then exists to represent the physical strength to undertake manual tasks; endure hardships; to care for the family and; to challenge negative connotations of the Black female aesthetic and mainstream beauty ideals by being comfortable in one's own skin. There in the process of in the process of accepting or resisting particular stereotypes, the large Black female body is central to this symbolism of Black women and strength (Beauboeuf-Lafontant, 2003). As such, despite images of White female beauty of slenderness and vulnerability, and 'the comedic exploitation that surrounds the large Black women, [many Black women know] that the most respected physical shape of Black women, within and outside the community, is that of the large woman (Gilkes, 2001, p. 183). Thus, the conceptualisation of the larger body as an image of strength is an important one for understanding the issues of body shape and size for women in the African Caribbean community as it is in is in stark contrast to mainstream societal discourse, where individuals who are overweight or obese are conceptualised as lazy, morally weak and out of control (Meleo-Erwin, 2011; Rich, 2005). To further illustrate the influence of this stereotype, in reference to Oprah after her considerable weight loss, members of her audience called into question her legitimacy for giving advice and openly criticised her and her now lack of authenticity (Stanley, 2007).

The second stereotypical image of the Black woman is that of the matriarch, which upon examination is also rooted in the notion of strength with regard to Black femininity. The matriarch image emerged in post enslavement US society and portrays Black women as aggressive, emasculating and fiercely autonomous within the family and wider society (Collins, 2000). This image is particularly politically charged one as it was used to construct Black families as 'pathological', focusing on single mothers who often headed these families. As with the image of the mammy, it was the Black Power movement of the 1960s that encouraged a counter narrative to this particular image of the Black family and rearticulated the matriarchal image of Black women to one that was a rejection of the placid mammy stereotype. However, the objection to the mammy is based on the image of smiling servitude rather than on physical traits. As such, the parental features of the mammy are retained, but transformed into a 'more acceptable image of [Black] women as "strong"'(Hill, 2009, p. 738); an image of strength that continues to permeate popular culture where Black women are portrayed as tough, savvy and streetwise (Emerson, 2002). The implications of this image are that whilst the strong Black woman may work to provide and protect her family, she is also seen to be hostile and aggressive. In a recent interview, Michelle Obama responded passionately to claims that she is matriarchal, stating that she is tired of the 'angry Black woman' stereotype that influences the lives of many Black women (CBS News, 2011). Although the construction of the matriarch is not founded upon a particular body shape or size, it may influence how Black women address health issues. Women who adopt this perceived ideal of strong and independent Black femininity are implicitly encouraged to adopt the notion that they can 'go it alone, without others, a notion that fosters silence and social isolation among those who feel they are less than a woman if they show signs of weakness and vulnerability' (Taylor, 1999, p. 738).

Investigative findings suggest that there might be a relationship between the stereotypes of Black femininity as strong and the health behaviours African Caribbean women engage in. For instance, when compared to the general population there is an over-diagnosis of psychoses in African Caribbean communities, yet there is an under-diagnosis of neurotic disorders such as anxiety and depression among women of this ethnic groups (Edge and Rogers, 2005); conditions that may be seen to be signs of powerlessness and vulnerability. Similarly, findings from population based studies show that there are significantly higher rates of undiagnosed depression in this community compared to the White British population, especially for women (Berthoud and Nazroo, 1997 ; Nazroo, 1997; Shaw et al, 1999).

Furthermore, research into the low rates of self-reported depression and help seeking behaviour among African Caribbean women from this ethnic group may be interpreted to suggest that the image of the Black woman as the matriarch and historical connections to the mammy role continue to shape understandings and lived experiences of Black femininity with regard to perceived strength. In their study into perinatal depression in African Caribbean women, Edge et al (2004) quote one participant in their study who states:

> I think it all relates to slavery … We had to be strong for our kids … we had to protect them, had to be strong for them … and it's just been instilled into the daughters … that you need to be strong, to hold your family together. You can't depend on no man … *You* [emphasis in the original] need to be a strong [woman] (Edge et al, 2004, p. 434).

This quote makes reference to the shared narratives of African American communities in the US and African Caribbean communities in the UK as both emerge from post slavery Black Atlantic communities and how these may influence behaviours, health and wellbeing.[8]

It has been suggested that it is the stress of living in a racist society that places minority ethnic communities at an increased risk of mental health illness and this contributes to the health outcomes. Investigation with African American women points to a relationship between levels of obesity and perceived racism. Both Sims et al (2008) and Vicennati et al (2009) report that elevated levels of cortisol, the stress hormone, is present in a significant number of overweight and obese women in the study who perceived more direct and indirect racism for whom emotional eating was a coping strategy. In related research, Kim et al (2009), report a relationship between increased stress and reduced likelihood of weight loss in a sample of African American women.

Biology

[8] The archetype of Black masculinity as aggressive, violent and volatile has been found to influence diagnosis of mental health conditions, even when comparable White patients exhibit similar symptoms (Lewis et al, 1990; McNeil, 1995). To investigate the existence of racial and ethnic bias in the diagnosis of schizophrenia, Hickling et al (1999) compared the diagnostic patterns of British and Jamaican psychiatrists and reported poor concordance between them.

Whilst there is much genetic variation within ethnic groups as there is between ethnic groups, it is important to consider how biology may contribute to health outcomes (Witherspoon et al., 2007). From this perspective, to see race is not always to be racist, especially within health research and healthcare provision:

> In practicing medicine, I am not colorblind. I always take note of my patient's race. So do many of my colleagues. We do it because certain disease and treatment responses cluster by ethnicity. Recognising these patterns can help us diagnose disease more efficiently and prescribe medicines more effectively. When it comes to practising medicine, stereotyping works (Satel, 2002).

Differences in body composition and body fat distribution between ethnicities has been identified as contributory to the increased rates of obesity related chronic illnesses in Black and South Asian communities (Rahman et al, 2009). In addition, there are other health conditions that are more prevalent in African Caribbean communities in the UK such as sickle cell which predominantly effects people of African heritage (Bloom, 1995); lupus has a higher prevalence rate in Black women than the general population (Danchenko et al, 2006; Johnson et al, 1996; Somers et al., 2014); rates of gynaecological fibroids and cysts (Stewart et al, 2013) and; differences have been noted in the type and progression of breast cancer in women of African heritage (Porter et al., 2004).

In so far as understanding how biology may contribute to health inequalities, a view must be taken that considers the influence of genetics on the impact of health behaviours. For instance, recent findings of research with African American women find that it is more difficult for them to lose weight compared to White counterparts when they follow the same diet and exercise regime (Delany et al, 2013). Such findings based on difference would have to be incorporated into health promotion information to ensure that services that meet the needs of the communities they serve.

Accessing healthcare services

As mentioned elsewhere in this review, when discussing issues of access to healthcare provision, this is where experiences for African Americans in the US and African Caribbeans in the UK depart from each other. The fundamental basis of the NHS that offers health care to all, that which is free at the point of access means that experiences of health and illness within the healthcare arena is different to the US where levels of healthcare depend on access to appropriate health insurance. Rather, in the context of the UK, it important to look at the utilisation of NHS services by minority ethnic groups and how these services respond to their needs. A study conducted by Sedgwick et al (2003) that assessed whether Black African and Black Caribbean people living with type 2 diabetes had had equal access to diabetes health care. Through quantitative analysis they found that after adjusting for need, African Caribbeans reported higher utilisation of healthcare services than the White British population. Overall findings showed that Black African and African Caribbeans had no less access to healthcare services relevant for diabetes care. In fact, the emergence of the inclusion and difference paradigm (Epstein,

2007) that seeks to accept and embrace difference between groups in society whilst attempting to develop and maintain inclusive health services has been adopted by the NHS.

However, in examining the figures that relate to the uptake of screening for particular health issues illustrate that uptake is low from particular minority ethnic groups, especially for women of South Asian heritage for cervical and breast cancer screening (Sokal, 2010), yet levels of uptakes for cervical cancer screening among African Caribbean women is above levels recorded for the White British population. In fact, research does indicate that African Caribbean women are well informed of the importance of screening and are aware of symptoms (Rudat, 1994).

The changing nature of weight

To explore the issues of that underpin the construction of health and wellness with regard to body shape and size, it is important to pay attention to the different spaces from which obesity discourse and body shape and size discourse are rooted. Where obesity discourse emerges from a contemporary biomedical perspective, discourses of body shape and size are anchored in the socio-cultural understandings of different societies over time and geography. As socio-political, economic and technological landscapes have changed, it is interesting that discourses of excess weight appear to have become conflated. For the purpose of this investigation it is essential to have an understanding of this social phenomenon especially on points where the perspectives may affirm or reject the others position.

This section will outline the elements of understanding that have influenced responses to this conflation and alternative perspectives that challenge dominant views of ‘fat’ in the West.

The history of fat

It is feasible to claim that cultural understandings of excess weight have been underpinned by economics within capitalist society and in previous times, excess weight was a signifier of wealth and prosperity of upper classes (Gilman, 2008). However, the social dynamic that underpinned this did have gendered differences. Whilst cultural norms legitimated the large male body as powerful, slenderness was deemed the appropriate representation of middle and upper class femininity as early as 1890 (Brumberg, 1988). It was at around this time period that witnessed the emergence of the diet industry with the commercial promotion of aids, remedies and treatments to lose weight, many of which were explicitly aimed at the female market (Foxcroft, 2012). Interestingly, this is still the case and whilst there are a number of diets aimed at men, the vast majority are offered to females as a way to slim and transform their bodies into the socially constructed image of slender beauty (Bordo, 1993). Recent estimations suggest that the diet industry in the UK is currently worth £2 billion, which is only slightly less than the NHS spend on Accident and Emergency services nationally (Elkin, 2013). The most recent popular diet being the 5:2, where you eat normally for five days and restrict calorie intake for two days, and currently features as the diet of choice on many of the front covers of women's magazines. The boom in the diet industry is taking place at the time when the rates of clinical overweight and obesity are rising, which prompts the suggestion that the diet industry exposes the insecurities of society and is based on exploitation and profit (Foxcroft, 2012).

However, this is not to critique all commercial diets as evidence does exist of their success in enabling people to lose weight. Jolly et al (2011) conducted an eight arm randomised controlled trial to assess the effectiveness of a range or weight management programmes:

> Weight loss programmes of 12 weeks' duration: Weight Watchers; Slimming World; Rosemary Conley; group based, dietetics led programme; general practice one to one counselling; pharmacy led one to one counselling; choice of any of the six programmes. The comparator group was provided with 12 vouchers enabling free entrance to a local leisure (fitness) centre (Jolly et al., 2011, p. 1).

Evidence collated from the trial found that the commercial weight loss programmes achieved significantly more weight loss and were more effective and less costly than Primary Care based services. From such evidence, it would suggest that future NHS services need to reflect the nature of commercial weight loss interventions for both health requirements for patients and would be financially prudent for the NHS.

The politics of fat

In the process of examining how societal changes have influenced how understandings of health and weight have evolved, it is important to consider how the politics that underpin the political landscape of

contemporary Western societies have contributed to perceptions of health and weight. Neoliberalism as a political ideology seeks to reduce the role of the State and shift focus to the individual. The era in which the NHS was first established was one of collective responsibility for the wellbeing of all in society. In contemporary Western societies, this outlook has been replaced by individual responsibility:

> despite the fact that a generally critical outlook on medicalization still prevails, a complex scholarship has emerged that is more respectful of the archival and field work of historical and social scientists and resists being forced in to a rigid ideological or conceptual framework. Medicalization is no longer understood as a nefarious collaboration of experts and state authority imposed from above, but by a process whereby medical and health precepts have been embodied in individuals who assume this responsibility for themselves (Health and Safety Executive, 2004, p. 117).

As a result, in the contemporary West, health is constructed as a choice that can be obtained through lifestyle choices. The body is construed as focal site of signifying practice of health and wellbeing (Crawford, 2006) and the slender body serves as a symbol of self-control. The performance of health is linked to body size where slimness is a symbol of self-worth (Lupton, 1996). Within this discourse emerges the position that individuals must choose health through engaging in the right health decisions. Through making the 'right' choices, this produces citizens that 'take responsibility for their 'health' and lifestyle, in the knowledge that they owe it not only to themselves to be the best 'self' possible, but also to society generally' (Tischner, 2013, p. 6). Health and wellbeing becomes anchored to morality

and through this lens, citizen fitness is conflated with slenderness and the large body becomes an emblem of the 'failed citizen' (Elliott, 2007). In societies that are concerned with 'risk' (Beck, 1992), the subsequent societal view is that overweight and obese individuals 'ought' to be more concerned about their health futures (Grønning et al, 2013) and should feel responsible for the financial burden placed on the NHS by obesity related illness. Thus, for those individuals who are clinically overweight or obese they are socially constructed as immoral and socially deviant for making the 'wrong' choices (Campos, 2004; Gard, 2005; LeBesco, 2011; Meleo-Erwin, 2011; Mold and Forbes, 2011; Rich, 2005).

Subsequently, this neoliberal approach that privileges individualism shapes the nature of interventions in the UK that aim to address the increase in excess weight of the nation. Public health intervention such as the 'Change for Life' campaign which is the marketing element of the 'Healthy Weight, Health Lives' government strategy for reducing obesity, focuses on lifestyle change and offers support and guide in a range of forms to help people make better health choices (Department of Health, 2009). Biomedical interventions that seek to treat the individual affliction of excess weight include bariatric surgery for those who meet specific criteria, have witnessed a year on year increase. Figures from the Hospital Episode Statistics show that the number of NHS commissioned bariatric surgery procedures for the treatment of obesity in 2003/4 was 470, increasing to 6500 in 2009/10. Further, NHS commissioned bariatric surgery is more common in women, most frequently in those aged 40-54, followed by those aged 25-39[9] (Dent, 2010). With regard to addressing excess weight across the lifespan, primary school children in reception (aged four and five) and in year 6 (aged ten and eleven) are weighed and measured as part of a national programme that collates data to inform and develop appropriate health services. This opt-out programme also identifies children who are overweight and to

[9] These figures do not include surgery performed in the private sector (Dent, 2010).

provides their guardians with information on how to address this issue (NHS, 2014c). However, this scheme has received backlash from parents and guardians who resent their children being identified as overweight and feel that this is a challenge to their parenting techniques.[10]

Societal resistance to government intervention as 'nanny-statism' (LeBesco, 2011, p. 154) is a reflection of a neoliberal society where individuals are encouraged to take responsibility for themselves and their families and rely less on governmental resources. It cannot then be surprising when there is resistance to the suggestions that seek to offer solution to the increase in obesity from both food manufacturers and the general public. In a report entitled 'Measuring Up', the Academy of Medical Royal Colleges (2013) outlined the suggestions from medical professionals to address the increase in obesity in the UK. Among the recommendations was to introduce a tax on sugary drinks; a proposal that was met with fierce opposition from soft drink manufactures and from within the mainstream (The Telegraph, 2013). As a result of the individualisation of health and the emphasis of 'choice', the discussion of how to address obesity is removed from the structural inequalities that contribute to rates of excess weight in areas of increased deprivation where cheaper priced food is typically higher in energy content.

[10] Many of the comments offered in the in the feedback section of the NHS National Child Measurement Programme website are from parents expressing annoyance at being told that their child is overweight and the lifestyle information that they were given.

Rather, the mainstream response to excess weight and obesity is manifested in the ‘shock-doc’; documentary and reality television programmes that feature the real life stories of super-sized individuals, such as ‘Supersize Ambulance (BBC, 2011b); ‘The Biggest Loser (ITV, 2012) and; ‘Supersize vs Superskinny (Chanel 4, 2013)’. This representation of the extremes of body weight issues enables people to disassociate themselves as potential candidates for obesity related chronic illness (Davison, Smith, and Frankel, 1991) and fuels perceptions of excess weight as a spectacle of moral failure. In addition, it also serves to contribute to the prejudice and discrimination faced by overweight and obese people (Puhl and Brownell, 2001, 2003)

Consequently, these conceptions of overweight and obesity have impact on an individual level. For those who are overweight or obese, weight based stigma and stereotypes can have a profound effect on psychological wellbeing with regard to depression, body image issues and low self-confidence and esteem (Luppino et al., 2010). Ironically rather than provide motivation for weight loss, stigma discourages overweight people from exercise (Seacat and Mickelson, 2009) and reduces perceived dietary control (Major et al, 2014).

Interestingly, the science that underpins this perspective of understanding the meanings attributed to excess weight are questioned. Whist the BMI remains an objective measure of excess weight, its validity has been challenged. Developed using White body composition as the standard norm, the universal application of the BMI is not representative of differ ethnic and racial groups. Findings show that there must be different BMI cut off points, and indeed different waist circumference for different

ethnic groups to reflect body composition differences and risks of developing obesity related illnesses (Deurenberg, 2001). Additionally, it is also important to acknowledge differences between ethnic and racial groups. For instance, Luke et al (1997) find that body composition of Black populations across the diaspora differ with regard to height, weight and waist and hip circumference, BMI and percentage of body fat as follows: African American>Jamacian>Nigerian. Further to body composition:

> Relative to their total fat mass or degree of obesity, Black women and children have a lower distribution of adipose tissue as visceral fat (IAAT) than as subcutaneous abdominal adipose tissue (SAAT) than do White women and children. IAAT is associated with different metabolic risk factors in Black Women than in White women and may be less predictive of health risk in Black women (Weinsier et al., 2001).

Fat studies

As an alternative discourse to the dominant knowledge of fat, purported by obesity discourse, the Health At Every Size (HAES) paradigm campaigns that diets and weight loss can actually have negative impact on health (Tischner, 2013). Rather, they advocate that health can be attained by people of any size or shape. Within academia, the articulation of an opposing view of weight has been dubbed 'fat studies' that 'seeks to reframe the weight discussion outside of health discourse that dominates popular culture' (Rothblum and Solovay, 2009, p. 2). This interdisciplinary area of study interrogates basis and the effects of 'anti-fat' sentiment and offers a model of empowerment for fat acceptance and

activism. However, there is criticism of the HAES movement for its lack of ethnic diversity in its claims to represent fat communities. In a similar vein to the critique of the second wave feminist movement, fat activists of minority ethnic groups in the US find problematic the Whiteness of the debates offered and the exclusion of experiences of African American, Latino and native women (NoLose, 2010).

Black oppositional gaze

In addition to oppositional gazes on the body developed in academia, alternative notions of the large body exist within different cultures that require attention. In their study that explored attitudes to weight of Black and White women in London, Shoneye et al (2011) found that Black participants had a more favourable opinion of larger body size and shape compared to their White counterparts. The findings from this study are similar to those found in similar research conducted with African American communities in the US who found that there is a cultural normalising and acceptance of excess weight for women of this ethnic group (Baptiste-Roberts et al, 2006; Gilliard et al, 2007; Schuler et al, 2008).

Findings of an investigation into the health beliefs of African Caribbean people, Brown et al (2007) reported that there was a good level of understanding of the biomedical understanding of the link between the onset of type2 diabetes and excess weight. Interestingly, in the previously mentioned study, Shoneye et al (2011) found that the Black women participants were more likely than their White counterparts to identify health as a motivator for weight management more frequently. However,

health risks are not always interpreted through biomedical discourses because individuals and communities construct their own knowledge about *who* is at risk of ill health.

The concept of lay epidemiology posits that individuals understand and interpret health risks through the observation of health and illness in personal networks and public discourses, and gain information through formal and informal channels in everyday life (Frankel et al, 1991). This perspective suggest that individuals are often aware of health risks as a result of public health promotion campaigns and initiatives, and have some understanding of what defines an individual as a 'candidate' for illness from biomedical perspectives. However, simultaneously individuals are well aware that in everyday life, health, life and death defy epidemiological risk factors: 'undesirable events that happen to some people sometimes, but not everybody always' (Davison et al., 1991, p. 2). This contradiction, dubbed the prevention paradox refers to this instance where the observed reality of everyday life that not everyone who engages in risky health behaviour will go on to develop chronic illness, and that some people who appear to live healthy lives will experience ill health. As health promotion increases awareness in society, at the same time it encourages attention to be drawn to 'unwarranted survivals and anomalous deaths that run contrary to public health messages' (Allmark and Tod, 2006: 461).

The prevention paradox model of understanding offers explanation as to how the stereotype of the big, strong Black woman is reaffirmed within the community, resulting in an reported normalisation of excess weight and obesity for women in African Caribbean communities. Whilst public health campaigns use statistics to publicise the health risks, in reality not every person who is overweight or obese will experience chronic illness such as type 2 diabetes, hypertension or stroke (Ortega, 2012).

Through the African Caribbean lay epidemiological view, the larger female body which appears to resist illness, through its strength and thus excess weight is not seen as subject to weakness (Shaw, 2006): 'what is common is right, we presume' (Rose, 1985, p. 35). This paradox is best illustrated in the findings of the previously cited study by Shoneye et al (2011). While the study finds that Black women are more likely to discuss the health implications of excess weight and obesity and refer to the health experiences of family members as reasons for lifestyle change, they often cite an advantage of having a larger body and shape as 'being less susceptible to illness' (Shoneye et al., 2011, p. 538). Thus, the complexity of understanding African Caribbean women's lay health beliefs is illustrated by the reality that women will employ a 'repertoire of health beliefs' (Davidson et al. 1991, p. 6) that they may draw upon in various situations to explain health and illness.

Weight management and African Caribbean women

When exploring the discursive construction of health and wellness with regard to body shape and size for African Caribbean women, it is important to acknowledge health information that is targeted at this particular ethnic and how it relates to culture, knowledges and traditions of the community. In the UK, the prevalence of overweight and obesity In African Caribbean women is higher than figures recorded for the general population (Omisore, 2008): 65% and 57% respectively (Hirani and Stamatakis, 2006). For African Caribbean women, these increasing rates of overweight and obesity have particularly serious implications for the health. Women from this ethnic group have an increased susceptibility to obesity related chronic health conditions such as type 2 diabetes, hypertension, cardiovascular disease and stroke (Forouhi et al., 2006; Tillin et al., 2013). It is also reported that people of minority ethnic

heritage living with such chronic illnesses experience worse health outcomes than the general population (Smith et al., 2000). Interestingly, research also finds that whilst African Caribbean women are more likely to be overweight or obese, they are also less likely to be embarked upon any weight management programme to address this (Shoneye et al., 2011).

Research that is solely concerned with the dietary habits of communities can be understood to be firmly situated within a biomedical paradigm. Investigation that explores the dietary habits of African Caribbean communities in the UK to find out what food is traditionally consumed is concerned also with the socio-cultural contexts in which food is located to understand the implications for health. In their study, Scott and Rajan (2000a) aim to: identify what constitutes a 'traditional' Caribbean diet in the UK among two generations of Caribbean people in South London (half of whom had been living with type 2 diabetes for at least 10 years) and; what are their views on the dietary information that they receive. Using survey data from 160 questionnaires and data from in-depth, the researchers collated a outline of a traditional Caribbean diet in the UK. Using food groups to facilitate to coding process, they suggest the following as a customary diet:

- carbohydrates from rice and rice and peas, yam, green bananas, plantains, sweet potatoes, cassava, breadfruit and dumplings
- meat and fish consumption typically includes a variety of fish, chicken, lamb, mutton, pork and a selection of traditional cuts of meat such as cow foot and pig tail
- fruits and vegetables comprising of a combination of what is readily available in the Caribbean and in the UK such as carrots, cabbage, tomatoes, bananas, oranges and apples

- dairy consumption including eggs, milk and yoghurt and cheese (which interestingly only 17% of respondents claim to eat regularly).

Importantly, the second part of this paper refers to and explains the culturally specific terms that are used by Caribbean communities to classify food (Scott and Rajan, 2000b). This is especially important as it illustrates how understanding is in part shaped by language and may result in confusion when technical terminology does not reflect colloquial language. To describe Caribbean starches such as yam, green banana, sweet potatoes, cassava, plantain, breadfruit and dumpling, the terms 'hard food', 'provisions' or 'ground provisions' are often used. 'Dry food' generally refers to meals without gravy or meals without fish or meat and; it also describes food such as bread, biscuits, crackers, bun and bulla. 'Fresh food' indicates freshly home cooked meals and food that is not processed or frozen[11].

Research conducted by Sharma and Cruickshank (2001) adds further to this typology of traditional Caribbean food eaten by African Caribbean communities in the UK by including details of how the food is prepared and when and with what it is eaten; see figure six. Similarly to Scott and Rajan (2000a), the authors state that 'when assessing an African-Caribbean diet, the importance of using the

[11] It is important to note that most participants in this study were of Jamaican heritage (53% of those interviewed), and although many of the foods listed are widely eaten across the Caribbean, there are other traditional dishes from other Caribbean counties that do not appear such as cou-cou (Barbados), griot (Haiti), oildown (Grenada) and pepperpot (Guyana).

correct terminology cannot be over-emphasised' (Sharma and Cruickshank, 2001, p. 453) and use examples to illustrate this. For instance, home-made 'soup' as understood as part of a Caribbean diet is very different to the European dish of the same name:

> being made of large pieces of vegetables such as yam, sweet potatoes and containing boiled dumplings as well as meat [...] per 100g, a typical [African Caribbean] soup here contained 102 kcal, 4.2g fat, 13.4g carbohydrate and 4.5g protein compared with standard vegetable soup in Britain containing 37 kcal, 0.7g fat, 6.7g carbohydrate and 1.5g protein (Sharma and Cruickshank, 2001, p. 453).

Further important examples include other 'everyday' items such as Caribbean green bananas, often referred to as 'unripe' bananas and yellow bananas as 'ripe' bananas; boiled rice is known as 'rice' to make distinction from' rice and peas'; 'potato' could refer to sweet potato or Irish potato and; bread may denote hard dough Caribbean bread 'which is firmer and sweeter than sliced European bread' (Sharma and Cruickshank, 2001, p. 453). The research also presents the tradition of particular food eaten on particular days and/or occasions, such as Caribbean soup that is usually eaten on Saturdays, fried plantain for Sunday breakfast and bun at Easter time. This paper also presents the religious aspect of food for African Caribbean communities, an element which is often omitted from investigation with this particular ethnic group. Although Christianity is dominant religious affiliation, there are differences, as referred to in this paper such as Seventh Day Adventists who may not eat meat or ingest stimulants, such as tea, coffee and chocolate. Although not mentioned in this paper, it is also important

to recognise that Orthodox Rastafarians traditionally follow a natural, *ital* diet which prohibits animal products and processed food[12].

[12] The adherence of an 'ital' diet which is vegan in nature, has been implicated in the reporting of rickets in Rastafarian children due to the reduced calcium intake (Bentley, Aubrey, and Bentley, 2004).

Table five: Description of traditional foods eaten by African Caribbean people

Food	Description
Hard dough bread	Dense white bread, usually unsliced loaf
Bun	Sweet flavoured bread, usually eaten with sliced hard cheese e.g. cheddar
Jamaican crackers	Similar to cream crackers but round and smaller, made with white flour
Cornmeal porridge	Made with hot milk or water and cornmeal flour (condensed milk may be added) flavoured with fresh nutmeg, salt, sugar and vanilla
Callaloo	Green leaves like spinach available tinned (usually in brine) or fresh, often cooked with salt fish, onions and oil usually boiled or steamed
Plantain	Usually sliced and fried (often eaten for Sunday breakfast). Maybe boiled and eaten as potatoes or put into soup
Green banana	Usually boiled
Yam	Available as white and yellow. May be boiled and eaten like potatoes or put into soup
Cassava	Has to be boiled, can be put into soup (eaten less often than yam)
Breadfruit	Can be roasted, fried or boiled
Pumpkin	Boiled and eaten with meal or put into soup
Cho cho or Christophene	Usually boiled, often put in soup
Sweet potato	Usually boiled, roasted or put in soup

Salt fish/ salted cod	Bought dried, usually soaked overnight to remove salt or boiled to re-hydrate before cooking
Salt fish fritters/ fish cake	Salt fish pieces added into a batter and deep fried
Ackee and salt fish	Ackee is a yellow fruit, cooked and added to fried salt fish
White fish	Usually cooked with oil, onions and highly seasoned
Homemade soup	Made with meat, dumplings and large pieces of vegetables in a thin stock. Usually eaten from a large deep bowl
Curry lamb, beef, chicken, mutton and goat	Meat is usually seasoned overnight and then fried in oil. Water is added and the dish left to cook until the meat is tender.
Roast lamb, beef, chicken, pork	Meat is seasoned overnight and roasted in the oven
Pattie	Semi-circular or oval pastry, flavoured and filled with seasoned meat or vegetables
Rice and peas	Peas may be black-eyed peas, pigeon peas, kidney beans or split peas. Onions and creamed coconut may be added.
Dumplings	Dough is made with white flour and deep fried or boiled

(Sharma and Cruickshank, 2001, p. 452)

In order to understand the culture in which food is embedded within communities, it is essential to understand the histories from which they emerge. For African Caribbean communities, there are is particular value and traditions placed among certain foods that have existed for centuries. During enslavement in the Caribbean, plantation owners would provide only basic food rations of flour and cornmeal and poor cuts or scraps of meat such as such as: lamb neck; ox tail; pig trotters; chicken back and feet. In order to make such meagre portions in to tasty meals, herbs and spices such as pimento, thyme and nutmeg were used for flavour; and food was salted to preserve it for later use. Rations were traditionally given on Sundays and were expected to last for the week. To supplement this, the enslaved often used small spaces of land to grow root produce such as yam, potatoes, cassava and vegetables such as carrots, onions and cabbage. This history is still evident in the traditional food choices of African Caribbean communities in the UK. For instance, the origins of the previously described soup comes from a time when the enslaved Africans would together use any leftover food from during the week with vegetables and flour dumplings to and make a huge pot of soup to share and eat communally. This soup, still referred to as 'Saturday soup' remains an important element of African Caribbean food culture.

A further important issue that is instrumental in understanding the food traditionally consumed in African Caribbean communities are the utensils used to prepare the food, which differ from traditional Western equipment. In understanding that the preparation of food for African Caribbean communities is rooted in a history of communal eating, it places into context the use of large steel spoons in Caribbean cooking as referred to by Sharma and Cruickshank (2001). As such, they suggest that it may be more appropriate to ask African Caribbean patients how many of these spoonfuls of food (such as

rice and potato) are consumed rather than tablespoons. The importance of developing understanding of how to correctly gauge portion sizes is of especial relevance for African Caribbean patients when exploring weight management. Food frequency questionnaires specifically designed for this ethnic group finds that as portion size of meals are larger than the White British population (Sharma et al, 2002). Additionally, salt intake is significantly higher this community, as is traditionally added to food during the marinating and cooking process in the form of seasoning and sauces (Earland et al, 2010). From the literature presented, it becomes apparent that generic dietary information may not be as relevant for African Caribbean communities (or indeed other minority ethnic groups that have traditional ways of preparing meals), when attempting to encourage lifestyle change for health. It is understandable why a number of respondents in research conducted by Scott and Rajan (2000b) expressed that they did not feel that dietary advice was not 'designed for them' (Scott and Rajan, 2000b, p. 215).

However, such insights have been acknowledged by health organisations and it is the findings of such research that is used to collate culturally appropriate dietary information. In addition to the NHS, health organisations such as Diabetes UK; the British Heart Foundation and Cancer Research produce and distribute pamphlets, leaflets and booklets that explore alternative ways to create and enjoy traditional Caribbean cuisine by adopting alternative ingredients and/or cooking methods. Through examining the features of an African Caribbean diet, it is evident that there is a cultural uniqueness rooted in history and that influences what constitutes a meal and; the names and meanings ascribed to it. The differences between a traditional African Caribbean and traditional European food and the understandings that

shape them are crucial when healthcare professionals are to engage in valuable discussion about lifestyle and diet.

However, whilst culturally appropriate information is vital, leaflets alone are not sufficient in lifestyle change and for some patients, the plethora of pamphlets given by healthcare professionals creates the sense that the information contained within is the only support available, and patients become ambivalent to them: 'it's leaflet, leaflet, leaflet then "see you later"' (Edge, 2011). Also, reliance on leaflets to provide health information to patients or disseminate information more widely is problematic in diverse cities such as Birmingham. Where there are numerous ethnic and racial groups a wealth of languages are often spoken and translation is often limited to the main languages spoken in an area (Lowe and Bedi, 1997) and; it cannot be presumed that all patients have a competent level of literacy and comprehension to fully understand the information contained within leaflets (Mumford, 1997; Williamson and Martin, 2010). From this perspective that considers cultural differences and the limits of written health information, it adds an additional dimension to understand why particular groups may experience worse health outcomes than the general population. Thus, the discussions with healthcare professionals are especially important when working with patients when encouraging them to implement lifestyle change for health benefits.

As there is a difference in the conception of food and how this influence eating habits, it is feasible to suspect that there is an alternative understanding of health in African Caribbean communities that may influence lifestyle choices. Such information would be especially useful for primary healthcare

professionals who must initiate discussion about health behaviours, importantly including weight management with patients of this ethnic group. Investigation that explores the meaning of health in the African Caribbean community and how such knowledges compliment or contradict biomedical or mainstream societal discourses of health, could be invaluable for GPS and practice nurses when working with women from these communities. Discussions about excess weight must be underpinned by the 'pre swallowing domain of behaviour, culture, society and experience' (Crotty, 1999, p. 109), that is shaped in part by ethnic difference.

Conclusion

The aim of this literature review was to present information that will provide the direction of this investigation and presented issues that shed light upon the strands that may inform the discursive construction of health and wellbeing in African Caribbean communities with particular regards to women of this ethnic group; body shape and size.

The search strategy and selection of literature was given and the range of sources used gave insight into multidisciplinary nature of such study. The chapter then presented strands of discourse that may contribute to the discursive construction of health in for African Caribbean women that may be useful when exploring weight and weight management.

The first strand explored is the historical discourse of Western understandings of health, which was then followed by an alternative discourse of health rooted in the African diasporic experience and how such histories may still shape thought in African Caribbean communities in the present. The second

strand presented in the review explored the complex nature of health inequities and the range of explanations that have been proposed to explain the continued persistence of health disparities for minority ethnic groups, with particular focus on African Caribbean women. The third stand outlined the ever morphing connotation of 'fat' and the historical, biomedical and political perspectives that have defined and thereby given meaning to excess body weight and larger body shapes and sizes in mainstream, academic and alternative cultural discourse. The final strand to be examined was the current approach taken by public health to address issues of weight and weight management that focusses largely on food and food preparation. This useful information that can aid in making dietary change for are widely available in the African Caribbean community and as such do contribute to the knowledge of health and wellbeing that circulates within the community.

It was important for this literature review to sketch out the various facets of knowledge that could contribute to the understanding of health and wellbeing with regard to body shape and size for African Caribbean women. As has been shown in the review, such knowledge can be drawn from and constructed using a range of formal and informal sources. As such, it was important to present them in a way that did not offer different positions of knowledge in an antagonistic juxtaposition, rather to show that understandings are fluid and take elements from varying perspectives to locate meaning of one's own health and wellbeing. Attempting to discuss them as discrete strands was not a simple task but was necessary in order to ground the research with clarity so that the places where the strands converge can be identified.

Therefore, an approach to applied health research that can capture this complexity whilst being responsive to the dynamics of African Caribbean communities is important for such investigation. The

following chapters put forward the methodology and the subsequent novel research method designed for this investigation.

Chapter Three

Methodological Approach

Introduction

In this chapter, the methodological approach taken to explore the research questions is outlined and rationalised. The chapter opens by presenting the need for research into issues of weight management, obesity related illnesses and at risk groups in the UK as made by NICE (2011). It then moves on to explore the notion of 'seldom heard' as a more apt approach to engaging with communities that are commonly termed as 'hard-to-reach'. It suggests that a shift in perception may encourage more dynamic approaches to research design and implementation which may increase participation from traditionally underrepresented groups. Black feminist theory is then presented as the methodological framework of this research that seeks to engage with African Caribbean women to elicit rich in-depth data. Further, the anthropological concept of liminality as posited by Turner (1967, 1982) will be outlined and justified within the context of developing innovate research methods to capture knowledges from subjugated communities through a multidisciplinary approach. The final section of this chapter explores the importance of acknowledging the influence of researcher positionality when conducting such qualitative investigation.

Theoretical ideas presented in this methodical approach chapter have been developed and published as a chapter in an edited collection, 'Blackness in Britain' (Andrews and Palmer, 2016). The chapter is entitled 'Learning from the liminal: Conducting health research in African Caribbean communities'

(Andrews, 2016) and details explores how alternative approaches to conducting health research with African Caribbean women and other seldom heard groups may allow for more nuanced understandings of health and health beliefs.

The need for research

At the request of the Department of Health, NICE has provided public health guidance on the prevention of type 2 diabetes in high risk groups in the UK among adults aged 18-74 (NICE, 2011); with focus on those from minority ethnic communities and from lower socioeconomic groups. The guidance acknowledges the multifaceted issues relating to obesity and lifestyle with relation to type 2 diabetes onset and complex relationship between population and community based intervention to address the increasing levels of obesity and related chronic illnesses. As such, the impetus of the document was to encourage the development and maintenance of successful and cost effective health interventions that reflect the diversity of the communities it seeks to serve. It is recognised that in addition to national campaigns, there must be local services that are tailored to the cultural dynamics of target communities. The guidance makes a number of recommendations on national and local levels, which were developed using evidence from 'systematic reviews, expert testimony and its members' knowledge, understanding and experience of the topic area' (NICE, 2011, p. 36); table six details the list of recommendations.

Table six: Recommendations for the prevention of type 2 diabetes in high risk populations

I.	Integrating national strategy on non-communicable diseases
II.	Local joint strategic needs assessments
III.	Developing a local strategy
IV.	Interventions for communities at high risk of type 2 diabetes
V.	Conveying messages to the whole population
VI.	Conveying messages to the local population
VII.	Promoting a healthy diet: national action
VIII.	Promoting a healthy diet: local action
IX.	Promoting physical activity: national action
X.	Promoting physical activity: local action
XI.	Training those involved in promoting healthy lifestyles

(NICE, 2011, pp13-26)

In addition, the guidance offers recommendations for research based on identified gaps in the evidence that centre on how to design and implement cost effective weight management/ lifestyle interventions. Tables seven and eight presents the list of identified gaps in evidence and subsequent research recommendations.

Table seven: Gaps in research evidence

I.	There was not enough evidence to judge the effectiveness of interventions to reduce the risk of – and prevent – pre-diabetes. In particular, there was a lack of evidence on how effective they are with people from black and minority ethnic and lower socioeconomic communities in the UK.
II.	There was limited evidence on how different approaches could be combined. (For example, targeting the population as whole, targeting 'high-risk' populations and other approaches, including 'individual' interventions.)
III.	There was limited evidence on the 'cultural appropriateness' of interventions and how they could be effectively adapted or tailored to prevent pre-diabetes.
IV.	There was limited evidence on how the environment in which people live may affect their risk of developing pre-diabetes.
V.	There was limited evidence on the effectiveness of interventions to develop the awareness, knowledge, understanding and skills of healthcare professionals and others responsible for people at high risk of developing pre-diabetes.
VI.	There was limited evidence on the potentially regressive effects of food taxation on health inequalities.

(NICE, 2011, p85)

Table eight: Recommendations for research based in the gaps in evidence

I.	How effective and cost effective are interventions which use either a 'total population' or 'high-risk population' approach to preventing type 2 diabetes among people from black and minority ethnic or lower socioeconomic groups?
II.	What are the most effective and cost effective ways of developing, implementing and assessing tailored and culturally appropriate community-level interventions to prevent type 2 diabetes among people at high risk? This includes people from a range of black and minority ethnic groups and those from lower socioeconomic communities.
III.	Which participatory approaches are most effective and cost effective among populations at higher risk of type 2 diabetes? This should consider the awareness, knowledge, understanding and skills of the providers of interventions for people at high risk of developing type 2 diabetes?
IV.	How do socioeconomic, environmental, biological and psychosocial factors determine diet and physical activity behaviours and how do they contribute to differences in the risk of developing type 2 diabetes?
V.	How do financial factors (including incentives, pricing and taxation of food and incentives, and pricing for physical activity opportunities) affect food and physical activity choices?

(NICE, 2011, p41)

One such gap refers to the 'limited evidence on the effectiveness of interventions to develop the awareness, knowledge, understanding and skills of healthcare professionals and others responsible for people at high risk of developing pre-diabetes' (NICE, 2011, p. 85). Subsequently, the recommendation for research suggests investigations should attempt to address the following:

> Which participatory approaches are most effective and cost effective among populations at higher risk of type 2 diabetes? This should consider the awareness, knowledge, understanding and skills of the providers of interventions for people at high risk of developing type 2 diabetes' (NICE, 2011, p. 41).

However, before any research can investigate the influence of healthcare professionals' knowledge and understanding of their patients on the prevention of type 2 diabetes, preliminary investigation that aims to record and explain the dynamics of understanding health with regard to obesity in culturally diverse patient groups must be conducted. These findings can then be used to inform healthcare professionals with the intention of improving health outcomes in at risk groups and research that evaluates the value of this information when working with patients can form the basis of further investigation.

The importance of research that captures contextual realities of groups that are at a high risk of developing type 2 diabetes and other obesity related chronic illness is also emphasised by Davidson et al (2014, p. 512) who suggest that future research and practice in this area should include: 'greater inclusion of ethnic minority populations in research' and; 'better design, evaluation and reporting of studies that include ethnic minority participants'.

Hard to reach vs seldom heard

To develop this area of enquiry, applied health research that seeks to inform practice must develop ways to recruit research participants from marginalised groups and collect in-depth data. In the case of this research, focus is directed to African Caribbean communities and discourses of health and wellbeing with regard to females, body shape and body size. Traditionally within medical research, African Caribbean communities and other minority ethnic groups are termed 'hard to reach' due to their underrepresentation as participants in both clinical and qualitative investigations (Redwood and Gill, 2013). The conception that particular groups in society are 'hard to reach' is highly disputed and ambiguous in its nature is commonly used within the discourse of health and social inequalities. The term is often synonymised or used with other terms such as 'vlnerable, transient, marginalised, refusers, hidden, forgotten populations, underserved, special populations, disadvantaged populations (Flanagan and Hancock, 2010, p. 2). Groups most commonly referred to by this label include those from minority groups such as ethnic groups, lesbian, gay, bisexual and trans communities and homeless or roofless people; hidden populations, such as illicit drug users and sex workers (Brackertz, 2007). In other instances the term is used to describe larger sections of the population such as older and young people and those with disabilities (Jones and Newburn, 2001). Within the context of health service provision, the term hard to reach refers to those who may experience the highest risks of mortality and morbidity from ill health, yet are 'underserved' due to lack of access to health services for a plethora of reasons (Freimuth and Mettger, 1990). As such, reducing health disparities is a central tenant of the NHS Plan and National Service Framework, in which the report recognises that particular groups are 'harder to reach' by mainstream services and that Primary Care services are especially crucial in providing healthcare provisions to those in the greatest need (Department of Health, 2002).

However, use of the term *hard to reach* to describe particular groups in society is not a neutral label; rather it is infused with preconceptions, many of which are pejorative that suggest that there is something deficient about these groups. Some of the stigmatising terminology that has been associated with hard to reach communities has been collated: 'obstinate, recalcitrant, chronically uninformed, disadvantaged, have-not, illiterate, malfunctional and information poor' (Freimuth and Mettger, 1990, p. 323). From this perspective, the issues of disparities in health outcomes and the under representation in health research of particular groups defines the problem as being with the marginalised group, rather than with the approach taken to engage with them. By proxy, this perspective justifies the routine exclusion of particular groups from health research and provides rationale for the gaps in knowledge about understandings of health in these communities. The acknowledgement that such hard to reach communities are 'inaccessible to most traditional and conventional methods for any reason' (Health and Safety Executive, 2004, p. 8) means that health research must question the perception of accepted qualitative research methods as 'gold standard' (Silverman, 2000, p. 291) that can be appropriated in a *one size fits all* manner.

Research methods must be the 'tools that enable us to fill gaps in our understanding of health and illness' (Morse, 2002, p. 116). However, Sandelowski (2002) observes that within qualitative research 'naïve views of in the interview, disembodied participant observation and virtual neglect of the material world have led to qualitative work that is not as full-bodied as it should be' (Sandelowski, 2002, p. 104). Rather, there must be the development of research methods that give whole voice to the communities we seek to conduct research with: 'The creation of respect and working relationships between marginalised minority communities and researchers takes time and effort (and indeed resources) but in the long run will be to everyone's benefit'(Johnson, 2011, p. 229). Firstly, it is

important to challenge the discourse that places communities out of reach to health researchers by changing the language used. In choosing to refer to groups as *seldom heard* as opposed to hard to reach, this sematic change places the onus on health researchers and service providers to seek new ways to reach out and engage with communities rather than blame them for their absence. In doing so, knowledges about these communities can be incorporated into developing and enhancing health service provision (Oakley et al, 2003; Redwood et al, 2012). Such information would go towards addressing the numerous health inequalities that minority ethnic communities face (Sproston and Mindell, 2006) as it could form the basis upon which further research into health service development could be based.

The need for an inclusive approach to research involvement is especially important in the current health research environment. A central element of gaining research funding is hinged on Patient and Public Involvement (PPI), where research bids must demonstrate that they have or will consult with a diverse range of respondents in developing the proposal (Boote et al, 2010). The emergence of 'recruitmentology', within the field of health research that interrogates the dynamics between culture, history, power and its influence when recruiting participants from minority ethnic groups is testament to this (Epstein, 2007, 2008).

Methodological framework

To develop a health research method that encourages participation from seldom heard communities to explore the discursive constructions of health, the methodologies that underpin the work must be rooted in a framework that takes into account the dynamics of the group; based on the intersecting social

issues and conditions that shape their experiences. It is imperative that novel research methods provide spaces to give voice to those that are often silenced in health research by using approaches that understand the reasons for under representation in health research and; that seeks to validate alternative perspectives. The aim of this research is to explore, describe and explain the discourse of health in African Caribbean communities, so that areas of complement and contradiction to biomedical and mainstream discourses of health can be identified. It is important to be able to distinguish between differing epistemologies, paradigms and methodologies so that the significance of opposing perspectives can be understood. For clarity, it is important to offer definition of terms in the manner that they will be used in this project. *Epistemology* refers to an overarching theory of knowledge and the standards used to assess the validity of claim of truth. In contrast to epistemology, *paradigm* refers to the interpretive models of understanding used to explain social phenomena. *Methodology* denotes to the broad principles of how to conduct research to investigate epistemologies and how interpretive paradigms will be used (Collins, 2000; Harding, 1987).

As this research is focussed on the health of African Caribbean women, the methodological framework will be rooted in a Black feminist epistemology that recognises uniqueness of knowledge created and affirmed by women in Black communities, using the paradigm of intersectionality (Crenshaw, 1990) as the interpretive framework. The importance of rooting this work in a perspective that opens up space for the acknowledgement of the wide ranging realities that Black women experience is central to further understanding. Critique of mainstream feminism that places middle class White femininity at the centre of understanding which can only offer a limited lens to reality that cannot reflect the lives of the majority of women; giving voice to few while silencing many (Davis, 1981). To challenge this narrow way of understanding issues as they relate to women across societal strata, hooks encourages

that the lens that focuses on the lives of women should be placed so that is looks 'from the margin to the center' (hooks, 1984). Such a standpoint includes and gives voice to the experiences of women who live between the intersections of: race; ethnicity; gender; sexuality; class; age and; disability, ensuring that they are included in any endeavours to improve social outcomes: 'the absence of these considerations weakens any feminist discussion of the personal and the political' (Lorde, 1984, p. 98).

Black feminist theory offers a framework through which the experiences of Black women can be articulated and understood within society. This theoretical standpoint acknowledges that the intersectional experiences for Black women shape knowledge held and maintained about society and the ways of knowing that are employed to articulate this knowledge. In her influential book on Black feminism, Collins (2000) suggests that **'**Black feminist thought can be best viewed as subjugated knowledge' (Collins, p. 251). Black women use alternative epistemological standards for assessing truth that are rooted in collective experiences, social conditions and worldviews that emerge as a form of understanding that Collins outlines as Black feminist epistemology. Whilst it cannot be stated that this alternative epistemology is claimed by all Black women, it does assert that there are differences in the criteria for substantiated knowledge between Black women and mainstream society. It is then important to appreciate the potential contribution that understanding such an alternative epistemology would have when developing a health research method that seeks to engage with African Caribbean women. As such, the contours of Black feminist epistemology and how Black women create and affirm distinctive knowledge standpoints, have been outlined. The first contour denotes lived experience as a criterion of meaning, which places those who have lived through experiences that they claim to be experts about are more credible that those who have may have read or heard about experiences (Collins, 2000). The commonly used African Caribbean phrase *you must be tested before*

you can testify is in reference to who can legitimately make claims on authority with regard to situations.

The second contour is the use of dialogue in assessing knowledge claims that places the process of discussion at the centre of new knowledge creation and validation. Through the exchange and development of perspectives through discussion, for Black women such talk becomes 'humanizing speech, one that challenges and resists domination' (hooks, 1989, p. 131). The third contour is the ethic of caring which suggests that ideas cannot be divorced from the sentiments from which they emerge. As such, 'personal expressiveness, emotions, and empathy are central to the knowledge validation process' (Collins, 2000, p. 263) and value is placed on communicative capacities of individuals. An example of where the ethic of caring in knowledge validation displayed through emotion is within Black church services where knowledge claims made in the pulpit are affirmed in an emotion call-and –response rhythm between the preacher and the congregation. The sound of what is being said and the expressive charisma of the preacher is just as important as the words being said and the message they are conveying.

The ethic of personal accountability is placed as the fourth contour of Black feminist thought in that assessment of an individual's claims of knowledge is evaluated concurrently with their character, values and ethical traits (Collins, 2000). From this perspective, all views are embedded and emit from their core beliefs (Kochman, 1981), and probing personal beliefs is not beyond the limitations of discussion when assessing knowledge claims. In fact 'claims made by individuals respected for their moral and ethical connotations to their ideas will carry more weight than those offered by less

respected figures' (Collins, 2000, p. 265).[13] Through understanding the premise of this alternative epistemology and incorporating its elements in to applied health research methods, it provides the foundation for an approach that may truly seek to engage African Caribbean women in the research inquiry to develop services that seek to address health disparities:

> In this alternative epistemology, values lie at the heart of the knowledge validation process such that inquiry always has an ethical claim. Moreover, when these four dimensions become politicized and attached to a social justice project, they can form a framework for Black feminist thought and practice (Collins, 2000, p. 266).

In the process of developing research methods that give voice to seldom heard communities, such as African Caribbean women, a certain degree of ingenuity is required. Approaches that build upon traditional methods of inquiry but break away from convention are required while maintaining research rigour is critical (Crosby et al., 2010). Methodological appropriateness for the recording of discourses of health in African Caribbean communities must understand that whilst this knowledge can be documented by anyone, it is produced by the women themselves and this appreciation must be at the centre of the approach employed. In doing so, power relations that define society can be challenged by

[13] See chapter 11 of 'Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment' (P. H. Collins, 2000) for full discussion of the contours of Black feminist epistemology.

the research process. Through research, the seldom heard community in question are empowered as agents of knowledge rather than as recipients of information.

The liminal space

The concept of *liminality* was first coined by the anthropologist Van Gennep in 1909, to describe the rites of passage through the life cycle and the rituals that define each stage of transition (Van Gennep, 1960). The concept of the *liminal space* was later coined by the anthropologist Turner (1967, 1982) who expanded upon the theory of Van Gennep from his field work with communities in Uganda, Zambia and Mexico. Turner posits that within hierarchical societies, spaces exits where the power relations that traditionally produces social inequalities such as: racism; patriarchy and; homophobia are suspended and contested power in forms that may be physical or metaphorical in nature. It is in such *in-between* spaces that exist between public and private where ideas can be formed, reformed and redefined without the constraints of wider societal conventions. What emerges from the liminal space is not necessarily a definitive answer, but rather an alternative way of understanding social realities where artistic, political, cultural and social ideas and concepts are in constant flux and contestation. Within post-colonial studies, the concept of the liminal is central to understanding cultural hybridity, a term which within this discipline of study refers to the cultures that emerge in societies that rise from cultural contact with European societies, such as those in the Caribbean and South Asian countries. For Bhabha (1994), the liminal enables the creation of cultures that exist between fixed identities and 'entertains difference without assumed or imposed hierarchy' (Bhabha, 1994, p. 5). As a seldom heard group, Black women have developed sites of liminality where alternative understandings and knowledge are created and affirmed. Arenas such as music, dance, fashion, literature and everyday

conversations are important locations for empowerment through the validation and affirmation of Black femininity (Farrington, 2005). As well as metaphorical liminal spaces, they also exist in tangible form in spaces that contradict mainstream discourses of power relations and allude to different meanings. For instance, Williams-Forson (2006) explores the relationship between food and power for Black women and suggests that the preparation of food is a liberatory act with regard to historical and contemporary social conditions and the kitchen exists as a space of emancipation from oppression. This notion is in contradiction to mainstream feminist thought that suggests the opposite and the kitchen and associated household duties are overt characteristics of patriarchal oppression (Johnson and Lloyd, 2004). Here, the importance of intersectionality as the paradigm to understand how different discourses that give the *kitchen* varied meaning is central. This example also serves to illustrate the role of liminality in what are perceived as commonplace spaces and the epistemologies developed and maintained in this space reflect different experiences of the society.

To capture and document discourses of health and wellbeing held by African Caribbean communities, with particular relation to female body shape and size, the research method is developed to address recruitment, trust and data depth issues by rooting the project in understandings gleaned thus far. Core aspects of the investigation are where the data collection will be facilitated to 'counter the scales of power' (Elwood and Martin, 2000) and; how the data will be captured in attempt to enable the 'subaltern to speak' (Spivak, 1988).

Researcher Positionality

As a member of the ethnic group being researched and as a representative of the academy, it is important to explore researcher reflexivity. As suggested by Milner (2007, p. 395):

'researchers need to reflect about themselves in relation to others – in this case, the communities and people involved in their research studies – and to acknowledge the multiple roles, identities, and positions that researchers and research participants bring to the research process'.

I am an African Caribbean woman, born in the UK to parents of Jamaican and Bajan heritage. I have been brought up within African Caribbean communities and am aware of the histories, social issues and cultural nuances that define African Caribbean culture, many of which are not readily visible to those outside of the communities. As such, this may afford my research the closeness that 'insider' accounts can offer to further understanding and depth to analysis. However, where participants may appreciate me as 'one of them', they may allude to the finer detail of points making the assumption I have an understanding of their perspective, often characterised by the phrase 'you know what I mean' (Ochieng, 2010).

Whilst this medical sociology research is being conducted within a university medical school, where typically epistemologies are rooted in Western conventional frameworks that shape the nature of inquiry (Gaventa, 1991; Ladson-Billings and Donnor, 2005), it is also shaped by my personal and cultural biographies. Thus, this research is positioned between differing epistemological positions, which have influenced the methodological framework. As an African Caribbean woman, the concept of developing research methods that truly engage communities that are seldom heard is one that is exceptionally personal. Reviewing literature about health inequalities serves to reinforce the realities of

health inequity that exists for my community and others experience. The social value of health services that meet the needs of those at increased risk of developing obesity related chronic illness such as type 2 diabetes and offers dynamic, yet cost effective care for those living with such conditions is incalculable.

As such, I feel that this investigation has two strands of researcher accountability. The first being academic accountability, ensuring that the research meets the standards of rigour and analysis to be deemed legitimate in making knowledge claims, adding to the cannon of understandings of lay health, researching seldom heard communities and the development of health services for at risk groups in society. The second is a community accountability that seeks to ensure that African Caribbean perspectives on health, as relayed to me by participants are documented and presented in a manner that does serve not to encourage derision, rather to place their understandings within cultural and wider contexts sensitively. Collins asserts that there is a particular role for Black women academics when working within a Black feminist framework:

> While a Black woman's standpoint exists, its contours may not be clear to Black women themselves. Therefore one role for Black female intellectuals is to produce facts and theories about the Black female experience that will clarify a Black women's standpoint for Black women (Collins, 1986, p. s16).

This is especially important for developing health interventions, that articulate a Black women's epistemology within the discourse of biomedicine to prevent, manage and treat obesity related chronic

illness. Although all research conducted should meet these strands of responsibility, they are especially compounded by the tensions between academia and the Black community.

For African Caribbean communities that have been historically denied access to and presently underrepresented within academia, as both scholars and research participants, there is a wariness of the university that views 'ontological knowledge [as] suspect and at worst pathologised' (Simmonds, 1997, p. 228). This further entrenches power/knowledge relations (Foucault, 1980), a problematic issue that has been explored and acknowledged with regard to gender (Oakley, 1981); ethnicity (Gunaratnam, 2003) and disability (e.g. Oliver, 1992). This reality may further scepticism of institutions such as the university and the knowledge it produces; a power dynamic that is embodied in the traditional researcher-participant relationship 'even when the researcher has an intellectual and emotional commitment to the people being studied' (Hammersley and Atkinson, 2007, p. 274). Thus, it cannot be assumed that because I am an African Caribbean researcher that the issues of scepticism from the community would be alleviated. For some my role as an Applied Health Doctoral Reseacher transcends my ethnicity and I am subject to the same suspicion as a representative of the university intuition and of biomedical dominance, irrespective of ethnic background. The complex reality has been dubbed the 'dilemma of the Black intellectual' (West, 2009). In taking lead from Simmonds (1997) the question posed is 'how does a black woman do medical sociology?'

To answer to this question, Few et al (2003) suggest recommendations for Black women conducting qualitative research on sensitive subjects such as health with Black women. They propose that the process of data collection and analysis should aim to: contextualize the research and researcher

subjectivity; triangulate multiple sources; monitor symbolic power and; understand the value of caring in the research process. In developing new knowledge that adds to the cannon of health epistemologies, the 'outsider within' status of the researcher can offer distinctive perspectives and interpretations on exiting medical sociology paradigms (Collins, 1986). For the study of obesity, related chronic illnesses and their prevention, this is of especial importance as research must explore alternative ways to respond to this public health situation.

Conclusion

This chapter has provided the background to the research paradigms of this research study and how they have formed the foundations upon which the research design is to be framed. The request for research as made by NICE (2011) to inform the development of cost effective and successful weight management interventions for the prevention of type 2 diabetes and other obesity related illnesses inform the rationale for this study as a contribution to further research that would be required in this area. In adopting the position of 'seldom heard' as opposed to 'hard to reach', the responsibility for giving voice to the traditionally underrepresented is placed with the health researcher rather than with communities and the position that research should give voice to these communities is pivotal in the desire to reach finely grained conclusions from the research process. Black feminist theory is outlined as the methodological framework through which this study seeks to give voice to African Caribbean women in this research and the anthropological concept of the liminal space informs where the data collection will be conducted. In the last section of this chapter, issues of researcher positionality, pertaining to both practical and theoretical issues were discussed and how researcher subjectivity forms

an integral part of this research. The following chapter presents the research design developed for this investigation that has been dubbed the ‘Big Talk Project’.

Chapter Four

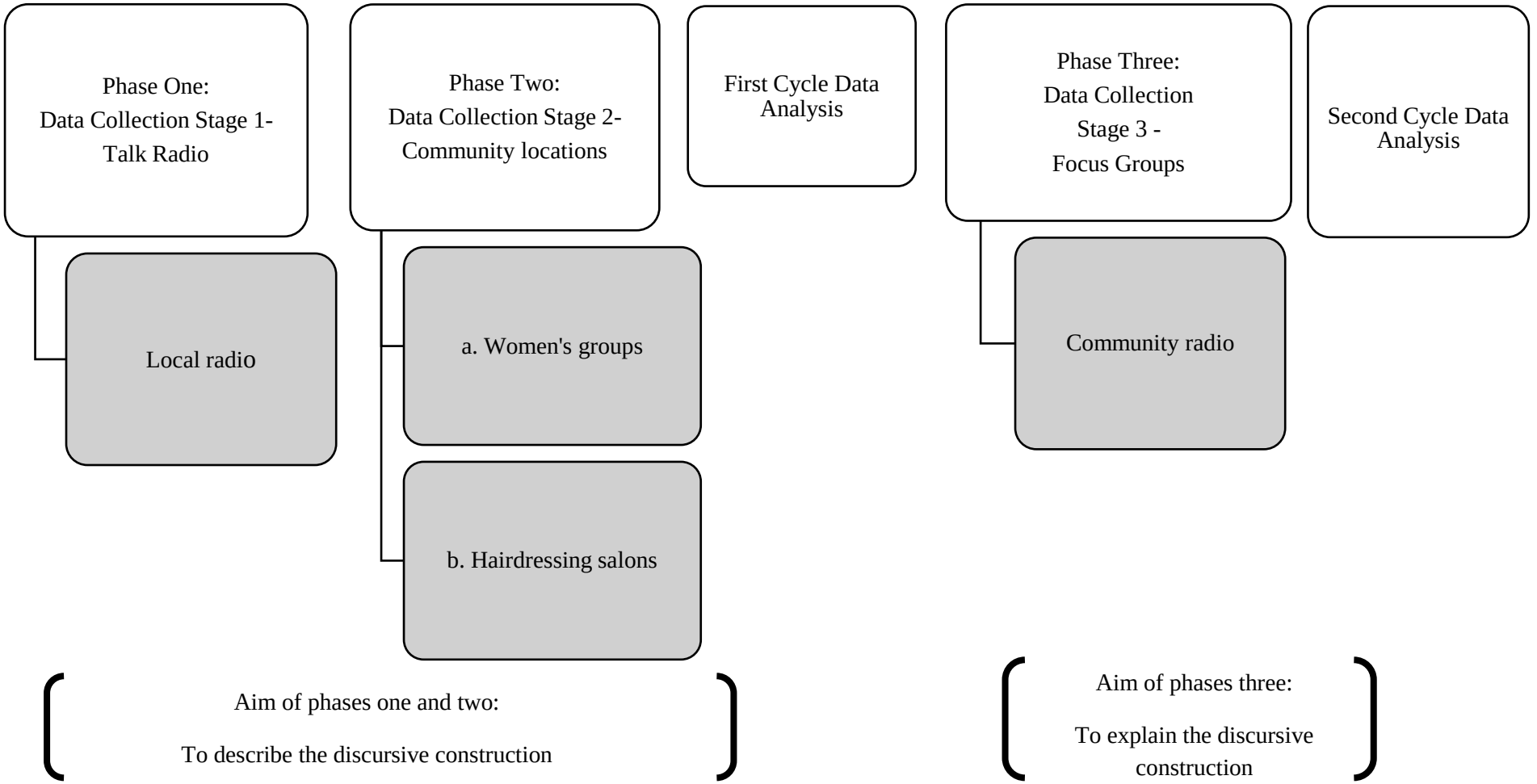
Research Design

Introduction

The research design gives a framework for the collection of data and the choice of design should reflect the dimensions of the research questions, research context and participants (Bryman, 2004). The process of developing knowledge is complex and multi-faceted, especially when researching with seldom heard communities and the research design of this research seeks to mirror this. In order to address the research questions, the research will be conducted in two distinct research phases, each using different approaches to collect good quality data. The process of 'triangulation for completeness purposes' refers to the' use of multiple techniques for collecting and/or analysing data in a single study' (Adami and Kiger, 2005, p. 19). There are different types of triangulation (Carter et al, 2014; Patton, 1999); this study will employed data source triangulation in the attempt to capture detailed insight into discourses of health in the African Caribbean community and how this may influence relationships with healthcare professionals and public health messages with regard to weight management. This chapter starts by outlining phases one and two of the study, where the aim is to explore and describe the discourse. In these phases, data collection is conducted within the African Caribbean community using talk radio, local community groups and hairdressing salons. Then an outline of phase three of the study, where the aim is to explain the discourse will be presented. Lastly, the chapter take present the

approach to data analysis that this project took. Figure seven depicts a visual representation of the research phases.

Figure two: The Big Talk Project research design



Geographical location of the research

This research was conducted in Birmingham, West Midlands, UK. Census figures indicate that African Caribbean communities are the third largest minority ethnic group in Birmingham (Birmingham City Council, 2014); and 56% of these communities reside within the Sandwell and West Birmingham Clinical Commissioning Group area (Baker and Jager, 2009; NHS, 2014a).

Learning from the liminal: Phases one and two

To capture rich accounts of discourses of health from within African Caribbean communities in the UK, research phases one and two were conducted in liminal spaces identified within African Caribbean communities in Birmingham. In such spaces, the investigation interrogated the counter narratives that exist in relation to perceptions of health and wellbeing and; how these may complement or be in opposition to dominant discourses. In order to understand the how alternative narratives of obesity and wellbeing operate in flux with relationships with health professionals (as agents of the dominant bio-medical discourse), this research engaged with African Caribbean women in Birmingham about the ways in which being subject to both discourses influence relationships with health professionals in relation to weight management in raising the issue of weight management.

Whilst the focus of the research was gender and ethnicity specific, it was imperative to acknowledge that alternative discourse is also shaped and mediated by African Caribbean males and those of other ethnic groups too. As such, the research conducted in phases one and two did not

exclude anyone from the research process, rather accepted input from all and viewed them as valuable in gaining understanding of health discourses for African Caribbean women.

Talk Radio as a liminal space

The influence of mass media on how people understand themselves and others and its contribution to shaping discourses of the social world has long been acknowledged (Durham and Kellner, 2006). As well as reporting news on health issues, mass media is also used as a platform to educate and inform audiences about lifestyle choices that can improve health outcomes and quality of life. As such, public health bodies have historically harnessed the influence of media to promote health messages. Recent mass media campaigns include: 'Act FAST' (Department of Health, 2012a) ; 'Smoke Free' and (Department of Health, 2012b) ; 'Change 4 Life' (Department of Health, 2012c). Research into the outcomes of such campaigns finds that that they do increase general understanding of health conditions (Bietzk et al, 2012) and do encourage people to implement healthier lifestyle choices (Hornik, 2002). As it has been shown that mass media is an effective way to disseminate information about health to the public, it is then feasible to assert that mass media could also be used as a valuable site to collect information from the public and be used for health research.

While it may initially appear to be a juxtaposition to place the concept of liminal spaces with mass media, 'fatosphere' research that explores how fat acceptance activists use internet forums to create a spaces of empowerment, reframing negative mainstream views towards fat is an exemplar of such a space (Dickins et al,2011; S. Lewis et al, 2011). For this research, talk radio was identified as a liminal space and it is upon this mass media platform that phase one of the research was conducted.

Talk radio is characterised by on-air radio discussions with programme hosts and telephone contribution from members of the audience, often on topical or controversial topics. This form of mass media is a valuable arena for research because it can be understood as one of the few spaces in society where public and private domains intersect. Audience members can choose to contribute to public discussion from their private domain, in a similar vein to internet forum discussion. For this health research, the nature of talk radio emerges as important for two main reasons. Firstly, due to the negative connotations often associated with fat and weight related stigma experienced by overweight and obese individuals (Puhl and Brownell, 2001, 2003). It is a benefit of this type of mass media that those who wish to participate can do so without being subjected to actual or perceived assumptions made on the basis of physical appearance. Over the radio, the individual is at liberty to choose whether to disclose information about themselves and their body in ways that cannot be achieved using other mass media such as television. Secondly, the very nature of disembodied discussion may encourage those who have never considered taking part in health research may choose to participate from the comfort of their own home where otherwise they may have declined or been more apprehensive about participation. As a liminal space, talk radio enables societal power dynamics based on physical appearance and relationships between researcher and participants to be temporarily suspended and re-appropriated for the duration of health research discussions on-air. For African Caribbean communities, this shift is especially important as there is a recognised and historically justified distrust of power relationships between Black communities and health research as discussed in previous chapters. Through this medium, those who choose to take part in the research will have more control over their involvement in the process. It was expected that that data elicited will be richer due to this, unlike if the research was using conventional ‘gold standard’ (Silverman, 2000) interview techniques of qualitative research, for example, one-to-one interviews in a designated university space.

It is understandable that comparisons between research conducted using internet chat forums and talk radio will be made, due to the anonymous nature of research participants. However, there are important differences between the uses of these mass media platforms for heath research. Although the growth of new media has accelerated in the last decade, 14% of households in Great Britain have no or limited access to the internet for numerous reasons (Office for National Statistics, 2015) and as such may be excluded from taking part in online research, especially about potentially sensitive subject matters. However, talk radio exists as a more democratic method of engaging with people as it facilitates communication with others on topics of interest in real time without the need for home internet access, just a telephone is required. Issues relating to internet usage can also reflect dynamics of power as research finds there continues to be a level of distrust held by some over using this type of media to communicate with others due to security and privacy concerns; even echoed by senior ministers (Wheeler, 2012) which is not conducive for encouraging participation using the internet.

For this research, radio communication is especially important, as this form of mass media has a especial significance for African Caribbean communities in the UK. In his research concerning African Caribbean organisations in the UK, Hylton (1999) explains that because historically African Caribbeans were excluded from mainstream radio, the community developed its own network of 'pirate', or unlicensed radio stations. These community radio stations have been used for music and talk and are well known in the communities they serve. On-air discussion and debate has been an essential element, used to disseminate information and a space for the people to explore issues in the community. In the UK, there are now licenced African Caribbean radio stations and shows targeted at these particular ethnic communities exist on national and local radio stations.

However, there continues to be a strong presence of pirate radio stations and independent internet stations.

Community groups as a liminal space

Whilst there is an underrepresentation of particular sectors of society within health research, there is not a complete dearth of investigation that includes traditionally marginalised groups. However, there is a critique that health research over consults particular members of communities who are relatively accessible, and as such become over-consulted and reluctant to participate and cannot always reflect the dynamics of the wider community in focus (Brackertz and Meredyth, 2009).

For instance, in the case of African Caribbean communities there is a tendency to approach churches when recruiting for research (Maynard et al, 2009). This is an especially apt space for recruitment as there is continuing increase in attendance figures in Black churches (Evangelical Alliance, 2008). However, it is important acknowledge that African Caribbean communities are religiously diverse. Over the last 20 years, Islam has become the fastest growing religion among Black people in Britain (BBC World Service, 2011; Reddie, 2009) and recent census data indicates an increase in Rastafarians in the UK between 2001 and 2011 (Rodgers, 2011.). It is also important to acknowledge the existence of other religions within African Caribbean communities such as: Jehovah's Witnesses; Seventh Day Adventists; Hebrew Israelite; Ethiopian Orthodox Christian; African Spiritualism and; those who may not subscribe to or affiliate with any particular religious orientation. By focussing on Black churches as a sites for recruitment would mean that large numbers of people are not consulted or included.

Additionally, much health research with African Caribbean communities is conducted with participants who are users of particular health services, for example research conducted by Brown et al (2007) was conducted with patients who are living with diabetes and engaged with specialist support services. While such research is essential for the development of services for the care of those living with health conditions, the scope for understanding how to prevent ill health may be limited. While this is not a critique of the valuable health research conducted with African Caribbean communities, it is a call to encourage more dynamic methods of participant recruitment from this particular seldom heard ethnic group. Phase two a seeks to address these issues by mainly conducting data collection with predominantly African Caribbean community groups that are not faith based but are self-defined, rooted in a shared interest. It is from this perspective that groups identified can be understood as liminal spaces in that societal divisions that can often create distance between individuals are paused and collective interests are intensified. In the task of recording discourses of health and understandings of the body, the use of this arena may allow for the nuances of different perspectives within an ethnically similar group to surface in a relaxed manner.

Further, when addressing issues of power in the research process, there are particular considerations when using community groups in this manner. The location of research data collection is a crucial element in the investigative process and to embed the research within the liminal space, it is important that the research took place in the group's usual meeting place. As such, it is important for the research to acknowledge the importance of the physical space and appreciate that the researcher became an invited guest into a space that exists as a 'home' for the group. From this perspective, the research must reflect the dynamics of being a guest in another's home and cannot assume that the traditional roles of researcher-participant will enable for detailed participant

responses. Rather it was important to adjust the dynamics accordingly to capture group discussion of the topic. Instead of using a traditional focus groups approach as a method of facilitating discussion, or group interview approach to ask specific questions, the researcher initiated discussion of the research topic and allowed the conversation between the participants to continue naturally. Use of this approach places the power of knowledge production with the participants; allows for group interaction to co-construct and locates understandings of health within a shared context. Importantly, as issues relating to health, body shape and size are sensitive subjects, the group themselves demarcated their own boundaries of discussion and regulated the tone of the conversation in a way that reflects the relationships within the group that cannot be assumed by the researcher.

Hairdressing Salons as a liminal space

For phase two b, the third site for data collection as identified as a liminal space for African Caribbean women are hairdressing salons. Whist hairdressing salons are principally rooted in economic activity, they also exist as unique locations of knowledge creation and affirmation for Black women (Battle-Walters, 2004). In the first instance, they are settings that are developed and maintained by Black women and exist within the mainstream as legitimate spaces for female beauty, yet offer services that cater to aesthetic choices that can sometimes operate outside European beauty standards. The legacy of binary distinctions between Blackness and Whiteness that emerged during the European enlightenment formed the basis of a mainstream discourse that ascribes beauty to European features and distain for African features (Hall and Gieben, 1992); hair is one such example. As such, Black women have articulated a range of hairstyles, grooming

techniques and products that reflect, reject or accommodate western standards. Within mainstream, hair styles may be viewed as an apolitical choice, but within Black communities, the signification of a woman's hairstyle is located in a wider cultural politic and the issues of Black women's hair are a passionately debated topic within Black communities, globally and locally (Banks, 2000; Mercer, 1994; Rooks, 1996; Tharps and Byrd, 2002). Therefore, the African Caribbean hairdressing salon can be read as a space that exists between mainstream and alternative discourses of femininity, sexuality and; body and beauty ideals and discussions about such topics happen regularly (Battle-Walters, 2004). Thus, this space is an ideal place to conduct data collection with regard to the research questions.

Although the customers who may be in the salon may be from different social backgrounds (such as age, employment, education), they will all share the commonality of wanting to *feel good about the self*, hence, having their hair done. The relationship between feeling good and looking good is an important in understanding the nature of excess weight and developing interventions to address obesity. Within mainstream discourse, the importance of looking good rather than improving health is often the driver of many fad diets that regularly feature in media aimed at women where the distinction between health and beauty becomes blurred and body work becomes the signifier of health (Monaghan, 2001)[14]. This ambiguous relationship between health and beauty is not constricted to the mainstream; in fact a recent front page of 'The Voice', the UK's Black national newspaper carried the headline 'Do women care more about their hair than their health? (Isokariari, 2013)'; see figure eight. The story that followed detailed the increase in overweight and obesity in

[14] See literature review for further discussion of this issue.

Black communities in the UK and suggested that for some women the prospect of ruining their hairstyle was a barrier to physical exercise.

Figure three: The Voice Newspaper, August 2013

(Isokariari, 2013)

When exploring body work for African Caribbean women and relationships to chronic illness prevention, the hairdressing salon is an especially poignant space to conduce this research as it has been found that beauty products used by some Black women can increase susceptibility to ill health; risks that women may not always be aware of. Research has found that the products used to chemically straighten afro hair, in a process called perming, can increase the risk of pre-term birth or low birth weight for women who use perms during pregnancy (Blackmore-Prince et al, 1999; Rosenberg et al, 2005); developing uterine fibroids (Wise et al, 2012) and; onset of alopecia and other hair loss conditions (Khumalo et al, 2007; Olsen et al, 2011). Also, the alarming practice of skin lightening or bleaching, a chemical process that lightens the pigment of the skin has also been found to have serious health implications, such as increased susceptibility to cancers (Kooyers and Westerhof, 2006); skin diseases (Mahe et al, 2003); hypertension (Bwomda et al, 2005) and endocrine disorders, including type 2 diabetes (Olumide et al, 2008). It is essential for any intervention that seeks to prevent chronic illnesses in diverse populations to have a foundational knowledge of the cultures of the communities that they wish to serve and have an understanding of issues which may not be obvious to those outside of the community but be of especial importance.

Additionally, the relationship between the hairdressing staff and the customer is one that contributes to the liminality of the salon and lends itself well to the data collection process. There is a considerable amount of time that African Caribbean women may spend in the salon for their appointment spend to achieve the desired style; for instance some braided styles can take up to 6 hours to complete. Further, the upkeep the style may require regular appointments at the salon. Thus, customers and hairdressers develop a particular relationship based on familiarity and trust that enable paths of communication that may not always be accessible for researchers, especially when researching sensitive topics. This relationship is one that has been used by researchers in the US,

where Black hairdressers were trained as lay health advisors for Black women with particular focus on breast cancer to increase uptake of screening (Wilson et al, 2008). In the process of being granted access by the salon to conduct the research, the women may feel more comfortable to take part in the research that will be conducted as natural group discussion between customers and hairdressing staff.

Data collected over research phases one and two were audio recorded and transcribed verbatim and field notes taken.

First Cycle Data Analysis

The data from phases one and two will be analysed using thematic analysis, an approach which enables the organisation and identification of themes from codes in the data to allow for interpretation. This method of data analysis was chosen as it is a flexible research tool that can be applied across theoretical and epistemological positions as part of a medical sociology investigation that incorporates interdisciplinary perspectives for understanding; yet retains methodological rigour. The manner in which thematic analysis will be used will be based on the guidelines outlined by Braun and Clarke (2006). Unlike methods that encourage objectivity in the analytical process, thematic analysis requires the standpoint of the research and the researcher to be made clear as coding and the development of subsequent themes is not a neutral activity. A continual process of reflexivity is necessary as this will influence how data is interpreted. As such, approaches to analysis should be considered before starting the process. The first decision is the approach to how themes in the data will be identified and organised. Data can be primarily identified using an

inductive *bottom up* approach that involves developing explanations *from* the patterns and themes of the data; from this perspective theory is the outcome of research. Alternatively a deductive *top down* approach involves using existing theory to explain and understand findings; from this perspective theory guides the research. The second decision concerns the level of analysis. Data can be categorised semantically, based on explicit, descriptive meanings or; latently, based on underlying conceptions (Boyatzis, 1998).

However, although such distinctions are made between the types of approach to be taken when conducting analysis, in practice this is not always possible and binary separations are difficult to make. In many cases, inductive reasoning influences deductive reasoning and vice versa. Similarly, latent perspectives impact upon sematic understandings and vice versa. The benefit of using thematic analysis is that its flexibility allows for a hybrid combination of pre-defined categories based on direction from existing literature with those that emerge from the data, enabling for more finely grained conclusions to be drawn (Charmaz, 2006).

Probing the knowledge: Phase three

Focus groups are defined as 'group discussions organised to explore a specific set of issues […] The group is 'focused' in the sense that it involves some kind of collective activity' (Kitzinger, 1994). There are a number of outlined purposes for the use of focus groups; most relevant to this phase of the study is to follow up initial research to clarify, elaborate or evaluate findings to ascertain views and attitude towards conclusions being reached (Barbour, 2008). Focus groups, as a method of qualitative data collection are widely used in health research. As suggested by Collins (1986) and

discussed within the context of researcher reflexivity, there is a responsibility of the researcher to develop understandings *with* communities rather than *on* communities; an issue that is amplified for seldom heard communities. Also, it cannot be assumed that the researcher's interpretation of the data, as a health researcher and as a member of the community being researched is a true reflection of the discourses of health in African Caribbean communities. Therefore, phase three will involve conducting a series of focus groups in community locations with African Caribbean women. The focus groups will be based on the initial findings from phases one and two to encourage further analysis, with the aim of *explaining* the observed discourses of health.

Although the focus group is a conventional research method, in this research it is used in a way that reflects the dynamics of previous phases in that knowledge is constructed in discussion with others, a central tenet of Black feminist and indeed mainstream feminist epistemology (Wilkinson, 1998). The defining element of phase three in comparison to phases one and two was the role of the researcher. Rather than encourage natural discussion as in phases one and two, conversation will be guided by a topic guide that will seek to facilitate exploration of the themes that emerged from the previous phases.

Second Cycle Data Analysis

In the second cycle of data analysis, the focus group data from phase three will be themed and coded using the same approach in data analysis phase one to develop the intial themes. The next stage of data analysis in the second cycle is axial coding for theme development. This process enables for the loose connections developed in the first stage of data analysis to be strengthened and

woven between and within themes for conceptual insight by interrelating substantive categories (Punch, 2005). Strauss and Corbin (1990) outline this approach to data analysis as one that consists of identifying the causal and intervening conditions, phenomenon contexts, actions and interactions and consequences as a way of interconnecting the data. Thus:

> 'the outcome of axial coding is an understanding of the central phenomenon in the data in terms of the conditions which give rise to it, the context in which it is embedded, the action/interaction strategies by which it is handled, managed or carried out, and the consequences of those strategies' (Punch, 2005, p, 210).

This particular approach to data analysis allows the research questions to be answered. Through the development of the themes in the first cycle of data analysis, it supports the discourses of health in African Caribbean communities to be mapped and its contours described. The stage of axial coding and theming of the data from phase three allows for further finely grained exploration of the discourse with regard to wider social contexts through the paradigm of intersectionality, illuminating issues that may be useful to answer the second research question.

Summary

As has been shown in previous chapters, the knowledge process is a dynamic process and it is important for health research to develop approaches to investigation that respond to this, especially when working with seldom heard communities. This chapter has outlined the triangulation research process of the three phases of data collection and the two stages of data analysis that will constitute

the Big Talk Project. The next chapter details the methods of data collection and analysis of this research investigation.

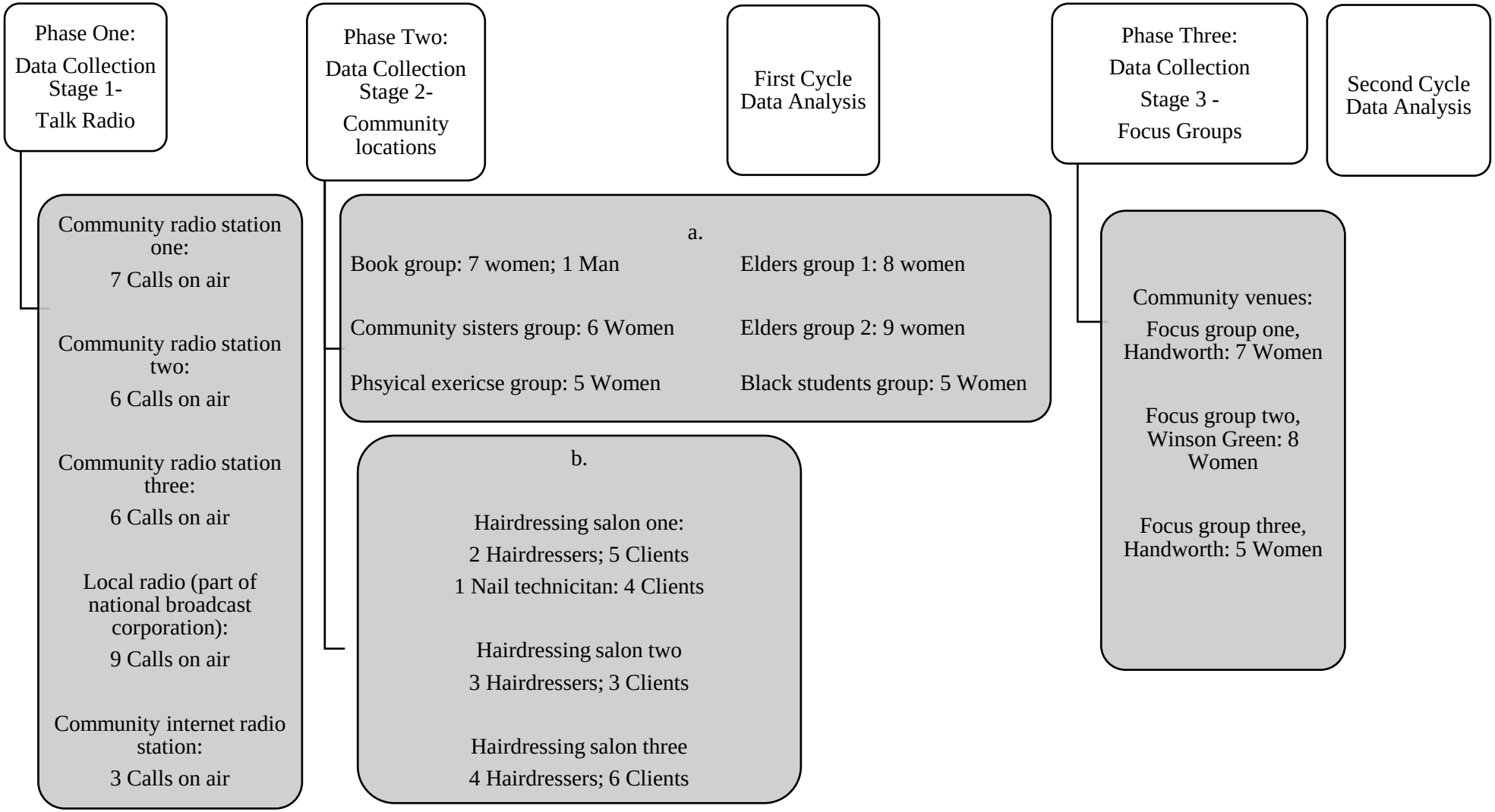
Chapter Five

Research Method

Introduction

Following on from the previous chapter, this chapter outlines the research methods and details of the theoretical and practical activities employed in this research that involve sampling, data collection and; data management, analysis and reporting (Carter and Little, 2007). In the first section of this methods chapter, the processes used to gather and interpret the data gathered from African Caribbean women and other members of the community members who participated in this research are presented. This section outlines the applied issues of gathering the data and the ethical considerations that were identified and addressed during the process. The second section of this chapter will outline the course of data analysis undertaken in this study and the processes through which the understandings that shape the findings of this research and discussion section of this thesis were reached. Figure nine depicts a visual representation of the research method as conducted.

Figure four: The Big Talk Project research method



Participants

The focus of this research was African Caribbean women aged 16 years and above. However, given the nature of the study, tight inclusion and exclusion criteria were inappropriate and contribution from other genders and ethnic groups was welcomed.

Phase one: Talk radio

The radio stations/ programmes to be used for data collection were predominantly maintained by and listened to by African Caribbean communities. However, as radio is a public medium and audiences are diverse, it would not have been possible to specifically recruit members of the public who are African Caribbean to interact with the radio station. Rather, as this research is interested in the wider public discourse about women's bodies and size, contributions from participants who are not African Caribbean women provided further insight into lay health beliefs.

Phase two: Community women's groups and hairdressing salons

Community groups and hairdressing salons selected for data collection were predominantly attended by African Caribbean women, but there were women of other ethnic backgrounds present. The salons used were sites located in West and North Birmingham where there are established African Caribbean communities. As the research in this phase was community led, it would have been inappropriate to exclude participation of members and their contributions to the data further to add understanding of the discourses being observed. In such instances, the ethnicity of the non-African Caribbean participants was recorded and analysed in the context of the conversation.

Phase three: Focus groups

The participants of this phase were African Caribbean women recruited through the previous phases. In contrast to the previous research phases, where inclusion to the study is partly defined by the location in which the data collection is situated, the researcher used gender and ethnic criteria to invite potential participants.

Recruitment

Phase one: Talk radio

A statement detailing the nature of the study was read to the audience by the researcher (appendix one) and listeners to the radio programme were invited to participate in data collection conducted during the broadcast. Information about phase three was also given to the audience and interested participants invited to contact the researcher for more information.

Phase two a: Community women's groups.

The group co-ordinators were contacted using information that is available from promotional material (leaflets, flyers, and internet) via telephone, email, or face-to-face. The researcher set up initial meetings with group co-ordinators of nine local community groups to discuss the nature of the research and ask if the group co-ordinator would mind asking the group whether they would be interested in collaborating with the researcher to gather data. The researcher asked if she could possibly attend a group session to introduce herself and the research to the group and to personally ask if they would be willing to participate. A participant information sheet (appendix two) was

given to each group member at this initial meeting and they were told that there was no pressure to decide at the time, rather the researcher encouraged the group members to take time to consider the request and contact her with any queries or questions. For those who decided that they would like to participate, the researcher attended a group meeting to facilitate a data collection session. African Caribbean women participants in this phase were also given a leaflet inviting them to participate in phase three of the research (appendix three).

Resulting from evaluation of the first data collection session with a local community group (see chapter seven), all subsequent sessions started with the researcher playing the 'vox pops', audio from the first talk radio discussion where African Caribbean members of the public gave their opinion of what constitutes the ideal shape for a Black woman. The group were then asked about what they thought of the opinions that they had heard. This method allowed the discussion to be framed within the research topic, but in a way that represented the data, rather than the voice of the researcher and was useful in starting meaningful conversation that took natural form as it progressed.

The length of the data collection sessions varied depending on the nature of the group, but on average lasted approximately fifty minutes and were ended by participants due to time issues or the natural ending of the conversation. At the end of the discussions, the researcher would thank each participant for their contribution and remind them of details contained on the participant information sheet.

Phase two b: Hairdressing salons

Contact details of African Caribbean hairdressing salons in Birmingham were sourced using the internet and local business directories. Salon managers were contacted (telephone, email, face-to-face) and informed of the nature of the research. A request for data collection to be conducted on their premises was made and suitable dates and times of data collection were discussed with the salon manager. Managers were asked to work collaboratively with the researcher and staff to inform customers when booking appointments of data collection dates and times. A request to display a poster in the window / entrance of the salon detailing the nature of the research and dates and times of data collection was made and accepted (appendix three). Managers and staff were also given a participant information sheet (appendix three) to refer to when informing customers of the research. Through this collaboration, customers were given adequate time to consider taking part in the study before their appointment.

However, whilst this is the preferred way of conducting research in this setting, there was the possibility that customers who had not pre-booked appointments would enter the salon during data collection and will not have been given details of the study at least twenty four hours in advance. This was an unavoidable consequence of conducting research in this setting and meant that some potential participants did not have the opportunity to consider the research for such time. However, as this study was low risk and only recruiting adult participants, such extensive time to consider participation is less vital than it may be in other more invasive studies. In such instances, customers who dropped in were advised of the research by the salon staff upon entry to the salon and directed to the researcher if they were interested to be given more information.

For this stage, only African Caribbean women were actively recruited. However, if conversations took place that included women who were not African Caribbean, they were not excluded. In this case, permission was sought to include them in the research data and they were given a participant information sheet (appendix two). African Caribbean women participants were also be given a leaflet inviting them to participate in phase three of the research (appendix three).

In a similar fashion to the local community groups, conversations in the salons were initiated by using the same audio from the talk radio programme. Discussions about the research topic took place naturally in-between other discussions not related to the research, with clients and staff contributing at different intervals as people entered and left the salon and staff were working with clients. On average, the researcher spent six hours in the hairdressing salons. Conversations in this setting often ended naturally, often when those clients who were present at the start of the discussion had finished having their hair styled and left the salon. When leaving the salon, each client was thanked for taking part and reminded of the information on the participant information sheet.

Phase 3: Focus groups

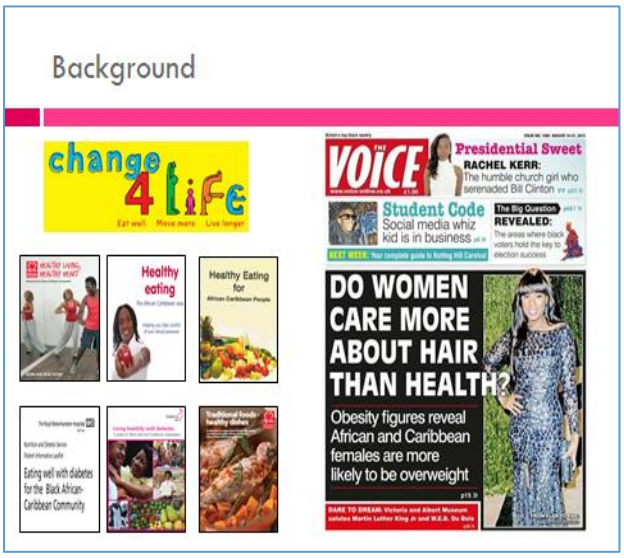
Participants in the focus groups were recruited from the previous data collection stages or had been in contact with the researcher who would have informed them of the nature of the research before attending the session. At the session, all participants were given participant information sheets to make an informed decision before data collection commenced (appendix two). In addition, posters were distributed and displayed in local community locations, inviting potential participants to

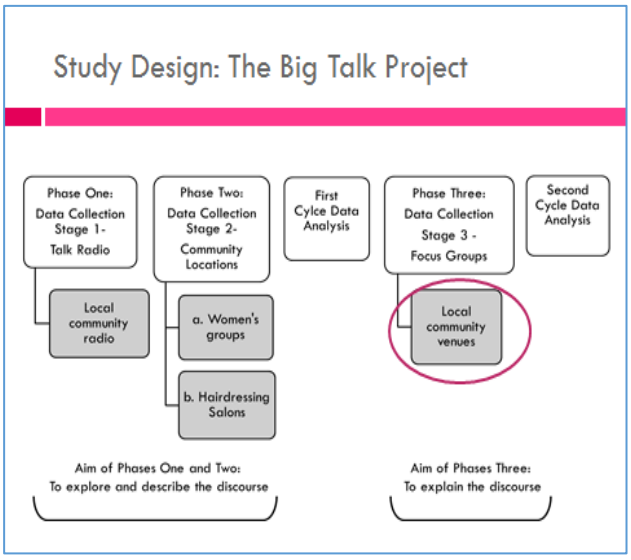
contact the researcher for more information if they were interested in contributing to the research (appendix three).

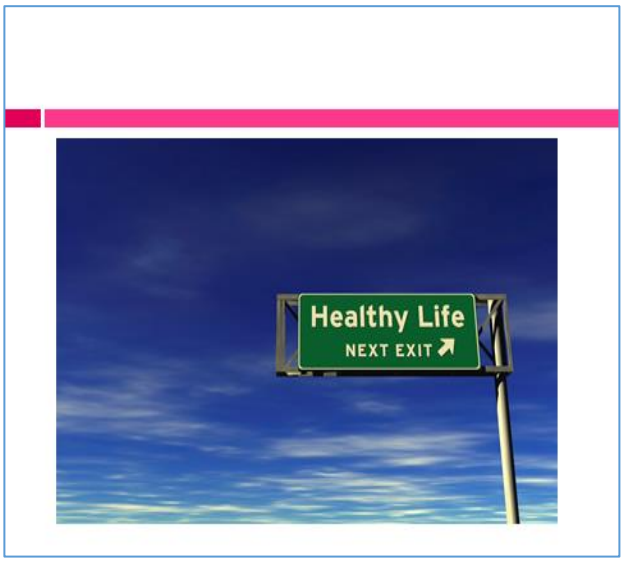
Three focus groups were conducted in African Caribbean community centre venues in Handsworth and Winson Green, Birmingham. A brief PowerPoint presentation was presented to the participants that severed a dual purpose. The first was that it provided visual representation as to the background of the study as the researcher used the familiar logos of the 'Change 4 life' (Department of Health, 2012c) and other images of health promotion to introduce the topic of health and its relationship to weight management. To relate the topic to the African Caribbean women who constituted the focus group and to embed the rationale for the study, on a following slide there was featured the front cover of The Voice newspaper that carried a headline that questioned 'do Black women care more about their hair than their health' (Isokariari, 2013). The next slide was a visual representation of the Big Talk project and the researcher used this to explain what how the study had been conducted in the previous two phases and why these focus groups were important for the research. The following two slides were pictures that were used to frame discussion and were used by the researcher to move the discussion on. The first picture slide was of signpost that read 'health', the second was of a traditional GP surgery consultation room. The final slide, used to end the discussion read 'thank you'. See figure ten for a visual depiction of the presentation slides.

The researcher referred to a focus group schedule to facilitate the discussion for the focus group schedule. The topic areas covered concepts of health; perspectives of the NHS and NHS healthcare professionals and; issues of weight management. The focus group schedule is presented in figure six.

Figure five: Focus group slides







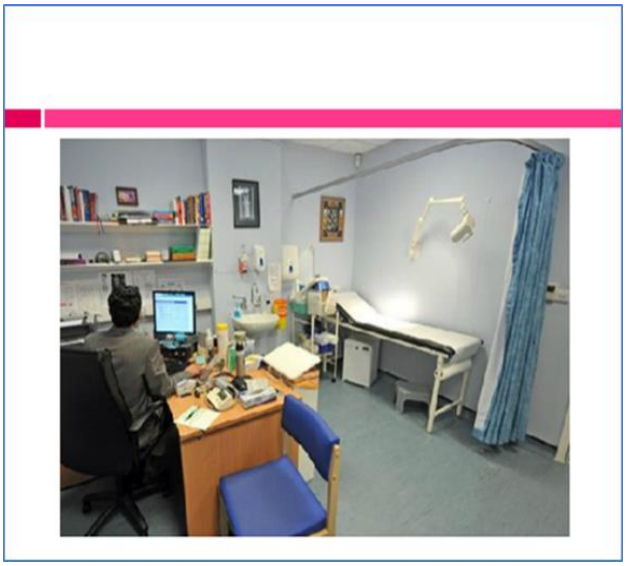


Figure six: Focus group schedule

Introduction

Good evening and welcome to this focus group. I would like to thank you all for taking the time to take part in this research study, I really am grateful.

Each member of the group to introduce themselves.

-Hand participant information sheets out to the group and read each section aloud and ask if any questions or queries before starting.

-As a group, can we please all follow some ground rules:

1. One person to speak at a time

2. Respect each other's contribution

3. Be mindful of use of language that may offend or upset others

4. Feel free to use your safe word at any point during the session.

Researcher to give each participant a small piece of paper with a discrete word written on it and explain how to use the safe word system. The duration of the focus group discussion will be approximately 1 hour.

-Start PowerPoint presentation

Opening Question:

So what does the word 'health' mean to you?

Key areas for discussion:

What does it mean to keep 'heathy?'

Do you feel that your views of health represent those that may be held by others in society?

e.g:

- Family
- Friends
- Colleagues
- Mainstream
- Healthcare professionals

What are your perspectives regarding NHS healthcare? e.g

- Interactions with healthcare professionals
- Help seeking behaviours
- Approaches to illness and treatment
- Understanding diagnosis

What are your perspectives of issues around weight and weight management?

- Raising the issue of weight management in Primary Care
- Racial/ ethnic issues
- Measures of weight used
- Gender

Summary and Conclusion

To conclude can we recap on the main issues that have been raised/discussed? Is there anything else of importance/relevance that you would like to add?

Ethical Considerations

Consent

As this research method sought to mirror natural talk, the process of gaining written consent for data collection and collecting demographic details of participants would have disrupted the dynamic of data generation and impact upon the levels of participation and data quality. Ethical framework guidance published by the Economic and Social Research Council refers to instances in research where 'highly formalised or bureaucratic ways of seeking consent should be avoided' (ESRC, 2010) when the process may impact on the relationship between the researcher and researched or in projects using novel methodologies. As a result, the process of seeking written consent was not applied and informed verbal consent from participants was sought instead.

For phase one, a statement detailing the study was read to the audience before discussion took place and the public were encouraged to participate (appendix one). The statement emphasised that by contacting the radio station to engage in the discussion was also consent for their data to be included in the study (BBC, 2011a).

In phase two a, verbal consent took place at three intervals. Initially, consent was sought from the group co-coordinator. Secondly, all potential participants were given verbal information (appendix one) and written information (appendix two) about the study and the opportunity to ask questions about the research. Individual verbal consent was sought from potential participants. Thirdly, verbal consent from participants was sought immediately before data collection commenced and recorders were turned on.

For phase two b, verbal consent was sought on two levels. Initially, verbal consent was sought from the potential participant after reading the participant information (appendix two) and addressing any questions to the researcher. Secondly, verbal consent from participants was sought immediately before data collection commenced and recorders were turned on. If a salon customer did not want to participate in the data collection session, this did not affect their appointment at the salon. In such instances, the customer was advised that the data collection would still be conducted with other customers and should they change their mind and wish to participate, they would be welcome to.

In phase three, participants were given verbal information (appendix one) and written information (appendix two) about the nature of research. As in phase two b, verbal consent was sought on two levels; initially after reading the participant information and participants were given the opportunity to ask questions before data collection commenced.

During the recruitment process for phase three, potential participants were asked to provide written consent for their personal contact details to be stored electronically so that they may be contacted by the researcher to organise the focus groups. On the recruitment leaflet (appendix three), a statement confirming that all information given would be stored securely in accordance with the Data Protection Act 1998 (DPA) and the University of Birmingham Code of Practice for Research and a tick box confirming consent was filled by participants.

Ethical procedures followed in this research investigation adhere to regulation set by University of Birmingham Research Ethics Procedure (University of Birmingham, 2015)

Recording and transcribing data

All verbal data was collected using audio recording technology. For phase one, the researcher was given audio recordings of the talk radio programmes; in phases two and three, a dictaphone was used to record the group discussions. A professional transcription service was employed to transfer the audio data to text format for analysis. Within the research, particularly phases two a and b when the groups were at ease, part of the conversation was conducted using Caribbean patois and sayings and physical expressions that accompany this cultural linguistic style. As expected, much of the patois could not be translated by the service and was subsequently translated by the researcher. Understanding of Caribbean culture and language is central for attempts to capture the essence of African Caribbean understandings of health. Particular phrases and expressions are important to develop a depth of analysis of the data; as such the researcher kept a comprehensive research diary that included reflections and observations during the research process that could be used to supplement transcripts of the sessions.

Participant withdrawal

Participants in phases two and three were informed prior to data collection they were free to leave the data collection session at any point. As phase three was focused by the researcher on the research topics which may be sensitive for some, each participant was given an individual 'safe-word' that she could use at any point during the session if they would like to excuse themselves from the research discreetly.

Participants of phases two and three were also informed that they may withdraw their data from analysis and must contact the researcher within six weeks of the data collection session to do so. The date by which the participant must contact the researcher to withdraw their data was given verbally by the researcher (appendix one) and detailed on participant information sheets (appendix two). This information regarding withdrawal was reiterated before recording commenced. For individual data to be identifiable should a participant wish to withdraw, the pseudonyms of participants were documented with the date of data collection, e.g. Sue12.01.12. To avoid identification problems, the researcher ensured that the same name would not be used by more than one participant in any data collection session.

If a participant wished to withdraw from the research, their data was identified by the researcher and would not be included in the analysis stage of the research. Due to the conversational nature of the data being collected in phases two and three, the implications of omitting participant data may disrupt continuity of the remaining participants' speech. However this would not affect the quality of remaining data for conducting analysis. Participants were told that paper based records which may detail any withdrawn data would be shredded using the university waste disposal system and withdrawn data stored electronically was erased from the University of Birmingham network drive.

However with regard to data collection stage two, participants were advised that they were unable to withdraw their data from the study. In choosing to take part in a discussion held in a public domain, such as talk radio, participants are aware that their contributions will be held and stored as an open source of information to the audience, similar to information that is stored when an individual contributes to internet blogs and forums. In the case of the BBC editorial guidelines, it is stated that 'generally no one has the right [to withdraw their contribution] to prevent their

contribution being used' (BBC, 2011b). As such, callers were advised that that their contribution may or may not be used as research data.

Confidentiality

Participants were kept anonymous in this study. For individual data to be identifiable should a participant wish to withdraw, the pseudonyms of participants were documented with the date of data collection, e.g. Sue12.01.12. To avoid identification problems, the researcher ensured that the same name was not used by more than one participant in any data collection session.

The transcribed data was stored on the University of Birmingham secured network drive. The contact details of those who expressed an interest to participate in data collection phase three were also stored on the University of Birmingham secured network drive. All data collected in this study was treated as confidential. If during the data collection phases, references were made that could identify a particular individual, those details were anonymised by the researcher during transcription. The community locations where data was collected were also assigned pseudonyms.

In data collection phase two and phase three this information regarding confidentiality was given to the participants verbally and were detailed on the participant information sheets. In data collection phase one, callers to the radio station were informed pre on air discussion that they would be identified only by the name that they choose to use and would be asked not to make any personal references about themselves or others during the broadcast that could identify them.

To observe confidentiality of data during this study, access to the data was restricted to the researcher and supervisors.

Storage, analysis, access and disposal of data

Recorded, transcribed, observational, email and text message data were processed and stored using electronic means in accordance with the DPA. Any participant contact information was stored on a database that also met the requirements of the DPA on the University of Birmingham secured network drive. All paper based records were stored in files which were kept secured in locked cabinet at the university. All data was referenced so that it could be accessed appropriately and was organised and analysed using NVivo version 10.

Primary research data and evidence was stored and remains accessible for ten years. In compliance with the DPA, at the time of disposal, paper based records which may detail any confidential information will be shredded using the university waste disposal system. Data stored electronically will be erased from the University of Birmingham network drive.

Risks

Due to the sensitive nature of overweight and obesity, it is imperative that during the data collection process, no derogatory comments are made in relation to individuals for the safety of participants. It was made clear in the participant information sheet and explained verbally by the researcher that the aim of this research is not upset or offend any participant. The researcher requested that those engaging in the research process will bear this in mind and endeavour to uphold this during the

session. Should such comments be made, the researcher sought to address them tactfully. If any participant feels that they would like any support in relation to weight management issues, the researcher provided them with written information about locally available support.

With regard to researcher safety, no personal details will be given to any participants. All participants were given details of how to contact the researcher at the University of Birmingham. During data collection sessions where the researcher was lone working, details of the location of the data collection session was made available to supervisors.

Ethical approval for this study was obtained from the University of Birmingham Ethics Board in November 2011.

Methods of data analysis

The following section of the chapter gives detail of how the collected data of phase one and phase two of the study was analysed. The first cycle of data analysis was concerned with the data gathered from phases one and two. The findings of this first phase were used to guide data collection in phase two; data from phase two was analysed in the second cycle of data analysis.

First cycle data analysis

The community based data collection methods that were used to research phases one and two were distinctly different, yet sought to capture the same discourse. As such, the data was analysed together, rather than separately though a process of thematic analysis using both inductive and deductive approaches.

The process of developing themes and codes using thematic analysis is an iterative process that requires the re-reading of transcripts before assigning a label, or code to text that is meaningful for the research. Once all of the transcripts were labelled, the codes were then organised into clusters with other codes that can be understood to be referring to similar topics. These clusters are then given titles that reflect the commonality of the codes within and are referred to as themes. Tables nine a to nine d detail a framework matrix of the themes that emerged from data collection sites in research phases one and two.

Whilst there was some overlap of the codes when defining themes and as such some codes appear in multiple themes, in total twenty themes were drawn from the data; tables ten a to ten e denote the codes that constituted the development of the themes.

Table nine a: Framework matrix of phase one data collection sites and the themes emerging from first cycle data analysis

Themes **Data collection sites**	African Diaspora	Biomedical/ Alternative Discourses	Caribbean Influence	Children and young people	Ethnicity	Exercise and Physical Activity	Experiences of Illness	Femininity	Food and food practices	Gender and sexuality
Community Radio one										
Community Radio two										
Community Radio three										
Local Radio										
Internet Radio										

Table nine b: Framework matrix of phase one data collection sites and the themes emerging from first cycle data analysis, continued

Theme **Data collection sites**	Globalisation	Image of self and others	Keeping 'healthy'	Language	NHS Healthcare	Relationships	Research	Socio-politics	Talking about weight with healthcare professionals	Weight management and excess weight
Community Radio one										
Community Radio two										
Community Radio three										
Local Radio										
Internet Radio										

Table nine c: Framework matrix of phase two data collection sites and the themes emerging from first cycle data analysis

Themes **Data collection sites**	African Diaspora	Biomedical/ Alternative Discourses	Caribbean Influence	Children and young people	Ethnicity	Exercise and Physical Activity	Experiences of Illness	Femininity	Food and food practices	Gender and sexuality
Book group										
Community sisters group										
Young women's group										
Physical exercise group										
Elders group one										
Elders group two										
Black students group										
Hairdressing salon one										
Hairdressing salon two										
Hairdressing salon three										

Table nine d: Framework matrix of phase two data collection sites and the themes emerging from first cycle data analysis, continued

Theme **Data collection sites**	Globalisation	Image of self and others	Keeping 'healthy'	Language	NHS Healthcare	Relationships	Research	Socio-politics	Talking about weight with healthcare professionals	Weight management and excess weight
Book group										
Community sisters group										
Young women's group										
Physical exercise group										
Elders group one										
Elders group two										
Black students group										
Hairdressing salon one										
Hairdressing salon two										
Hairdressing salon three										

Table ten a: Themes and codes emerging from the first cycle data analysis

African Diaspora	Biomedical/ Alternative Discourses	Caribbean Influence	Children and young people	Ethnicity
Biology Black essentialism Diaspora History Racial differences	Alternative discourse Biomedical discourse Challenge to the biomedical discourse	Caribbean culture Caribbean lifestyle Cultural expressions Diaspora History Religion	Age Obesity and children Relationships with children role of parents school	Ethnic differences Influence of other ethnic cultures Interaction with GP other ethnic groups

Table ten b: Themes and codes emerging from the first cycle data analysis, continued

Exercise and Physical Activity	**Experiences of Illness**		**Femininity**	**Food and food practices**
Barriers to exercise	Advice from other professionals	Interaction with other healthcare professionals	Biology	Age
Encouragement to exercise	Blame	Lack of awareness	Black essentialism	Caribbean food and food practices
Exercise and physical activity	Condition awareness	Lack of services	Black femininity	Diets
Ideal exercise setting	Distrust	Lack of support	Diaspora	Distrust of food manufacturers
Making lifestyle changes	Education	Measuring health improvements	Gender relations	Fast food
Measuring health improvements	Fear	Other weight related illnesses	Health issues for Black women	Food and food culture
Price of exercise	Health complications	Personal health issues	Relationships with partner	Food and portion sizes
	Health issues for Black women	Social implications	Stereotypes	Food scandals
	Help seeking behaviours	Treatments	Weight after children	Healthy food
	Individual differences			Politics of food
	Interaction with GP			Price of healthy food
				Resistance to change

Table ten c: Themes and codes emerging from the first cycle data analysis, continued

Gender and sexuality	**Globalisation**	**Image of self and others**	**Keeping 'healthy'**	
Media	Global	Big is beautiful	Alternative discourse	Holistic healthcare
Gender relations	Internet	Big is not always beautiful	Biomedical discourse	Making lifestyle changes
Relationships with partner	Mainstream images of health and beauty	Body modification	Black culture	Mental health
Sexuality	Media	Body shapes	Definitions of health	Morenga
Stereotypes	Perceptions of big women	Clothes sizes	Emotional health	Other lifestyle habits
	Role models	Fashion	Green juice	Physical health
	Slenderness	Health at every size	Health at every size	Public health messages
	Stereotypes	Ideal body size and shape	Health in non- Western cultures	Spiritual health
	Weight stigma	Image	Herbalife	Symbols of health
	Western culture	Particular body parts		
		Slenderness		
		Symbols of health		

Table ten d: Themes and codes emerging from the first cycle data analysis, continued

Language	**NHS Healthcare**		**Relationships**
Cultural expressions	Biomedical discourse	Lack of awareness	Actions of others
Term 'diet'	Condition awareness	Lack of services	Relationships with children
Words to describe body shape and size	Distrust	Lack of support	Relationships with other family Members
	Fear	NHS Politics	Relationships with others
	Health issues for Black women	Public health messages	Relationships with partner
	Help seeking behaviours	Racism	
	Interaction with GP	Stereotypes	
	Interaction with other healthcare professionals	Treatments	

Table ten e: Themes and codes emerging from the first cycle data analysis, continued

Research	**Socio-politics**	**Talking about weight with healthcare professionals**	**Weight management and excess weight**	
Reference to the research	Work	BMI scale	Biology	NHS
Research participation	Racism	Health status of the healthcare professional	Causes of obesity	Obesity and children
Research savvy	Poverty	Individual differences	Diet pills	Obesity as an illness
	Politics	Raising the issue of weight	Diets	Overweight and obesity
			Distrust	Support services needed
			Green juice	Term 'diet'
			Herbalife	Weight after children
			Individual differences	Weight loss or gain weightwatchers
			Interaction with GP	
			Interaction with other healthcare professionals	

The aim of phase three of the research project was to explain the captured discourse through focus group discussion based on the findings of the previous research phases. As illustrated in table nine, a large number of themes surfaced from the vast amount of data collected during the collection phases. Due to the nature of the research method that encouraged participants to speak openly, not all discussion captured focused on the research topic but referred to other issues in related areas. Through examination, it became apparent that four particular themes lent themselves to answering the research questions more directly, yet offered enough space and overlap to explore other issues that had been assigned to other themes: biomedical/ alternative discourse; keeping 'healthy'; NHS healthcare and; weight and weight management. The construction of these four central themes to understanding the discourses, with specific reference to research questions are explored in the findings chapter.

Second cycle data analysis

Transcripts were themed and coded using the same approach as in data analysis phase one. No new themes emerged from the data. During the analysis of data collected in the research phase three of the study, it was found that there was a continuation of overlap between the themes and codes being place in multiple themes. The codes from the focus groups data largely mirrored those from the previous data collection phases. However, a number of new codes emerged from the data which could be placed within existing themes, adding layers of perspectives for analysis. Tables eleven a to eleven e detail the initial themes and codes. The four themes used to guide the focus groups in data collection phase three highlighted in red and the additional codes that emerged from phase three are highlighted in blue.

Table eleven a: Themes and codes tables with additional codes emerging from second cycle data analysis

African Diaspora	**Biomedical/ Alternative Discourses**	**Caribbean Influence**	**Children and young people**	**Ethnicity**
Biology Black essentialism Diaspora History Racial differences	Alternative discourse Biomedical discourse Challenge to the biomedical discourse Conflicting information	Caribbean culture Caribbean lifestyle Cultural expressions Caribbean spoken language Diaspora History Religion	Age Obesity and children Relationships with children Role of parents school	Ethnic differences Influence of other ethnic cultures Interaction with GP other ethnic groups

Table eleven b: Themes and codes tables with additional codes emerging from second cycle data analysis, continued

Exercise and Physical Activity	Experiences of Illness		Femininity	Food and food practices
Barriers to exercise	Advice from other professionals	Interaction with other healthcare professionals	Biology	Age
Encouragement to exercise	Blame	Lack of awareness	Black essentialism	Caribbean food and food practices
Exercise and physical activity	Condition awareness	Lack of services	Black femininity	Diets
Ideal exercise setting	Distrust	Lack of support	Diaspora	Distrust of food manufacturers
Making lifestyle changes	Education	Measuring health improvements	Gender relations	Fast food
Measuring health improvements	Fear	Other weight related illnesses	Health issues for Black women	Food and food culture
Price of exercise	Health complications	Personal health issues	Relationships with partner	Food and portion sizes
	Health issues for Black women	Power relationships	Stereotypes	Food as medicine
	Help seeking behaviours	Social implications	Weight after children	Food scandals
	Individual differences	Treatments		Healthy food
	Interaction with GP			Politics of food
				Price of healthy food
				Resistance to change

Table eleven c: Themes and codes tables with additional codes emerging from second cycle data analysis, continued

Gender and sexuality	Globalisation	Image of self and others	Keeping 'healthy'	
Media	Global	Big is beautiful	Age	Holistic healthcare
Gender relations	Internet	Big is not always beautiful	Alternative discourse	Making lifestyle changes
Relationships with partner	Mainstream images of health and beauty	Body modification	Biomedical discourse	Mental health
Sexuality	Media	Body shapes	Black culture	Morenga
Stereotypes	Perceptions of big women	Clothes sizes	Definitions of health	Other lifestyle habits
	Role models	Fashion	Emotional health	Physical health
	Slenderness	Health at every size	Family history	Psychoneuroimmunology
	Stereotypes	Ideal body size and shape	Food as medicine	Public health messages
	Weight stigma Western culture	Image	Green juice	Religion
		Particular body parts	Health at every size	Spiritual health
		Slenderness	Health in non- Western cultures	Supplements and vitamins
		Symbols of health	Herbalife	Symbols of health

Table eleven d: Themes and codes tables with additional codes emerging from second cycle data analysis, continued

Language	**NHS Healthcare**		**Relationships**
Cultural expressions	Alternative healthcare	Legitimacy	Actions of others
Term 'diet'	Biomedical discourse	Lack of awareness	Relationships with children
Words to describe body shape and size	Choice	Lack of services	Relationships with other family Members
	Condition awareness	Lack of support	Relationships with others
	Diagnosis	NHS Politics	Relationships with partner
	Distrust	Power relations	
	Fear	Public health messages Racism	
	Finances	Stereotypes	
	GP Surgeries	Treatments	
	Health issues for Black women	Western healthcare services	
	Help seeking behaviours		
	Interaction with GP		
	Interaction with other healthcare professionals		

Table eleven e: Themes and codes tables with additional codes emerging from second cycle data analysis, continued

Research	**Socio-politics**	**Talking about weight with healthcare professionals**	**Weight management and excess weight**	
Reference to the research	Work	BMI scale	Biology	NHS
Research participation	Racism	Health status of the healthcare professional	Causes of obesity	Obesity and children
Research savvy	Poverty	Individual differences	Diet pills	Obesity as an illness
Health research	Politics	Raising the issue of weight	Diets	Overweight and obesity
	NHS politics	Raising the issues of body shape	Distrust	Support services needed
			Green juice	Term 'diet'
			Herbalife	Weight after children
			Individual differences	Weight loss or gain weightwatchers
			Interaction with GP	
			Interaction with other healthcare professionals	

As in the first cycle of data analysis, it was important to identify which of the emerged themes contribute understanding directly related to discourses of health in African Caribbean communities. As a continuation of the identification of the themes, a further two themes: diasporic influence and; experiences of illness, are central for further understanding as they were much drawn upon during the focus group discussions to offer explanation for perspectives of health. Those themes are presented in the findings chapter to address the research questions.

Summary

In this chapter, the methods used to capture and analyse the data for this research investigation have been described. The chapter was presented in two sections: the first section presented the practical methods of gathering the data including issues of recruitment, data collection processes and ethical considerations; the second section outlined the approaches taken to data analysis over the two analytical cycles. The following chapter presents the thematic findings of the research.

Chapter Six

Thematic Findings

Introduction

In this chapter, the findings from the data collection phases are presented. The aim of the study is to provide understanding of discourses of health within African Caribbean communities and; how these may influence relationships with healthcare professionals when exploring issues of weight and weight management with women from this ethnic group. This chapter details the themes which emerged from the data through the analytical process of thematic analysis; the second section explores the interpretive themes. Table twelve offers presents a chart of the six main themes that construct the discourses of health for African Caribbean women. Figure six is a visual representation of how the paradigm of intersectionality circulates to shape this discursive construction. As such, the thematic findings address the first research question:

What are the discursive constructions of health, wellness and the body that exist for African Caribbean women?

Table twelve a: Six main themes of the discourse of health for African Caribbean women

Diasporic influence	**Biomedical/ Alternative Discourses**	**Experiences of Illness**	
Biology Black essentialism Caribbean culture Caribbean lifestyle Caribbean spoken language Cultural expressions Diaspora Ethnic differences Influence of other ethnic cultures History Racial differences Words to describe body shape and size	Alternative discourse Biomedical discourse Challenge to the biomedical discourse Conflicting information	Advice from other professionals Blame Condition awareness Distrust Education Fear Health complications Health issues for Black women Help seeking behaviours Individual differences Interaction with GP	Interaction with other healthcare professionals Lack of awareness Lack of services Lack of support Measuring health improvements Other weight related illnesses Personal health issues Power Relationships Social implications Treatments
Keeping 'healthy'			
Age Alternative discourse Biomedical discourse Black culture Caribbean food and food practices Definitions of health Diaspora Emotional health	Family history Food as medicine Gender relations Green juice Health at every size Health issues for Black women Health in non- Western cultures	Herbalife Herbal treatments Holistic healthcare Making lifestyle changes Media Mental health Other lifestyle habits	Public health messages Religion Spiritual health Stereotypes Supplements and vitamins Symbols of health Western food and practices

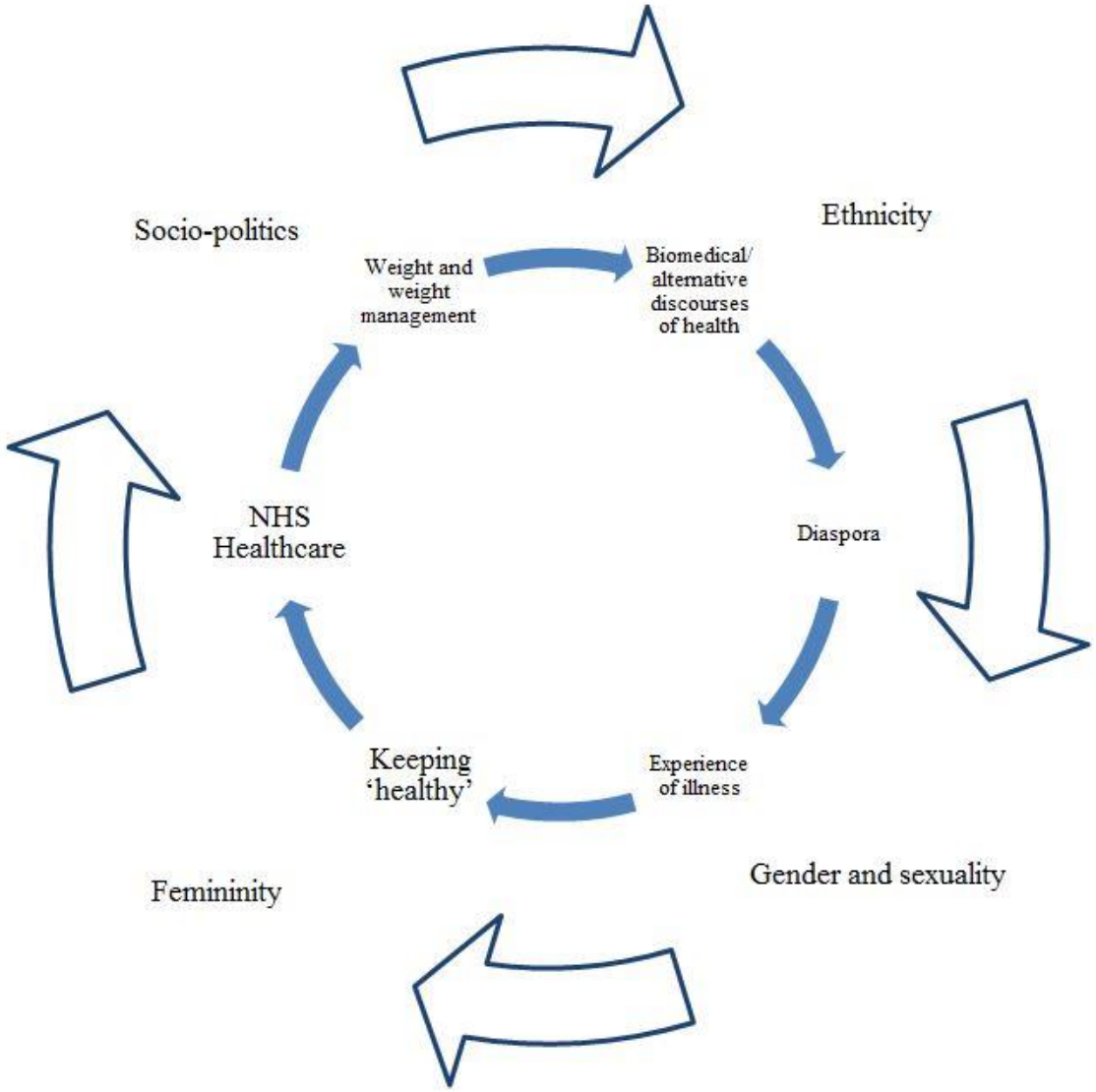
Table twelve b: Six main themes of the discourse of health for African Caribbean women, continued

NHS Healthcare		**Weight management and excess weight**		
Alternative healthcare	Interaction with other healthcare professionals	Big is beautiful	Health status of the healthcare professional	Obesity as an illness
Biomedical discourse	Lack of awareness	Big is not always beautiful	Herbalife	Overweight and obesity
Choice	Issues of engagement	Biology	Ideal body size and shape	Raising the issues of body shape
Condition awareness	Lack of services	Body modification	Image	Raising the issue of weight
Diagnosis	Lack of support	Body shapes	Individual differences	Support services needed
Distrust	Legitimacy	BMI scale	Interaction with GP	Term 'diet'
European Healthcare services	NHS Politics	Causes of obesity	Interaction with other healthcare professionals	Weight after children
Fear	Power relations	Clothes sizes	Mainstream images of health and beauty NHS	Weight loss or gain
Finances	Public health messages	Cultural expressions	Obesity and children	Weightwatchers
GP Surgeries	Racism	Diet pills		Words to describe body shape and size
Health issues for Black women	Regulations	Diets		
Help seeking behaviours	Stereotypes	Distrust		
Interaction with GP	Treatments	Fashion		
	Trust in the service	Green juice		
		Health at every size		

Figure seven: Intersectionality paradigm

Inner circle: Discourse themes

Outer circle: Interpretive themes



The themes are presented in a style that seeks to explain the features of the themes while retaining the 'essence' of the data as given by those who participated. Some of the quotes offered in this chapter are included as lengthy extracts of transcript with elements of Caribbean vernacular. This is a conscious decision that seeks to convey the depth of what was said by participants. This style of reporting data is an attempt to not lose the evocate power of qualitative research data that has the capacity to communicate what an experience or understanding is like to prompt a sense of recognition and empathetic comprehension in the reader (Todres, 1998).

Themes of the discourse

Biomedical/alternative discourses:

Those who took part in the research offered a range of understandings of health from positions that could be placed on a varied scale of biomedical positions and alternative standpoints. Such findings are consistent with other investigations that have explored the dynamics of lay health beliefs (Davison et al., 1991; Frankel et al., 1991; I. Shaw, 2002). From the findings, it was possible to identify where participants referred biomedical frameworks of understanding health and it was evident that public health messages related to lifestyle, diet and health outcomes has influenced knowledges:

> To be honest we all need to eat less and move more get the heart pumping get a bit sweaty. Not to get thin but to get fitter.
> (Community radio programme*)*

> At the end of the day you really need to change for life like the advert says. If you change your habits you change your life you know you can live a bit better for a bit longer. Your heart your cholesterol your blood pressure it will be a good change for life you know. Put down the fags and drink and go for a walk everyone can do it.
> (Black students group)

Direct reference to public health campaigns and discussions about particular lifestyle choices for health that feature in such campaigns was present. Use of terms such as 'fatty deposits' and 'body mass' come from the discourse of such campaigns and the knowledge of symptoms of health conditions is indicative of the influence that such campaigns may have on the communities:

> You know that advert to tell you about stroke. First you listen to the speech you know if it sounds funny then the face. It's important that we know what to look out for I used to keep one of them leaflets on my fridge you know so that you can know what to do fast. Too many of our people have strokes we all need to know this stuff.
> (Elders group two)

Additionally, mainstream societal conceptions of health that are also bound with beauty ideals and aesthetics were also probed by the participants and the perceptions of health and slenderness explored:

> It's all about the image at the end of the day. If you are slim they assume that you are healthy because there is no obvious fat but that's not true. There can be fat on the inside too, just because someone is big does not always mean that they are unhealthy like the bigness

> could be muscle and toned. Just because you drink coffee and smoke all day to stay slim does not make you healthy even though that's what it might seem like.
>
> (Young women's support group)

Associated with mainstream images of health and the body were references to the use of diet pills that straddle both biomedical and mainstream perceptions of health and ways to lose weight which is exemplified by comments such as 'diet pill prescriptions' and 'medicines to help burn fat'.

It was also apparent that alternative approaches to health, rooted in a more holistic standpoint were adopted by most of those who took part in the research. Perspectives that placed spirituality, morality and relationship with self and others as indicative of good health were expressed regularly by those who took part in the research:

> To be healthy you need to have your heart, mind, and spirit in the right place. Live good and do good, and good will be with you all the days of your life. The body will follow where the soul leads.
>
> (Elders group one)

With regard to biomedical treatments, responses that have been coded within this theme include those that describe such interventions as artificial chemicals and poisons rather then health sustaining. Interestingly, during the local radio station programme the discourse used by the consultant physician to convey the message to the audience about the need to consider lifestyle for type two diabetes prevention changed during the show through his interaction with callers, almost in a fashion that may scare people into considering healthy lifestyles. After being questioned about

the validity of the BMI for use with African Caribbean women he states he refers to the medication as poison, a point that is picked up and taken further by the presenter:

> Consultant physician: Well it's not about making Black women feel bad you should celebrate your body. Of course, you should you should enjoy your heritage and how you look etcetera but do you want to bury your head in the sand when things are going wrong just because of that? And when you do have problems and you come and see a health care professional doctor or nurse if they are too afraid of approaching you then all they are doing is treating your symptoms. So [the studio guest] was on nine different poisons for her blood pressure and er is that the right approach?
>
> Presenter: And er I think you've said a key thing there nine different poisons because that's what we're doing, we're putting artificial chemicals into the body to help it work.
> (Local radio programme)

With views that medication can be toxic, there is an emphasis towards more natural forms of treatments, drawing upon more common alternatives such as those that can be purchased from high street shops that specialise in herbal supplements. Additionally, there was particular reference to plants, herbs and foods that have been commonly used in the Caribbean to treat ailments and to maintain health such: as green juices made up of green fruits and vegetables; seeds and leaves of the moriga plant; fever grass and; king of the forest plant. Those who expressed such views were also knowledgeable about the benefits of such alternative treatments and were aware that biomedical research has also recognised these benefits and made reference to the use of aloe vera for a range of health conditions and sour sop for cancer treatment. As such, the participants explored issues of

power and health knowledge, questioning the authority given to western science over other forms of knowing:

> I never know why people are surprised to hear that what we been using actually works. How do you think that we managed to live so long before they come with their medicine bag? Science isn't just for scientists, old wives and their tales is science too. All this about plants and herbs comes from generations of looking into how to make people better it's the same as what they do in the lab, but of course what we got isn't science. It's really offensive when you really think about it. It kinda means that nobody but them can be right about anything. (Hairdressing salon two)

Interestingly, what transpired in this theme were the hybrid understandings of health that incorporated perspectives from biomedical, mainstream, and alternative perspectives to convey knowledges of health. In some cases this knowledge is used to challenge biomedicine, highlighting the legitimate issues in practice. In other cases it shows that health care provision must be aware of the contradictions and ambiguities in the how patients understand health and then the health behaviours that they employ especially with regard to weight loss. Regarding the BMI scale and its use with Black women, it became apparent that the women who took part in the research were well aware of its problematic universal use and in many cases, and cited perspectives that are supported by research:

> Black women are naturally bigger our bones are heavier, our bodies are thicker, we wear our health on our hips. We can't look like the girls on tv because we aren't built that way and starving yourself to look like a celebrity really is not the way cos it won't happen for you.

> But also the doctors need to be reminded of this too that chart is not for us is really doesn't help us at all Black women are different to Asian women, White women, Chinese women. We're all women, but we aren't the same these GPs need to new ideas.
>
> (Community sisters group)

Yet in contrast to such astute positions are those are quite inconsistent in nature as they draw from different perspectives to legitimate particular health behaviours. For instance, during the data collection session with the student group, there was much discussion about the need to live an active lifestyle, with a balanced diet and regular exercise. As the research was coming to a close the researcher asked about a plastic sports bottle containing an unidentifiable liquid that belonged to the one of the women. She answered that it was Herbalife and subsequently, all but one of the women produced similar bottles. It transpired that this drink is part of a weight management programme that is to be drunk three times a day in place of meals. When asked about the ingredients of the drink, no one was sure but did confirm that it was made of all natural ingredients and as such would not react with any medication or cause any health issues for anyone taking it. Whilst the use of such weight management plans is not unheard of, it is interesting for this research as during the session the women had spoken at length about concerns of synthetic ingredients in medication and in food and; the need to live an active lifestyle with a well-balanced diet. The fact that each of the women chose not to raise the issue of Herbalife suggests that even in the liminal space, researcher effects on the participant responses is still an issue that must be acknowledged. Choosing what information to share with is also an prominent issue for those within healthcare services, especially primary care. The problems of saying what you think others want to hear is a real issue means that for research, the intricate nuggets of details may not be captured and for healthcare services, incorrect or incompatible treatments and advice may be offered, especially when patients are taking

complementary or alternative medicine and not disclosing these details (Robinson and McGrail, 2004).

Keeping ‘healthy’:

Notions of how to achieve and maintain health were explored by those who took part in the research and are included in this theme. As a continuation of the previous theme, it was possible to identify the different approaches to concept of ‘health’ and lifestyle habits that reflect differing discourse of health. With regard to food it was discussed as a central tenant of health, sustaining health or negatively influencing it:

> Food can keep you fit and strong it can be your medicine or it can make you worse. It can be like poison, toxic to your body.
> (Internet radio programme)

> Medicine is not healthcare, food is healthcare. Medicine is sick care. We need to get this straight and know that everything has a place.
> (Hairdressing salon two)

There was much probing as to the nature of Caribbean food and how it features in keeping healthy. Hard food such as: yam, boiled dumpling and green banana; fresh fish and meat and; fruit and vegetables such as coconut, callalo and akee were often referred to important foods for keeping up strength. Whilst it was agreed that Caribbean food is fundamentally healthy, it is the ways that the food is sometimes prepared and portion sizes that can compromise this.

> But you have to remember that we come from a people that had nothing so what we had, had to last. That's why its full up of salt to preserve it. The food we got was the poor food, you had to season it up nice to make it good.
> (Elders group one)

> Listen, if your mama couldn't give you anything she could give you a good meal no one would be hungry. Whatever she had could stretch to fill everybody and if someone pass the house, the food can stretch to feed them too. It's how we live to show love, you fill the plate. And to show the love back you eat it all, it can't waste.
> (Hairdressing salon one)

Through discussion, it was apparent that those who took part in the research were aware of the need to reduce the fat content and increase fruit and vegetables in diets. There was often particular discussion of importance of reducing salt content of diets and there was especial reference to the salt added to food and pre-packaged seasonings that often contains high levels of salt and how it is possible to adapt cooking methods to avoid using excessive levels of salt and cooking methods that can increase fat content:

> You don't have to fry. Baked or grilled can taste just as nice it doesn't have to be bland I think that people think that the food will be tasteless if it's not covered in seasoning but you can do the seasonings yourself. Buy the pimento, garlic, ginger, pepper, just buy it fresh it doesn't have to come from a jar you don't need to use that all the time. My husband was shocked when I made him fried chicken in the oven, baked it, not fry. He couldn't believe it could taste nice and not fry, but he has to lose some weight so I told him that there is no

more fry in this house.The kids need him.

(Community radio)

Within discussion of relationships to food, issues pertaining to generational difference, elders and children and young people was referred to often. Generally, there was concern expressed for elders in the communities who continue to cook food with increased levels of salt, who may find it difficult to change taste and habits and the nature of the support that they may get from healthcare professionals:

> The GP said my nan was resistant to change. I was pissed when he said that I was so angry he really hurt her feelings you know. I told him my nan is not resistant to change, she is making changes to the life that she has lead for eighty-odd years they have taken a lifetime to build up you can't change them with your ten minutes and your fenky leaflet that ain't helping. How about talking to my nan rather than accusing. They may be only words to him but they can cut deep you know.
>
> (Young women's support group)

For young people, there was concern regarding fast food and the availability of cheap high density food, especially for school aged children. In more than one data collection session, attention was paid to the proliferation of fried chicken take-away shops in the local area, often very near to schools and bus stops:

> You can't walk in this place without seeing one of those shops and after school the shops are full of kids buying that greasy chicken and chips for 99p.You should see all of the kids all

different uniforms all Black and Asian kids eating that trash all up and down Soho Road. I blame the council there is always a new one opening somewhere it's not good for them not at all.

(Hairdressing salon three)

During the data collection sessions, the importance of physical exercise for keeping healthy was expressed and how improvements in the body can be noticed once a regular routine is established. Social support from others was explored as an important motivation for keeping up with regular exercise regimes. During the exercise group research session, the women spoke about how they supported each other to keep up activity:

Voice 1: We started off by doing it for Cancer Research because we were doing a sponsored walk in Cannon Hill Park and we kept it up, and the reason I kept it up is I have worn my cartilages away in my knees and was advised to exercise and I've got sciatica in my back, which is not nice at times.

V2: That's something, because sometimes you don't want to go out, but we did it. Six o'clock, we would meet in the morning.

V3: We used to walk twice a week, didn't we?

V4: I met her for six o'clock then we walked down and meet [name]. She'd be by the park.

V3: And we used to do three laps of the park [all laughing].

V5: Until we got to the end. Then we left [name] she walked on, by the time she got home it's been an hour.

V2: And then when it got too dark for the park into the really dark mornings, we took to the streets and done around the streets.

V4: We went all the way round the park.

V3: Seeing the same people at bus stops and [..]

V5: And people look at us but it's better when you're in a group you know, together.

V1: […] And it's made such a difference to my knees and my back unbelievable. (Saturday morning exercise group)

It was expressed that lifestyles of those who live in the Caribbean are healthier that those in the UK due to the freshness of food and more opportunities to engage in physical exercise especially walking; a view echoed by first, second and third generation participants:

It's better over there back home cos like you walk more, you don't have to drive everywhere. The weather is better so you don't have to spend half the year wrap up in the house I mean like I've never been but I know that it's better it must be right?

(Black students group)

Barriers to exercise were explored and issues pertaining to cost of formal exercise and lack of time, especially for working parents was a concern for the participants. Particularly, there was a distinction between those who wish to use formal gyms for health and minimal weight loss and those who had more significant weight to lose and issues of confidence of going to a gym:

> I know that I shouldn't be bothered because I'm there for the right reasons but you know I still feel a bit funny about getting started in case people look at me. They probably won't look, but I don't need the pressure so I don't bother to go, I just get stressed at the thought of going. You know, look at that big Black girl sweating and look at her hair what a hot mess. (Book group)

Hair was also addressed as a barrier to exercise to some of the women in the research and concerns about damaging hair was expressed. However, hair as a barrier was not a universally held view and in one instance a hairdresser challenged the views of her client, whilst she was braiding her hair:

> Client: [looks to hairdresser, making eye contact in the mirror] I know that you say that it's ok, but I just don't wanna mess up the 'do – sweating, swimming, jumping around Zumba. All this action plays havoc with the look [all laugh] if there was a way to do exercise and not sweat I would do it every day.

Hairdresser: Yeah, but if you wrap[15] it up of course you can swim. I'm teaching my son.

Client: Black people don't swim [all laugh]

Hairdresser: [Kisses teeth and laughs] Well this one does [laugh] we go Saturday mornings just wrap it up good, get a good cap and you are good. As long as you know how to care for your hair of course you can sweat. So what you do in the sun - you sit in the house and don't want to sweat? You go party and sweat but can't Zumba and sweat? That don't make sense. Sis, get in the water [all laugh].

Client: Well coming from you I better believe it [laugh] maybe I should be coming swimming with you [laugh].

Hairdresser: You should come. Hair isn't a good enough excuse anymore. I go and look at my hair and I still go, me a mermaid' [all laugh] [the hairdresser had quite an elaborate hair weave].
(Hairdressing salon two)

The women also spoke of the importance of mental health, from emotional and spiritual perspectives. The need to be happy with self was paramount, and the need to develop buffers from mainstream depictions of health beauty and embrace a more inclusive view that places value on holistic health rather than mainstream images:

[15] To wrap hair means to cover and tie with a headscarf, preserving hairstyle and maintain moisture in hair.

> Black women are bigger than White women, the sooner we accept that the better we will all be. We can't look at others and expect to see ourselves because it's not like that, it's better to take the best care of what you have. If you're big it is beautiful, if you beady[16] you beautiful too. If you got African hair, it's beautiful too. If you think like that, you can keep your head in the right place – healthy. Then you can be realistic honest about how you treat your body and your mind and how you let others treat you.
>
> (Community sisters group)

It was evident that positions advocated by the Health at Every Size academic and social activist movement is embraced by some who took part in the research, and understandings of being big, beautiful and Black adds layers of intersectionality to this mainstream discourse:

> In the western societies tend to associate slenderness with health and I don't think that's necessarily correct and that we tend to use profiling. If you take myself for example, I'm 5 foot 7, I'm 15 stone, I wear a size 18 to 20 clothes. However I play netball twice a week, I go gym, I don't drive so I'm very healthy yet still if I go to my doctors as soon as I look on that chart [laugh] I know that I'm gonna be in the you know the obese the morbidly obese area and that can be quite disheartening. So you know, I know that erm I have quite a healthy lifestyle, I know that there is no question that I may need to loose so weight and I will do that within my own time, but I don't think that just because someone is necessarily big that it means that they are unhealthy and again I'm using myself as a prime example .
>
> (Local radio programme)

[16] Slim.

NHS healthcare:

This theme refers to the interaction and relationships that those who took part in the research have with the NHS, public health message and healthcare professionals. With this theme in particular, there is much overlap with biomedical/alternative discourses theme but it was important to develop a theme that explored how these understandings and experiences may contribute to shaping relationships with healthcare professionals and how this may shape help seeking behaviours.

Those who took part in the research generally acknowledged that there is a sense distrust of the healthcare system and it was evident that this scepticism operates on both individual and structural levels and has direct influence on help seeking behaviour. During the research process, many of those who took part shared personal experiences of receiving services from the NHS and whilst there were some positive stories shared, there were an overwhelming amount of narratives that pointed to negative and often disturbing experiences. Some were in reference to particular individuals such as a GP or nurse and how this particular person had offered care that did not meet the expected standard; others were more concerned about a system of poor care from the NHS. During the research session with the community sisters group the conversation went on to explore why there is suspicion of the NHS when the institution has long history of employing African Caribbean women:

> Well, that makes it even worse, even those on the inside don't trust it. It's not that you don't always trust the medicine: sometime you do, sometimes you don't but it's the whole system from the doctors all the way up to the top. If we live in a place that can see our kids fail in school, our kids with no jobs, so many boys in prison, why would they care if we're sick too? Look how many Black nurses and no Black managers. What it that they call it? Yeah

> glass ceiling. I'm not saying that people don't care, I'm saying that the system doesn't care and we all know. So, if we got our own way of viewing health, then it makes sense doesn't it.
>
> (Community sisters group)

It also became apparent through the research that issues of race, ethnicity and gender were important for the participants when assessing relationships with the NHS and its healthcare professionals. The women in were well aware of mainstream stereotypes that contribute to racist archetypes that can influence perceptions of individuals:

> Well, if we follow what the media says Asian women are not allowed to leave their house, Muslim women are all forced to wear that hijab and Black women like to fight we all know that's what they think of us. The minute you go in the door, there's an image so people can't see you as you. But sometimes they can see past that and that's when you get the best appointment. But if people always see you as that as someone with attitude and always ready for war then it's horrible, it really is horrible. You don't want to go back.
>
> (Community radio programme)

Additionally, to the feelings of invisibility as a person due to stereotypes, it was expressed that a lack of awareness of African Caribbean communities and culture was an important contributing factor that must be considered when examining this particular seldom heard group:

> I think it's because we speak English, wear the same clothes, lots of people are Christian they this we don't have a culture but we do. Our language is different, patios is different. I

> swear some people need interpreters [all laugh] its true. And a lot of our culture is in the words, the language, but if you don't take the time to find out then they will never know. I think we should all tick the box that we need interpreters and speak hard patios in the surgery [all laugh] maybe then we will get noticed [all laugh, nodding].
> (Elders group one)

> This woman came to my Nan's and my Nan had to run her out. Like she came to her house and was disrespectful and my Nan wasn't having it. She didn't take off her shoes, she hardly even said good morning and didn't even look at my Nan in her face. You know in our like our culture, that's bad. If you don't know about our people, then don't think you can come in the house and care for us especially for old people. My granddad was vex vex vex [very annoyed].
> (Young women's support group)

The women in the study also reflected on what they perceived to be a lack of awareness of health conditions that African Caribbean communities experience such as: skin conditions such as eczema, pigmentation and keloids; genetic conditions such as sickle cell disease and; food intolerances such as lactose intolerance. However, the health condition that was referred to most commonly was fibroids and cysts as a health condition effecting African Caribbean women where there was no directed services and a lack of awareness within the health service. Reasons for the lack of awareness were rooted in the notion that 'nobody cared' and the history of gynaecology experimentation and practice on Black women were spoken of, as if giving context for the perceived lack of services and support. There was also a suspicion levelled at the State and questioning why there are no targeted services and it was suggested that the option of

hysterectomies as treatment rather than alternatives approaches was part of the continued forced sterilisation projects of Black women in previous decades. However, such deep seated emotional suspicion does not mean that African Caribbean women do not seek biomedical support for fibroids and cysts. In fact a number of women spoke of using private healthcare services for this particular health issue.

During a data collection session in a hairdressing salon a woman spoke about her problems conceiving. She said that she had been visiting her GP for months before she persuaded him to refer her to a gynaecologist as she has a family history of fibroids and cysts. After investigation, it transpired that she had fibroids and was told that she would need a hysterectomy. Another African Caribbean woman recommended a White male Jamaican doctor who has a private gynaecology practice in the city and has treated many Black women who have been given similar diagnosis and treatment options by the NHS. She said that after the first consultation she knew that this doctor was different:

> It was good to find someone who knew about how Black women's bodies work and understand that we are not all the same. All women are not the same. I was so thankful to be there in his office God knows I was so so thankful to be there, I cried all the way home. (Hairdressing salon three)

She went on to tell how she sold her car and her husband took on extra work to pay for the treatment which she described as 'the best money she will ever spend' as she and her husband went on to conceive a baby girl naturally. This woman went on to say that she is aware that other women in the community have also been treated by this doctor with positive results and regularly shares his

information; after sharing her experience, two other women in the salon asked for the doctor's details.

Weight management and excess weight:

This theme focusses on how the understandings of weight and weight management. Again, there is much overlap with other themes, especially 'keeping healthy' but this theme seeks to further probe issues of weight management within biomedical discourses and relationships with healthcare professionals.

Talking about weight was discussed in the research process and the issues of raising this topic with family and friends who may be overweight or obese. Issues of terminology used to describe excess weight were only expressed on the radio in a single instance where a caller was wary of using the word 'fat':

> Because they're fat, they're obese or overweight, sorry, I don't mean to misuse the word fat, that's very insulting, erm .
> (Internet radio programme)

Interestingly, it was suggested that the societal fear of offending people was doing more harm than good and that people should feel confident to tell those close to them that they should consider weight management techniques:

> I mean if you are saying 'oh your fat' just to hurt people, that's not nice. But I know that if I

say anything to a friend, they are gonna know that I am saying it for the best like I want them to be healthy. So they might be mad for a little bit, but I know that they will get over it I hope.

(Saturday morning exercise group)

Within Caribbean culture, there is value in directness and honesty and for some, this shapes how they many raise the issue of how it has been raised to them:

[Laughing] I would have to tell them I'd say 'girl your batty is getting too big for you to handle so you better stop frying them dumpling and get on the bike or something' [laugh] that's what my auntie said to me she told me that 'my size doesn't suit me and that I need to lose a few stone' just like that [laugh] I was shocked and a bit sad for a bit, but I knew I was fat, I was just hoping nobody else noticed too [all laugh].

(Black student's group)

I was with my grandma on the bus and we saw someone that she used to work with and they were chatting and the lady was saying how she got this with her knee and that with her back and whole heap of pain and aches and my grandma just said 'if you lose some weight it would be better' and she went on and on about how the weight is pressuring the bones and how she should get a hola hoop to lose weight on her hips [all laughing] I couldn't believe it and the woman is nodding with her saying 'thanks for the advice I'm going to try' [laugh].

(Community sisters group)

These comments are especially interesting considering the objections to raising the issue mentioned

in previous themes, as such issues of legitimacy on who has authority to comment on the body is important to be probed. However, within this exploration of legitimacy to comment on the weight and offer advice and support is the importance of individual differences. In sharing her experience of weight management support with her practice nurse, a woman in the exercise group states:

> I'm big-boned and I remember when I first went to my doctor, or the nurse, they had a scheme going where they check you, you go in and they check you every week and advise you on what to eat and at the time I think I was fifteen stone and she said I need to come down to about thirteen. She said 'by your height you're supposed to be about eleven and a half, so […] But she says don't go below twelve and a half because you'd look gaunt, because of your bone structure'. And to me that was good advice, because otherwise I would have looked ill it was nice that the advice was for me about my body not just from a sheet or the computer.
>
> (Saturday morning exercise group)

Diasporic influence

This theme explores the importance of the African diaspora in understanding self and health. Among the research participants, there was a range of first, second and third generation African Caribbean women, who each all stressed the importance of remaining connected to African and African Caribbean understandings and perspectives when addressing health issues. This notion of connectedness to the diaspora is a central tenant of African Spirituality, manifest in the concept of 'Ubuntu', meaning I am because you are, where the concept of self is formed interdependently with

the community (Hilliard, 1997). The importance of Ubuntu and health was explored by participants during a focus group session:

> Voice 1: I think also – I don't think as a black woman you can be healthy as an individual. For me the more individual you are then the more unhealthy you are. So for me my health is kinda – it's like it's – what's the word – inseparable kinda from….
>
> V2: It's interdependent on everybody else's.
>
> V3: Yeah, on like community wellbeing. So in terms of particularly mental health, like I don't feel you can feel like free and liberated truly when we feel generally oppressed. We might have elements where we feel liberated and – but really there's a certain weight that you might not always be aware of. But in terms of like mentally well; I think it's definitely – it's a community thing. Like if the community feels strong, even if you might not feel physically well, then I think that gives you a certain strength. And by community it's not just so and so down the road, community means everyone, Jamacia, Ghana, Gambia, Haiti everyone. We cannot be healthy if others are not, you know what I mean?
> (Focus group three)

The importance of connectedness between people of the diaspora suggests that a commonality between individuals exists that can be understood through the physical and metaphorical 'body' and how this relates to wellbeing. From the data, this connectedness could be explored from three perspectives: biology; tradition and; culture.

Issues relating to beliefs of a biological commonality of people of the African diaspora is rooted in the notion that there are differences between racial and ethnic groups that challenge a one-size-fits-all approach to interventions. This perspective links to issues attributed to the previously explored biomedical/alternative discourse theme. During the focus group discussions, reference was made to the commonality of particular health issues of Black communities globally; in particular skin issues were probed:

> I mean, look how many Black, Caribbean, African, South American, Black people have got skin problems, everyone knows someone who has eczema or keloids or pigment problems. The list goes on and to be honest the doctors don't know what to do for us except give us really strong like steroid cream that's why we go back to basics [laughs] back to what Nanny, Mama, Bibi, Jaddah, what ever language you wanna use, would have used. We as a people have our own way of treating our own problems. It's not to say anything is wrong with what they are doing for themselves and their skin problems, but this is what we have to do for us, here and at home. Our skin is different and it's like they don't know we're different or they don't care – I don't know which it is.
>
> (Focus group one)

Additionally, from the data it became clear that issues of the diaspora and health also manifest in who can be regarded as a healthcare professional, and that this accolade is not reserved for those who are endorsed by the NHS, but also those who practise traditional medicine from within the African diaspora:

> ‘Well, my friend from Uni is from the Congo, and he always says like they had the herbs and natural things before they had the doctors and the qualifications. When I first met him he was like, ‘Oh, I’m going as a doctor of….’ One time I was like, ‘What type of doctor are you gonna be?’ He gave me the evilest look and said, ‘You don’t know? Herb doctor. What is wrong with you?’ He was so offended that I asked him like, ‘You don’t need a certificate to be a doctor!’ He was so angry with me for even asking [laugh].
>
> (Focus group three)

Interestingly, it was not just the older participants who expressed respect for traditional medicine and those that practice it:

> Voice 1: You gotta have respect for all kinds of medicine not just one approach. Like if your doctors tells you something like ‘drink this to be healthy’ you’re gonna be like ok, not too sure about this. But if the bush doctor, no we shouldn’t say that makes them sound crazy, like herbal doctor, herbalist tells you to have something you might listen a bit more. It’s better to be in tune with nature than erm
>
> V 2: Pzifer
>
> V 1: Yeah that’s it or one of those next big ones. And people think it’s just old people that go to the herbal people, nuff young people go for to see them, some of the young people that I work with go to that lady in Handsworth, the one who can prescribe you a diet and make you cream and shampoos and stuff [laugh] and Black people all over the world going to the herbal clinics, we all do it [laughs].

(Focus group one)

Fascinatingly, it also became apparent that alternative discourse of health within the African Caribbean community exists as a way of remembering and preserving culture, not just as a counter view to biomedicine. Although people become removed from traditional homelands, physically (through migration) or metaphorically (over generations), the desire to retain traditional customs prevails and health practices of this particular community may be viewed as such. For instance, the Jamaican tradition of keeping a small glass bottle of white rum and pimento on the window sill, for use of the treatment of pains such as stomach ache, menstrual pains and flu like symptoms was explored in one of the focus groups and the image of the bottle was remembered fondly when speaking of grandparents and other family elders:

> Voice 1: Talking about this really makes me emotional – like we really have to hold on to this knowledge like in honour of those who have gone before us you know, like to keep our culture. And more importantly, it works. But this generation– our generation – my generation is probably the last generation that use them things, isn't it? Because if you don't have the pimento and the white rum how are your kids gonna know about it, your kids ain't gonna have no pimento– so really you're stopping this generation.

> V 2: I suppose it's not just about health, but it's about our culture and history we should keep it alive, even if we don't always know why – but we should find out why from the elders before they leave us, if you know what I mean.

V 3: Sometimes you do things to feel closer, like when I drink my honey and lemon when I'm grinding up my ginger to put in there, I always think of my Grandad.

V 1: You should do some research on that [addressing researcher] I think it would be interesting to the community and to doctors and nurses, the NHS. Then they would understand bit more about why people do certain things. If there was a way to record all the remedies that people use to treat themselves and their families, I bet no one has done that for Black Caribbeans in the UK it would be a good idea. Everyone has stories to tell, there just needs to be someone to want to listen.

(Focus group three)

Experiences of illness

This theme explores the ways that experiences of ill health and related interaction with healthcare services and professionals. Whilst there is much overlap with the theme NHS Healthcare which refers to the interaction and relationships that those NHS, public health message and healthcare professionals, it was important to interrogate experiences of illness as an independent theme. In doing so, it offers particular insight into emotional issues such as fear, blame, trust and distrust into contexts of being a patient or a friend or relative of someone receiving care.

Particular issues pertaining to the health of Black women featured heavily in this theme and from those who chose to share their personal stories about their diagnosis, there was a general tone of disappointment in the healthcare system. For some, the disappointment came from a perceived lack of knowledge by their healthcare professional. During a focus group discussion, a participant shared her experience of being diagnosed with a gynaecological condition:

> I had these tests and he was coming back and he was saying oh inconclusive. So basically I just felt like he was so dismissive and I just don't think that he really understood the significance of something being wrong with your ovaries as a woman at 25 or 24 or whatever having that over your head. Whether or not he thinks I'm just being silly because I've watched a programme about it and I'm making stuff up. I was like can I have an ultrasound please and he's like oh well, there's a waiting list and it's expensive and I'm like but it's my health, you know. At one point, I was seeing a lady doctor and it felt a bit more supportive with her but then she left. The last time I went I was asking this doctor, this male Asian doctor, did actually find cysts when they looked at it? But they said it's not polycystic ovaries, it was a whole other thing and I don't know what that means. But I said oh, will that affect um will it affect a pregnancy? And he was like, if you can get pregnant. I was like, oh my God. I know that might be the truth but you don't have to say it like that. I was in pieces for weeks, I was just gutted. I just felt really alone, I don't know what's wrong with me, they don't know what's wrong with me and I'm just supposed to be ok [starts to cry and is comforted by the researcher and others in the group. Researcher asks if she would like us to stop the session but she says she would like to carry on]. I just feel really disappointed, nobody cares and I don't know what else to do and it's not just me, there are lots of women Black women with this and nobody has a clue what to do.
>
> (Focus group one)

At this point, it is important to express that with the data there was not an expectation for all healthcare professionals to know everything about all health conditions, rather it is perceived to be a lack of understanding regarding particular health issues. Such feelings are not specific to this

particular ethnic group, however the explanations offered to understand this situation are. The women who took part in the focus groups explored the intersections of race, ethnicity, gender and class through the lens of an African Caribbean positionality to probe this:

> Voice 1: My mum's White and I went to the doctors like a year ago, two years ago and um I was complaining of a pain and the doctor, the first thing he said to me was, 'what have you taken for it?' And I said, nothing and I said it's my choice that I don't take paracetamol, I don't take painkillers, I just don't do that because I like to know what's going on with my body and he was kind of like almost having a go at me and I'm 25 or I was 25 at this time for not taking these painkillers. So anyway he did some tests and I did actually have an infection and that was what was causing the pain whereas if I'd been taking these painkillers I might not have known that, I might have just stayed at home and it was actually quite bad by the time it got diagnosed. But when I went home and I was telling my mum and I was kind of cussing about it and saying why is he talking to me like that? And my mum says I don't know why they talk to you like that because they never say that to me. she said that when she goes there and she's like oh I never take painkillers they just say okay [name]. Obviously she's older than me as well so that's to take into consideration but she's also a White middle class woman and I think she is received differently. If she's saying something as a confident, White middle class woman, middle aged, saying 'I don't take painkillers' they take that as okay, that's your conscious decision. But if I'm saying it, it's like 'oh you must be stupid, what's wrong with you, why are you not taking painkillers, you know what I mean like?' I can't, I haven't got the right to make that decision, I'm using wrong logic or misinformation

Researcher: And how does that make you feel to think that between you and your mum you get different type of treatment?

V 1: Well it, it's complicated I guess because it's not just in some terms with doctors, it's a whole thing and I think that's a big thing about being dual heritage, it's like I'm neither. Either of my parent's experiences is not going to be my experiences so I can't necessarily relate to any. So, there's a lot of things my mum will come to me and say 'oh why does that happen to you? These things always happen to you'. And I just think well, 'I'm not like you'. Like my mum's never been pulled over for example, but my dad has probably been pulled over ten more times than me, you know what I mean, it's difficult but it's just an ongoing like negotiation again. As a dual heritage person that you just come to accept and it's difficult because I guess I'm not having that family sameness where I can go home and I'm talking about my experiences and someone say yeah, I understand, I identify with that.

V 2: Yeah it's difficult.

Researcher: So, do you think it's hard for people to accept that this is your reality?

V 1: Definitely, but definitely if you're White, I think it's even more difficult. Even though my mum is a mother of four dual heritage children I still think she struggles with accepting her privilege and the way that she's received is differently to how her children are received because she just sees it as we're her children. And I'm so like my mum in so many ways,

so it's kind of hard for her to see that people would see me as any different to my mum but [yeah] they don't and yeah, I do think that's disappointing.

(Focus group one)

Voice 1: It was so hard to go to the GP and tell him my problems because I knew that he had no idea about my problems you know how my body worked. It was just hard you know but you have to go through the GP to get referred so fair enough. But rather than say oh I'm not an expert in ovaries [laughs] he gives me advice on losing weight but doesn't seem to register that my condition is doing this to my body and telling me that I am fat isn't helping he could have googled the condition and read it. To be honest with you I wonder is it because I'm Black? Or is it because I'm a woman? Or is it because I live in Aston? I mean if I lived in like a richer area like Sutton, Sutton Coldfield and I went to a nice little quiet surgery with only a few patients would it be the same?

V 2: But I'm sure sometimes Asian women get it too you know.

V 3: You think so?

V 4: Yeah of course! Not the same as what we get but they get it all the same – oo look at poor Mrs Ahmed in her veil I bet she can't speak English so we won't bother ask about her pain, you know what I mean?

V 2: But at least they have Asian doctors.

V1: Yeah but Asian ain't all the same you know just like we ain't all the same like Black ain't all the same. You got them rich rich Indians you know some of the Sikhs have a lot of money driving up and down in the big cars and then you got them real poor ones, the untouchables that live in the shit basically back home and over here too.

V 2: For real. You got them rich Sikhs in Handswoth Wood and the poor Pakistanis in Alum Rock, the Muslims.

V 1: But at least the Pakistanis have some of their own in the surgeries, what have we got? [collective agreement]
(Focus group 2)

Voice 1: I was reading about this diabetes in the paper the other day and they were saying it's gonna cost blah blah amount of money because more people are getting it and the NHS could go bankrupt blah blah and I just thinking that's the whole point. They don't want people better so that people can stay well and live a happy life [laugh] they don't want people to get sick and cost money. There is a difference between the two.

V2: Yeah because if they wanted to improve people's diabetes like the risk you have to change more than that because I think I was the same thing in the paper, The Metro, and it was basically saying that poor people eat poorly like eat bad food and that they need to eat better and I was like –what! Of course poor people eat poor food cos that's what they can afford!

V 1: Mom's go to Iceland – of course they do! The food is cheap, crap but cheap and probably giving the kids all these problems. It's hard when you are trying to do your best but everyone is saying that you're doing the wrong by your kids. But at the end of the day if the NHS really wanted to help people, Moms, they should look at the whole system instead of blaming them for there like situations it's more than just not buying fizzy pop, look at the whole lives of people and then you can see.

(Focus group 3)

Those who took part in the research also offered perspectives as to how these social categories of difference are given meaning during encounters with health services and how this may influence help seeking behaviours and subsequent health outcomes. In each of the focus groups, there was discussion about those who have experienced negative health outcomes after not seeking medical attention when the symptoms were first noted and alternative treatments not providing effective improvement:

Voice 1: But there has to be a balance I mean if the mix up mix up drink [alternative remedy] isn't working that you have to get help. There's a balance. Sometimes it good but sometimes it can be not so good.

V 2: Because you don't know what you've got.

V 1: Exactly. [Name] was sick for a time, she ignored it; she dropped down dead.

V 2: [Name], she had lots of headaches she ignored it; she dropped down dead. Both brain haemorrhages. So it's like a where do you draw the line sort of thing.

V 3: True. [Name] had to have his leg off after his diabetes sent his foot bad but he wouldn't go. Took everything else like herbal, but wouldn't go to the doctors and everyone was telling him but he was like no I ain't going.

V 1: I bet he wished he gone now though.

V 2: People just need to get it right, like trust that there is more than one way to do things. No one wants to be sick so you have to trust them to make you better.
(Focus group 3)

From the discussions, an important barrier to seeking help for health conditions is based upon how the women feel that they are perceived by healthcare professionals and indeed, how they perceive themselves and other Black women. The role of stereotyping Black femininity in the clinic setting, in the diagnostic process and within wider social settings was put forward and how this may influence when medical attention is sought:

Voice 1: My mum always says to me that you've got to be strong in life, you're a Black woman. So if I seek help it's desperation really but if I was to seek help it would be desperation. I'd always think that I could sort things out by myself.

Researcher: Mmm and do you think, do you think it's a good thing?

V 1: I think it is like, like, you know, not being funny or anything but like sometimes I'd be around like White people and they're crying for things and I'm like I can't believe what they're crying for [laughter] yeah and I just can't believe it, like at school I went to a predominantly White school and the things that they used to cry for I couldn't believe somebody would cry for it. Black girls aren't allowed to cry.

V 2: But in, in like contrast I don't believe it's a good thing because sometimes like my mum used have this problem, um she thought that oh if my head's hurting me I'll just make some bush tea and drink bush tea and that's fine but sometimes it can be deeper than just a headache. It can be there like you getting worse, getting worse but they think oh I'm taking it under control and I'm dealing with it you know the way I'm meant to deal with it you know as opposed to crying for no headache and don't need to go to no doctor I'm a strong woman who can take care of myself and my family. I ain't got time for sickness. (Focus group 1)

Voice 1: I think it's a complicated issue when it comes to depression and so definitely it's bound up in issues of race not just how, er, outsiders see us but also how we see ourselves and that erm what's it called, myths that we believe into about how we're supposed to be. And issues of gender as well, Black women take on so much – so much of, er, and so many other people's burdens including those of men and having to support the family and pillars of the community and all that that don't get diagnosed or factored in as part of why sometimes we suffer the way in which we do. And then we're expected to be silent about

it because we think well we have to be strong and it's just like this circular thing that happens.

V 2: Not so much that you have to be strong it's more, that you know that others are carrying a burden too, so it's not really about strength it's about survival. Sounds dramatic, but it is. And because we know that everyone, Black and White have their own crosses to bear, we won't share our misery. White people share, talking therapy, we don't. Sad really, really sad situation. This myth of the superwoman, sad.
(Focus group 2)

Voice 3: Black women don't have time to be depressed, we've got too much things to do.

V 2: Yep, we've got too much people relying on us. I couldn't image the day that I went to the doctor to say that I was depressed about my body, depressed about this depressed about that, nah man, I can't do it. We've got too much bills to pay, dinners to cook, kids to take to school, Nan to take care of. We've got too much community thing – we haven't got time. I know that other like, women get stressed but it's like for us we can't take that time out because we don't have that option because people don't see us as people. Believe me, for most Black women, if they decided to go to the doctor and say they're depressed, they've been depressed for years before they've even decided to go.
(Focus group 3)

During the sessions, there was much sharing of quite personal doctor-patient relationships with before, during and after diagnosis of health conditions, ranging from extremely positive to more

concerning instances and how these influence the view of the NHS. The following excerpt of data illustrates the range of experiences sand the ease at which relative strangers were willing to share:

> Voice 1: I love the way that he sits you down and when he's not available there's two other GPs that I see, one's, er, Asian, the other one's from Eastern Europe and they've got a similar approach. They're not there with a pad, they want to sit down and hear and suggest non medical remedies.
>
> Researcher: Okay so it's not always about the ethnicity or the racial background, it's more about the…
>
> V 1: Approach definitely. I mean I had an issue with my back I went to see him and he talked me through certain things in terms of you know just simple things when we need to go the toilet, if we don't go at the time we need to go that can have an implication on back pain. And I thought about that and I was thinking, do I sometimes do that and sometimes I probably do you know as people it can wait but from since he's told me that no it can't wait because that's having an impact. Er, but yeah their approach generally is good.
>
> V 2: I had a similar experience my GP is also, er, of Asian background and I think it also has something to do with where I live now because I used to live in the centre of Birmingham and I went to the GP in the Boots there and it just got increasingly busy and busier as more people moved into the centre but I moved, I'm now in Bournville and a nice little GP centre where they have time to sit down with me. And I was having, I have a condition that causes me nerve pain and whenever I'm stressed out it's even, er, it's even

worse and so she was exploring this with me and she said, well why are you getting so stressed, what's happening in your life and we explored those things and I had something I didn't even know about, she recommended, er, a charity to me that ran, er, therapy sessions and it was because of her. Because I went to the doctor with this like increased pain that she explored my stress and then said, well here's something and maybe you should reach out to them and you can have some therapy sessions where you can talk about these things that are causing you stress in your life and then impacting your actual health. And I'm so thankful because no-one ever did that before like ask me about my sort of wellbeing, that general sense and how it was impacting the specific pain I was experiencing.

V 1: It's interesting because I had issues with my white blood cells being particularly low that my, the GP from Eastern European, from Eastern Europe she was really concerned and she actually said to me, what' going on in your life right now and I said I've split with my husband, that was over two years ago and she said, I think that may have a factor to play in all of this because she was really concerned. And then afterwards things were fine so it's good that they do take the time to explore what's the underlying issues.

V 3: Well, for me it was totally different my experience. I found out that I had, er, cancer and I had been going to my doctor for a year saying there's something wrong, I don't know what it is, why am I getting all these different things, er, you know I'm worried because I'm going every few weeks to my doctor until he starts to call me trouble and I'm getting really pissed off with that you know. That was the worst thing he could have done to me, calling me trouble like I'm some small child. And it wasn't, if it wasn't for a new doctor, er, poor girl just started I would have thumped him, because the doctor came in and he

said, ‘oh here’s trouble again’ and I was going to kill him and he said ‘you’ve been coming every week and I can’t help you, you are not sick’. And for me, that’s about the way they see us, I’m a big woman, I don’t go red, I don’t look pale do you know what I mean so I’m not going to look really sick.

V 2: We often don’t look unwell do we.

V 3: Yeah, er, but it’s the way they see us Black women, we can’t be sick. So I saw this new doctor and I just told her I was really just sick, sick and tired of not being listened to. She sent me for an x-ray a CT scan and the poor woman had to tell me I had cancer, I feel more sorry for her. For me that was about race, there’s no way I could have put that into an official document but it was about the way he saw me. If he’d have seen me in a different way, he would have been more cautious, but I think the teaching of doctoring is very hierarchal anyway so there’s a point where they look down on you. The traditional doctor always kind of looks down on the patient, they know better than you in terms of they don’t ask you how you feel or what you feel it’s going to be, they tell you, you just give them the symptoms and they tell you what it is. And I do think that just the tradition of medicine, and if you’re Black and in that – that matrix you’ll get lost completely. Er, but the – the cancer thing for me was a big wake up call that I could have been ill for months and months and they said I, I had a big, er, tumor on my side here [gesturing to a site on her body], er, it eventually took a kidney away because it killed, er, my kidney. Er, and they didn’t see this, and they never see it because they don’t see you. They didn’t see my cancer because they didn’t see me.

V 4: I know or they see you but not in the way that you want to be seen: as a person that understands and likes to think for yourselves. It's different when you have a long-term illness, sometimes it is like the doctors want you to give over your body to them, soul everything I'll give you an example – because you know that I've got the lupus and we battle with that. When I first started to go to clinic – all we sort of do is have holy debates because they wanna give you this and you're saying, 'no, I'm trying that.' The minute you're trying something alternative then you have to have this debate. When they tell you that these are the drugs they're gonna give you, I'll say I'm gonna go away and research it and read about it – then I'll come back to clinic and let you know. It's like…

V 3: How dare you! Yeah I get that a lot from my doctor.

V 4: Shock, horror, you – I'm the doctor. I have to say to the doctor, 'I know you're the doctor and I'm the patient….' But I have to say to him, 'I have got capacity to make my own decisions and I will wait and make my own decision that is in my best interests. I've taken your advice on-board' and he sat down there looking at me because I'd said to him that I had capacity to make my own decisions. He was like, 'I'm the doctor and…. ' I said. 'And I'm the patient and it's my body you're dealing with'. There are doctors and then there's God, that's how they see it. You are so lucky if you have a GP that is not like that – which surgery do you go too? I think I would like to swap!

(Focus group 2)

Interpretive themes of the discourse

Through the process of coding, a distinction can be made between codes that provide the outline details of discourses of health within African Caribbean communities and; those that provide the social contexts that frame these discourses and how they may influence the health beliefs, practices and relationships with healthcare professionals for women of this ethnic group. What follows are the interpretive themes from the data, which do have elements of overlap between them. These outlined interpretive themes will further shape discussion relating to the research questions. The codes that constitute the interpretive themes of: ethnicity, femininity; gender and sexuality and socio-politics exist in a way that influences understanding in arbitrary and fluid manner. Simply put, as people do not live in bubbles that neatly demark between different areas of social life, separating the individual from family, communities, work, politics, histories, media and so forth. As such, the analysis of this data seeks to reflect this interrelated reality.

Ethnicity

The women who took part in the research explored issues relating to ethnicity and how perspectives of identity are partly forged through such issues and how they may influence health practices. There was a general approach that whilst there may be some similarities with other ethnic groups, African Caribbean as an ethnic category had its own characteristics that are important in shaping self:

> Voice 1: Being African Caribbean, it's more than just saying that you are from the Caribbean you know. I think that people like people who are not us think that all we do is eat rice and peas and listen to reggae and have carnival [laughs] Of course that is part of the

culture but it's a small tiny part. It's about the values that we have in our homes families our work, culture, our ways [group agreement].

V 2: Yeah, it's about our religions, cultures, it's the way we dress, the way we speak to each other, the words that we use [laugh] we're quite complicated really, us Caribbean people [all laugh] It makes us who we are.

V 1: It's like how you are in the world, how you see things

V 3: Yeah and how you are as a person, where you are from and where your people are from. The same for everyone, it's like all people got their own way, it's part of how you do you.
(Focus group three)

However, whilst there was a view that African Caribbean as an ethnic category was distinct from others, including other Black ethnicities, there was recognition that while ethnicity may be rigidly defined, the cultures of these categories are not fixed and static. Rather they can take on hybrid forms in ways that appropriate different elements of other ethnic cultures. During a focus group discussion, this hybridity was explored through food:

Voice 1:But it's not like you have to do the same ol' same ol' to be Caribbean my gosh! Some times we just gotta let somethings go man! Like for some people, Saturday it has to be soup, Sunday it has to be rice and peas, it's ok to change [all laugh].

V 2: [laugh] it's true what you eat doesn't have to prove anything.

V1: Exactly.

F3: Well my Nan shocks us all the time, we go over for Sunday dinner and what we get is a surprise every week [all laugh] I think she has Come Dine With Me fever [all laugh] the other week we had lasagne, it was really nice.

V4: Good for Nanny [all laugh] but even when we cook other food like not Caribbean food it still tastes like our food, we can't follow recipes [laugh] we always adding our own stuff to the food.

V3: [Laughing] it's so true, my Nan's lasagne was lovely but it didn't taste like any other lasagne I've ever had it's the seasoning [all laugh and agree] we can't let go of the all purpose and our own herbs, my Nan puts pimento in everything [laugh] You can always tell if a Caribbean person cooked your food [all laugh].
(Focus group 2)

Interestingly, it was the younger participants who took part in the research that expressed that they made more of an effort to retain what they perceived as 'authentic' African Caribbean ethnicity and its culture than the older women:

Voice 1: I feel like we have to hold on to something, it's like a link to the past it would be too easy to forget so I feel like I have to make the effort, like with food, holidays like

traditions so that they don't die out for us. Got to keep it alive you know it's our job for the next generation coming up don't you think? Got to keep the old remedies [group agreement] keep us all healthy body and mind, well that's what I think anyway.

V 2: Right there with you sis. We have to keep it up, it's part of like being from the Caribbean well, your parents or grandparents, I ain't even been but I know I need to keep it. (Black students group)

Femininity

As the research was primarily concerned with understanding discourses of health held by African Caribbean women, it is not surprising that discussion concerning issues of being a woman and concepts of femininity arose and what is means to *be* an African Caribbean woman was explored. The importance of the ethic of caring was deemed central to discussions of femininity and could transcend the issues of race and ethnicity, but rather was rooted into wider issues for women. During a discussion about the roles that women have within the family and the distribution of caring duties, it was remarked that:

Voice 1: It's the woman's role anyway, not just Black like Caribbean women but everyone. We live in a time where it's supposed to be equal rights and that but it always falls to the woman, even if you're auntie, god mother, niece whatever you got to look after the kids, the hubby, the parents, the grandparents, the neighbours, then you expected to volunteer in all these things for the community. I know that men help too, but when they help they get a round of applause, [partner's name here] expects banners and balloons [all laugh] but when

> the women do it, it's just done, that's it. I'm not complaining, I'm just saying that's how it is.
>
> (Focus group one)

It was also discussed how issues of expectations of femininity and roles within families can often mediate how health issues for the family are addressed:

> Voice 1: I think because over the years, generations, it was always the women who took care of health, like the herbal women all over the place, it was the women. So it's still funny how women are still in that role now. Like who knows when the kids need to go to the dentist, or if they have taken their vitamins or stuff like that? It's usually the woman, even if your man needs to go to the doctors for something, it's sometimes even the woman to push him to go.
>
> V 2: Hmmm. So really to get better health for the families talk to the women but if you say that, like if there were posters saying that all over the place, then people would be saying it's sexist but it's not. And to be honest even with all different kinda families like erm, like same sex families I bet that there is one who does more like looking after than the other. It can't be perfect balance all the time.
>
> (Focus group three)

However, global views of ethics of caring did divorce when exploring issues of food and food practices, in that the African Caribbean women expressed a more positive view to cooking and the family than mainstream feminist discourse, a finding also expressed elsewhere by Bramble et al (2009). As expressed by a participant in this study:

Voice 1: Feed the body and the mind that's why it's so important to give them good food and teach them, the kids, boys and girls. You have to have them in the kitchen with you, show them how to cook how to take care of themselves. That's what is so sad about all these fat fat kids, they need to know the right way.

V2: It's true, and I think that's difference for us, like the boys are sometimes pushed more than the girls to know how to cook. I used to love it when Daddy went in the kitchen, good food tonight [all laugh] but some of these other cultures, the boys can't do anything like my friend [name] she's Indian, her husband won't cook and she won't let him or the son cook.

V3: True. You have to teach your kids that they don't have to rely on anyone they have to be able to look after themselves. If I drop down dead tomorrow my spirit would haunt the place if I know my son couldn't make himself a decent meal.
(Focus group one)

You know, I feel bad that I am at work all week, hardly see them sometimes, but they know mommy loves 'em. When they get home, dinner is always cooked and ready for them to heat up even if I'm not there. I suppose I spoil them really, but it is to show that I care.
(Focus group two)

I love nothing more that hearing [name] pop a belch after my dinner [all laugh] it's true [laugh]. I love the kids asking for more, makes me feel like I'm looking after them. I think that's why we have problems with erm, what is it, portion sizes! The bigger the plate the

> more I love you [laugh]. I know some women moan moan moan about cooking, you wanna hear them at work, on and on, but I keep my mouth shut because I don't mind it, it's caring. (Focus group three)

Such insight into how the participants in the study are aware of the similarities and differences between the roles of women that tie into ethnic differences in expectation in gender roles in the family. This perspective causes for attention to be paid to the nuances in family dynamics between different groups in society that may influence health understandings and relationships to healthcare professionals.

Gender and sexuality

As a continuum from the previous theme, issues pertaining to gender and sexuality were also expressed by those in the research and reflected an alternative perspective to dominant discourses. As is often anecdotally presented within mainstream and African Caribbean discourse is the perceived preference for larger women by Black men, a different perspective of beauty standards which was discussed by the women in the focus groups:

> Black men do like bigger women. Not like overloaded, but someone with a bit of shape, a woman's body. Nice bottom, nice hips, looks like she don't starve herself [laugh] that doesn't mean that she doesn't take care of herself, but she's not like a piece of thread. (Focus group one)

> Of course some women are naturally small of course but if you are not eating to stay maga [thin] then why would you be attractive to anybody? No one wants that.
> (Focus group two)

> Well there is a thin line between everything. It's ok to be thin, but not too thin. It's ok to be fat, but not too fat, just right. It's where you need to be and anyone that decides to be with you have to want you for you. Not the size of your thighs, but for you. It's true. But I do think that we have it easier that some other like women, especially White women, they got this thin thin message bombarded at them all the time, it's bad really they are encouraged to have an unhealthy body, yet be healthy minded.
> (Focus group three)

From the data, it was interesting how the difference in portrayal of gender and sexuality was noted by those in the research and sympathy for those who are more overtly subjected to particularly restrictive images of beauty. However, it was noted by younger participants that a different form of beauty ideal did exist for Black women that focused on the buttock and stomach area and is popularised by music performers:

> Voice 1: Like there seems to have this Nicki Minaj figure that's in at the moment, like a humongous bottom, this seems to be the latest figure because it wasn't in a trend, in wasn't in a few years ago but seems to be the latest thing. To be granted as having a nice figure you've got to have a tiny waist, a massive bottom and you did have a nice body with a tiny waist. Just false really.

V 2: The worse thing about it, often Black women are going into surgery to get that figure, like bottom implants. Remember that girl from London went to America and died.

V 1: Hmm, but people want the shape like Nicki Minaj seemed to set it off, didn't she?

V 3: They think of that as an ideal body Black women should have, it's about being sexy not healthy.

V1: I think the thing about the shape is that it is not as achievable for everybody because it's a genetic thing. You either have it or you don't. Anyone can starve themselves to be size zero but not everyone can have a good bottom you know what I mean. Really it sets Black women up to fail from every angle, there's a song by Lil Wayne and he actually says 'you're a [expletive] with no ass, you ain't got nothin'. How is that supposed to make people feel?

V 3: Really bad, yeah.

V 1: If you haven't got that you're not attractive and health doesn't come into it, it's just like your value is almost decreased

V 2: So there are Black women that don't fit that stereotype, this curve thing and they're still Black and they're still healthy, just don't fit the image.

What transpires from this view point is that the idea that Black women are buffered from the negative effects of mainstream depiction of beauty may not necessarily be so. Rather there are directed images of the sexuality that pervade Black culture, that whilst promote a different body shape, can manifest in the same contractions as the images of mainstream femininity regarding ideal body image and health. As such, we must then view the issues of body shape and size not just a guided by a history that affirms bigger bodies, but one that is places understanding between mainstream, global images of the female body, local understandings of the body driven by images in the UK and those that are offered by public health and; African Caribbean perceptions of the female body shape rooted in history and stereotypical ideals.

Socio-politics

The final interpretive theme that emerged from the data is a broad one that encompasses wider contemporary social and political issues that may influence perception of health and illness. The economic downturn and subsequent changes to the nature of public and private services in attempts to address this issue have meant that people relate to themselves and society differently. In so far as employment, there was a sentiment among some of the participants that the personal definitions of illness had changed due to uncertainty in the workplace:

> I mean, there was a couple days a few weeks back where I felt so rough and any other time I would have called in sick. My stomach didn't feel too good, but since they've been talking about redundancy I make sure I am there everyday, trust me. I can't loose this job over sickness. I know they can't get rid of you for being sick but you don't want to give them any excuse you know.

(Focus group two)

> I'm on a zero hours contract so they might call me the night before or the morning and tell me to go in. I can't not go, I need the money so I've had to cancel a few hospital appointments so that I can go into work. I called to cancel one time, the receptionist tried to give me a lecture about how important it is to make it to my appointments blah blah and I should prioritise. I was so pissed at her, how dare she tell me. Of course, my health is important but so is my mortgage So unless I'm coming to live in her house she better keep her trap shut. It's not easy these days.
>
> (Focus group one)

The proposals that times are harder than were previously were also echoed in discussions of reductions in funding from national and local government for services that were aimed at supporting communities:

> As a social worker, I see, right there on the front line what these cuts are doing to families. It's not good, not good at all. I mean with all of this going on, it makes you thankful that you don't have the struggles that some people have to even put food on the table. I mean, you see on the news them a'chat bout heat poverty, but when you go into a cold home and you see a family or an old person, freezing in their own house it saddens your soul, it goes deep.
>
> (Focus group two)

The women also had particular views of how the current economic and political climate was effecting the NHS:

Voice 1: My GP surgery is packed all the time and I mean all the time I don't know how they cope and to be honest I don't know how they can give good care. If you had to see God knows how many people in a hour, how good would you be? I'd probably be on snooze after the first few [laugh] auto pilot.

V 2: Yeah, it is a lot and then you have these toffs on the telly, Conservatives with their nonsense about NHS needs to change this and change that, how about they come spend a day with them. I'm not a doctor, but even I can see that it's a bit much for them. But then again, they do get paid a lot so I suppose it's a bit of both.
(Focus group one)

V1: [Participant is a nurse] Only a doctor said yesterday, 'More referrals…money.' That's what he said, you know.

V 2: The NHS is a business.

V 3: I was gonna to say that, it wasn't before, but it is now.

V 1: For anyone who comes into outpatients – they get £150 for every new patient and for every follow-up patient they get £50. So what they're trying to do now is discharge all the follow-ups so that they can encourage more and more new, because they can't physically fit all of these follow-ups and all these new in at the same time. They want the new – it's a business.

V 2: I'm gonna say that there's a lot of money to be made off sickness in all aspects and who gets the money? It's turning into America, I had a leaflet come through the door for health insurance the other day telling me to 'beat the NHS queue'. It's disgraceful. (Focus group three)

Summary

Through the data analytical process of thematic analysis using the grounded theory approach to coding and theming (Strauss and Corbin, 1990), the main contours that outline the discourse of health within African Caribbean communities has been presented. The themes of biomedical/ alternative discourses; diaspora; experiences of illness; keeping 'healthy'; NHS healthcare and weight and weight management were found to be central in addressing the research question.

Further interpretive themes of ethnicity, femininity, gender and sexuality and; socio-politics were presented intersecting themes that provide wider social context to the proto themes of the discourse and will be useful in relating the findings to discussions that seek to address the second research question that probes how these discourse of health within African Caribbean women may relate to healthcare professionals and receive public health promotion messages with regard to discussing body weight and weight management programmes.

Chapter Seven

Conducting Community Based Research in Liminal Spaces

Introduction

Owing to the continued underrepresentation of seldom heard communities in health research, it is easy to assume that such communities do not want to take part in research. However, as communities often at the sharp end of chronic health disparities, it would be unfair to conclude that they do not want improved outcomes for themselves and wider society. Yet, the task of embedding community participation in health research and implementation of health interventions successfully is not an easy task (Parry and Wright, 2003). Therefore, research must re-evaluate its research tools to identify which aspects of the research process do not relate to the communities that it seeks to engage; those for whom their first language is not research and report the realities of doing such work. When working within academic institutions, it is often easy to forget, or indeed to be unaware that research tools are not culturally or politically neutral. Rather, traditional approaches to research methods can be viewed as representations of the symbolic power that is granted to the university institution as western dominance over the knowledge production process. Therefore, research methods must be translated into meaningful practice to engage communities for increased participation and data quality in ways that acknowledge and address these issues. Qualitative methods dubbed as 'gold standard' must be redefined if they are to encourage participation from seldom heard groups. Issues such as site of research, research activity and recording of data must be considered as issues of importance when seeking to give voice to seldom heard groups through approaches to conducting health research. The development of novel health research methods is therefore not just concerned with increased participation of seldom heard communities in health

research, but in the value and depth of the data that is collected from them, increasing understanding to develop effective health care services and interventions. This chapter gives an evaluation of the method that was developed and applied in this research.

The aim of the first phase of data collection of the Big Talk Project was to explore discourses of health in African Caribbean communities in Birmingham so that it may be mapped for analysis. To collect such data, research methods that reflected the dynamics of African Caribbean communities, that spoke in a language that was meaningful to potential participants was developed. A community based method, rooted in the understandings of the liminal space and framed within a Black feminist epistemology was applied in three distinct settings: talk radio; hairdressing salons and; community groups. The research sought to capture natural talk about health in a way that was led by community participants, yet meeting the standards of research and academic rigor held maintained by the university. As a member of the community that was engaged in this research, it was important for personal networks not to be used as part of the research process, to gain access to spaces or to recruit participants, so that a research method that truly seeks to engage with the communities could be developed. What follows is an evaluation of the research method used in each setting, exploring the benefits and limitations of using such a community based approach for health research.

Research phase one

Talk Radio

Research was conducted on three different talk radio stations that host shows that are particularly aimed at African Caribbean audiences in Birmingham. The first talk radio research session took place on a local station that is part of a national broadcasting corporation. The second took place on an internet radio station that produces podcasts of its discussions. The third data collection sessions took place on a local independent community radio station.

There were particular ethical considerations in using this type of media for research purposes, namely issues of consent and participant withdrawal of data from the research. For callers who contact the radio station expressing the desire to take part in on air discussion, there is an assumption that they understand that their contribution will be made public, in a similar vein to internet posts. Once individual views are made public via mass media, they become accessible to the public and private rights are suspended. With reference to one particular station, the radio broadcast including callers contribution will be available online to be accessed to the general UK public for a time after the show has aired and individual contributions are cannot be removed. With assistance from the producer of a radio programme, a statement outlining the nature outlining the nature of the research and the contact details were read to callers to the radio stations before they are transferred live on air, thus giving opportunity for callers to decline to contribute to the research or to continue with informed consent.

As a social researcher, who is not media trained, in order to facilitate this research, there had to be a certain reliance upon the radio producers and presenters and a good relationship had to be

maintained. Each radio producer and presenter were given detailed information about the aims of the research project as a whole and the rationale for using talk radio media as part of this research phase. The response from the radio staff was extremely supportive of the research and it was evident that they had made conscious effort to encourage lively discussion of the research topic. For the show conducted on the local station of the national network, the producer developed as short audio of vox pops, very short interviews with African Caribbean members of the public about body ideals for African Caribbean women, which was played as an introduction to the show:

> Voice 1 (female): The ideal shape for black women erm I think is a small waist fairly not too broader hips but a nice curve and a decent sized bum.
>
> V 2 (male): Erm my ideal shape probably about 5 foot 6 5 foot 7 erm I don't like her too skinny I just like a nice erm I just like a nice round woman you know.
>
> V 3 (female): A good size bum (laugh) and a flat tummy.
>
> V 4 (female): Curvaceous and hour glass figure erm not skinny but not fat like in the middle.
>
> V 5 (male): 12 to 14 kinda curvy kind of.

V 6 (female): Coming from our origins and background even dating back to like ancient ages, Black women have always had the curves on them. It's something that's in our genes and it's something that we have inherited from our ancestors.

Voice 7 (male): I like a nice curve fluffy type of woman really that's what everybody looks for at the end of the day yeah cos it symbolises health.

Voice 8 (male): I would say curvy that's what they call them ennit you know what I mean big hips big bottom yeah it's mostly in Jamaica.

(Local radio programme)

Also, a particularly interesting section of audio was played during the programme to stimulate discussion:

V 8 (female): Black men like women with a behind and with a front on them you know. If n African Caribbean countries, islands or whatever, you'd actually see that the women actually like to look erm a bit big. Not just for men but because it symbolises wealth for the women like you're eating good and your looking good that's what it's about you know. Obviously when it comes to men, they do like their women like that who doesn't? You want a woman that looks good, you don't wanna have a woman who's looking stick thin and unhealthy. You want somebody with a bit of flesh on them, something to grab on to ennit.

(Local radio programme)

On the internet radio show, audio of different voices speaking about obesity and related health and social consequences in short sound bites was played to frame the subsequent discussions:

Voice 1 (male): If you go with the flow in America today, you will end up overweight or obese, as two-thirds of Americans do.

V 2 (female): I don't want to be fat for the rest of my life. I've got diabetes.

V 3 (male): Sleep apnoea.

V 4 (female): High blood pressure.

V 5 (male): I get dizzy when I get up.

V 6 (female): Everything's hurting now.

V 7 (male): If we don't now take this as a really serious urgent national priority, we are all of us individually and as a nation going to pay a really serious price.

V 8 (male): Went in for an interview, it's actually for an ice cream sales person and he said to me, 'I really think that you're going to eat the profits. I really think that you're going to make the company lose money.' And I'm like, 'You're joking, right?' And he goes, 'No, I'm dead serious.

V 9 (female): People that I don't even know have walked up to me and taken items out of my shopping trolley and say, 'you don't need that'.

V 10 (male): Next month the UN will single it out as the world's greatest health challenge, which governments have deliberately ignored for 40 years. This latest warning comes from leading doctors in the UK, the United States and Australia.

V 11 (male): Just about all countries, apart from the poorest countries, are hitting with an increasing trajectory on obesity, particularly for adults. So at the moment about 2 billion people in the world that are overweight, about 2 billion adults in the world that are overweight are obese and about 170 million children. And, particularly in low and middle-income countries, this is going up in a very steep trajectory.

(Internet radio programme)

For the local community radio programme, the talk took place between music of various genres that was specifically selected to relate to the research topic of African Caribbean women and body ideals. Songs played included:

Baby got back (Sir Mix-a-Lot, 1992):

I like big butts and I cannot lie,

You other brothers can't deny

Fat she fat (Holt, 1983):

You say mi lucky,

To have a fat charming girl like you.

Bootylicous (Destiny's Child, 2001):

I don't think you're ready for this,

Is my body too bootylicious for ya babe?

Gal wine (Chaka Demus and Pliers, 1994):

Mi seh big fat gal love maaga man,

All di maaga man love di big fat gal.

Trans: I say the big fat girls love slim men, all the slim men love the big fat girls

Maga Dog (Tosh, 1983):

When I was with you look how you big and fat girl,

Now you look like a real wet rat […]

Sorry fi maga dog,

Maga dog tun round bite you.

Translation: When we were together, you were eating well, now are separated you have lost a lot of weight and you are much less attractive. However, I don't feel sorry for you, as you didn't appreciate me.

(Community radio programme)

For each radio station, the contribution to the actual talk show varied. For the show that took place on the local station of the national broadcasting corporation, the researcher was a featured guest in the studio, along with a consultant endocrinologist from University of Birmingham and an African Caribbean woman who was recently dubbed 'Slimmer of the year' in a local competition after losing over ten stones in weight. For the internet radio show, the researcher did not take part in the programme as an invited guest, rather the research topic was chosen as an area for debate and discussion hosted by the usual presenters. For the community radio, the researcher was the sole guest on the station on four occasions. As a 'guest' on a radio programme to facilitate research exemplifies the tensions of using community based research methods in this approach to conduct the investigation in that the researcher must, to some degree, give over ownership of the research

process to others to facilitate data collection in such spaces. With specific reference to talk radio, this situation brings to the surface issues relating to using an entertainment space, sometimes employed in an educational capacity as a research space and the difference between a media interviewer and a qualitative health researcher with regard to points of interest. For instance, on both the local station and the community station, there were points raised by callers that may have been probed in further detail if it were a one-to-one interview or if the researcher was in sole charge of directing the show.

In retrospect, the use of guests and pre-recordings and specially chosen music, while make good radio may have inadvertently placed limits on the discussions that could have been held on the air. Keeping the discussion focused to the topic would ensure that the discussion remains coherent and logical so that listeners can follow the thread of the discussion. However, for the task of capturing real speech and the natural progression of ideas may have been stunted by the requirements of offering listeners entertainment. Following on from this point is the observation that there is a difference in interview style between radio presenters, who often take a more provocative approach to probing interviewees and qualitative health researchers, who attempt to give interviewees space to explore ideas at their own pace. This difference is best exemplified by the following quote during a discussion of about excess weight round the middle area of the body:

> Presenter: I mean for you [name] is that what you have a larger belly? […]
>
> Caller T: 'Yes there's a little extra weight around the tummy [laugh].

Presenter: [Laugh]

(Local radio programme)

Although this particular style of interviewing did cause some uncomfortable moments for the researcher, this is standard practice for this type of media. While not orthodox academic research style, the callers responded well to this type of probing, giving answers that may not have emerged using traditional methods and whist the style may be deemed confrontational to a media novice, callers were continued to be very open with their perspectives and shared personal information on-air. For instance in this case, the caller went on to share personal details pertaining to her appearance:

Caller T: 'I'm 15 stone 5 foot 8 and a size 18 clothes'.

(Local radio programme)

What also became apparent in using talk radio as a liminal site for research is that the power relations that do usually define relationships between biomedical and alternative discourses was inverted and the traditional doctor-patient power relation was challenged and; that the disembodied discussion releases callers from the connotations ascribed to physical appearance. On each of the radio shows, callers questioned the validity of claims made by biomedical understanding and offered other perspectives rooted in alternative epistemologies to counter mainstream and

biomedical positions. Interestingly, in the show that took place on the local radio station, a number of callers used the opportunity to question the validity of clams made by biomedicine by challenging the guest consultant:

> Caller S2: Well I don't mind the fact that I'm a big woman well I am a big woman. I'm natural, I'm naturally curvy cos I'm a Black woman and black women are naturally curvy. I just wanted to ask, do you think that erm BMI is an accurate reading when you're going off body weight and height? Caribbean people are naturally bigger boned.
>
> Presenter: Oh well that's a question I will put to our doctor here Dr [name]. Is that the case you know? Is BMI the correct method of measuring those of Caribbean descent, African descent?
>
> Consultant physician: Well it is useful, we also can use something called waist circumference or neck circumference. If somebody has got a big neck or like we said before fat around the belly, that's what's dangerous really. BMI may not always be accurate with people who are very muscular but having listened to this conversation tonight it's such a contentious area and as a doctor how do I bring the subject up to African Caribbean women basically?

Presenter: Er I mean [Caller S2] that's a fair point because er you know there you are you're hearing the doctor say actually, it's more about the thickness of your neck or the thickness in particular on the stomach area.

Caller S2: Right, but I was under the impression that the BMI was calculated by body weight and height. If your're naturally bigger boned then obviously you're gonna be heavier.

Presenter: Yes but er as your hearing though from the doctor's concerns it's the stomach. It's the fact that the weight is around the stomach and in a sense [referring to the consultant physician] is that anything to do Dr [name] with the skeleton with the bones that you have?

Consultant physician: That usually doesn't, so if you have weight around the tummy that's what's associated with heart disease and things like that. The other thing that we didn't discuss if you are heavy, just imagine the weight that you're putting on your joints so as you get older you're e going to develop osteoarthritis you won't be able to get about. While the young lady my look very curvaceous and everything's fantastic, but as you get older it's not so good when you can't get about.

Presenter: Ahhh you see [Caller S2] I mean is that something that you that you're beginning to feel a little bit of a symptom of are you concerned that's what's going to happen to you as you get older?

Caller S2: No, I'm not really concerned about it to be fair. My family, some of them are curvaceous women and some of them are pretty thin and they're not really unhealthy women they don't suffer with arthritic joints and heart problems or anything else

Presenter: Well obviously, I can't go against your opinion and your thoughts in terms of your family and you personally, but I appreciate you choosing to call us and to share your thoughts about how you see yourself as a Black woman. I appreciate that thank you very much for calling.

Caller S2: Thank you.

(Local radio programme)

Interestingly after the show, the consultant stated that he has never been challenged by a patient in that way before and that this was a new experience for him. However, this challenge to the authority of biomedical understanding does not mean that listeners do not want health information; rather the opposite can be claimed. While conducting research on the community radio station, there were a number of calls from listeners who wanted advice about particular health conditions, dietary

change and medication. As such, the presenters had to make announcements that the researcher was not a health professional and cannot give advice. During many calls answered by the researcher off-air, callers were urged to visit their GP or practice nurse to discuss their issues.

With regard to technical issues, there was a problem in recording the radio shows that took place on the community radio station. With limited resources available to repair the system, the recording facility was unreliable at the best of times, a situation that proved to be extremely frustrating as a researcher. Nevertheless, comprehensive notes were made during the shows sought to make record of the points raised to supplement recordings.

After the shows, the researcher was contacted by members of African Caribbean communities who wanted more information about the research so that they may take part in later research phases. Remarkably, the researcher received a call from a lady who had listened to one the talk radio shows and felt compelled to call and tell of her experiences of living with anorexia nervosa as an African Caribbean woman. She spoke of the misunderstanding of her condition and the silences within the community with regard to anorexia and bulimia. This was a perspective that was not considered prior to this call and the opinions of this lady may not have been captured through use of traditional methods.

Research phase two

Hairdressing salons

Research was conducted in three different African Caribbean hairdressing salons in Birmingham during salon opening hours. The date and time were specified by the salon managers and each research session took place on Saturday afternoons. Each salon employed a different number of hairdressing staff on the days that the research took place, ranging between three and five hairdressers. In addition to hairdressing services, each salon also offered manicure and pedicure services within the main salon area and clients using this service also took part in the research sessions.

In using this site as a space for research, the most pressing ethical issue that had to be considered and addressed was informed consent. The researcher had previous meetings with the salon managers before the data collection sessions to inform them of the nature of the research project and of the necessary information to be given to clients when booking appointments and to the staff that would be working at the time. Similarly to using talk radio, a degree of power must be passed to the community in order to use this approach to research, it had to be ensured that the managers were committed to enabling this research and had to trust them to follow guidance. Also, this was important for the salon managers to inform clients of the research taking place as good business practice. When clients did come into the salons for pre-booked appointments, they expressed that they were aware that a researcher would be present and that they would be invited to take part in the research. For those clients who did not pre-book appointments, a large poster detailing the nature of the research was placed on the front door to the salon or in the main reception area. In each salon, the initiation of the research process started when at least three clients were in the salon. The researcher introduced herself and gave some details of her background and then the nature of the research. When giving details about the research, it became apparent that use of conventional research terms and procedures in this space would not be conducive to collecting the natural speech

that was the aim. At one point, the researcher referred to the women in the salon as ‘participants’ rather than ‘clients’ and an individual expressed discomfort with that terminology. Additionally, when the researcher stated that clients would be unable to withdraw their data, the response from the clients and the hairdressers was suspicion and asked if the researcher would give them any reason to *want* to withdraw the data. The researcher explained that sometimes, people change their mind about wanting to be involved in research and in some cases that they can request for their contribution to be removed, rather than the researcher giving cause for concern.

Once the discussions had started and the clients were engaging in the topic, it become more complex for the researcher to control the process of introducing recently arrived clients into the conversations and asking for verbal consent. In most cases, the clients themselves invited others to join in and ‘take part in the chat’ and the researcher would have to wait for a natural pause in the discussion to give the details of the research and so forth. Interestingly, there were occasions where the other clients gave the information before the researcher had the chance to. Also, there were clients who did decline to take part in the research and the researcher did witness attempts by the involved clients to bring them into the conversation, addressing comments and questions to them: ‘so what do you think?’ This was a challenge ethically, as the clients should not feel pressured to take part in the research by others, yet what authority do does the researcher have to tell the women what they can and cannot say in their own space? Also, the clients regularly attempted to draw the researcher into the conversations that they were having, asking for opinions and perspectives and to share personal experiences. Similar to talk radio, there is a degree of loss of control of the research process in using a method that intentionally allows this part of the investigation to be directed by the community.

However, in this temporary loss of control in the research process illustrates that the clients were willing to take ownership of the data collection with the aim of collecting good quality data on the research topic. There were many instances during the discussion where a client or hairdresser would pause the conversation, turn to the researcher and ask ‘did you get that?’, to ensure that points that they considered to be of especial importance were being recorded. This dynamic of the liminal in the hairdressing salon is partly enabled by the trust afforded to the researcher through the relationship with the hairdressing salon. It is not sufficient to expect that ethnic and racial concordance would foster confidence in the researcher and the research. Rather, the trusting relationship that exists between hairdresser and client, partly rooted in a nurturing caring ethic and the act of giving responsibly of creating aesthetic style to another creates an intimate relationship between them. Thus, if the salon manager and hairdressers trust the researcher and the research, then the clients can also. From this understanding, wider observations of the way that conversations sometimes about personal topics can take place at ease within the salon space, with hairdressers and clients sharing experiences and perspectives, that the researcher was granted permission to record.

Although no demographic information was taken from clients who took part in the research in the hairdressing salons, it was evident that there was a range of ages, employment status, religion and Caribbean heritage. The diversity within the clients during the research process was not oblivious to the clients and was referenced during the knowledge production and affirmation process:

> It’s different for the young people now, isn’t it? What do you think? [gesturing to the youngest client]

(Hairdressing salon 1)

[To the client who stated that she had an administration job] Well you have a job that will give you breaks, flexible so you can go to the doctors. What you are like me and have a cleaning job in the morning and evening and care work in the day for a couple hours. When are people who work like me supposed to go to the GP?

(Hairdressing salon 1)

So what do Rastas think about that? [gesturing to the Rastafarian hairdresser]

(Hairdressing salon 2)

Everything always about Jamaica. Just remember that other place is in the West Indies too you know, we do it different in Grenada.

(Hairdressing salon 3)

Due the time spent in the salon as clients, the women used the opportunity of taking part in health research to express concerns about other health conditions that effect women of African heritage that they feel do not receive enough attention, in particular fibroids and cysts. As a health researcher, a representative of the University on occasions the clients and hairdressers implored for their requests for more research in this area of genecology to be relayed on their behalf and it was

suggested that the next research project should be in this area. This situation represents a paradox of conducting health research with communities: in the process of involving communities an enabling them to influence the research leads to expectations, which may at times be unrealistic. As a researcher embedded in the community being researched, there is understanding of the need for particular investigations yet I am not in a position to assure clients that this health issue will be explored in the near future which is very difficult to reconcile.

In moments such as those where expectations of future research were asked of the researcher, it was often the hairdressers who addressed the clients and expressed the limitations of the researcher as unable to define the research that is conducted in the department and the issues pertaining to recruitment of African Caribbean communities to health research:

> She can't do everything, she is only one person but we have to support the research that we have at the moment that is looking out for us we say. We want help, but no one ever takes part in the things [the research] but what she is doing we have to help as much as we can, one one coco full ah basket [every little bit helps].
>
> (Hairdressing salon 3)

During the time in the salon, the role of the hairdresser as a source of health related knowledge to the clients became apparent, and they operate between biomedical and alternative discourses of health. While doing the hair of the clients, the researcher heard the hairdressers giving advice for hair growth, skin conditions and dietary issues, drawing upon an eclectic repertoire of perspectives.

For instance, the researcher recorded advice for a woman who has a skin condition that results in dandruff-like flakes on the scalp and hair. The hairdresser urged her to make an appointment to speak to her GP, but she also suggested that the client squeeze a lemon and ask her husband dab the fresh juice on her scalp with cotton wool. She said that the citric acid would refresh and hydrate the scalp and reduce the flaking over time. However, if the juice does not give the required result, the client must ask the GP for a certain prescription only ointment and use it sparingly on the scalp only rather than the hair.

One hairdresser in particular had a good knowledge of type 2 diabetes; she disclosed that since her mother was diagnosed with the condition; she spends a lot of time researching about the illness's diagnosis, progression, treatments and prevention. She went on to explain that she learnt that type 2 diabetes had been linked to hair loss, to which the women in the salon expressed surprise. The hairdresser then went on to give an impromptu diabetes awareness type lesson about the condition and the side effect of decreased circulation that may contribute to hair thinning. The clients asked the hairdresser many questions, to which she could answer many but was honest when she could not and directed people to the internet to find out more:

'If I can learn all of this, so can you. The information is there, we have to stay healthy for the kids if not for yourself then you have to do it for them.

(Hairdressing salon 2)

Whilst the hairdressing salon enabled the researcher to gather insight into the research topic that may not be accessible in other spaces, there were practical issues with regard to audio recording the discussions. Although the salon managers had attempted to make the salons more suitable for audio recording by turning the radios and televisions off, the general noise of the salon made it unsuitable for audio recording. Hairdryers, telephones ringing (both the salon and personal mobile phones), water splashing, individual conversations and people coming in and out of the salon resulted in poor quality recordings. As such, the researcher took notes at length during the research process. The clients and hairdressers were informed as to the reason for taking notes and were not fazed by this

Community women's groups

Data collection was facilitated in a number of women's community groups consisting of predominantly African Caribbean women across the city of Birmingham. In total, research was conducted with seven community groups: a book club group; a community sisters support group; physical exercise group; two elders groups; a Black women's student support and; a young women's social group.

To access the groups, the researcher first made contact with the group co-ordinator, using details that were found using the internet or through enquiries at local community venues. During this initial contact, the researcher introduced herself and the research and asked the co-ordinator to consult with the group to find out if they would be willing to take part. Of the nine groups contacted, seven agreed. The time and date of the data collection was confirmed by the group and the researcher was invited to attend the groups session to conduct the session. The ethical considerations of conducting the research with the community groups were less complex than with

the talk radio and hairdressing salon sessions with particular regard to gaining informed consent as the space for research was more conventional in nature; quiet, focussed and there remained a degree of control for the researcher. The first community group research session was facilitated with an elder women's church group in the church hall meeting room. During the introductions, it transpired that this particular group is regularly consulted by researchers from various organisations, such as the local council, charities and other social organisations. As such the group were quite research savvy and had particular expectations of the research process which involved being asked direct questions, to which they gave answers. Thus, when attempting to encourage the group to speak freely about the research topic, there was a degree of confusion and the researcher was asked *'*is this proper research?' However, after a short exchange of impromptu questions from the researcher about the topic, the group started discussing the topic independently, but periodically referred to the researcher for further questions. To meet the expectations of the group, the research session was conducted in a more focus group style than organic conversation. In subsequent discussion with the research supervisors, it was thought that the vox pops, recorded as part of the talk radio show could be used a conversation initiation technique, so that it is the voices of other members of the community that help to ignite discussion rather than the lead by the researcher. In subsequent data collection sessions, this strategy proved highly effective and this situation did not arise again, although this could be due to the fact that the other groups had never been consulted for research previously and had no expectations as such.

Although the community groups meet in community spaces that are open to the public, it was important for the researcher to respect the dynamics of each particular group so as to foster a respectful relationship. This was especially important for two reasons: the first to ensure that the group would engage meaningfully with the topic and; secondly the researcher also becomes the

embodiment of ‘health research’ and there is a responsibility to demystify research which may then encourage those in the group to consider taking part in research in the future. Anecdotally, during the data collection session with the first elder women’s group, lunch was served and consisted of steamed fish, potatoes and vegetables and the group was joined by the rest of the church members working on site, including the Pastor to eat together. The Pastor stood to say grace over the food and proceeded to point to the ways of food culture in the West where ‘we eat for fashion rather than nourishment and are not grateful for the food that we are blessed with. Rather, we turn away good food and say we don’t like it rather than receive it as a gift that we must be thankful for’, and continued for a short while before concluding with a flourishing ‘Amen’ echoed by the others around the table. The researcher doesn’t eat fish, but to respect the space, she endeavoured and succeeded in clearing the plate. The risk of damaging the relationships with the group and upsetting the nature of the liminal space was more important than having to consume her most detested food.

Unlike in the hairdressing salons, women of other ethnicities were present in the group sessions and took part in the research. In the physical exercise group, there was a White Irish woman; in the book group there was a Black African woman and in the community sisters support group there was an Irish woman and a South Asian woman. While the research is focussed on the African Caribbean community, discourses are not produced in isolation and historically minority ethnic communities in Birmingham have lived in the same geographical areas of the city as neighbours, sharing resources and influencing each other’s understandings of themselves and others. As such, the contributions from the women of other ethnic background add additional dimensions to the data collected:

Yeah well we have lots in common you know. Our families would have come to England for a better life and when they got here it wasn't a picnic you know. Not at all.

(Community sisters group)

Well in the Caribbean there is lots of mixing. There are lots of Indians in Trinidad and Chinese people in Jamaica.

(Book group)

In Ireland we weren't well off but my Mam used to fill our plates, it was like magic. It's like that for Black like Caribbean people too, plates full, pockets empty. Nobody in the area is hungry it's the way that we live. Sharing, all of us.

(Saturday morning exercise group)

In Zim [Zimbabwe] a big body is the sign of a healthy woman. Yes her body is good, she can work well, have babies and cook too the perfect woman [laugh]. I think is the same for all Black people. Well not all, but for a lot of us maybe.

(Community sisters group)

With these group liminal spaces, the women appeared to know each other well and would often refer to each other to illustrate points they were making or to prompt another to make a contribution:

> [Gesturers to woman in the group] Remember when that happened to you? Tell us what happened again'.
>
> (Elders group 1)

> 'When [name] son was is hospital she had to fight to get them to listen, remember?'
>
> (Black students group)

Additionally, the process of developing and maintaining knowledge through affirmation and disagreement in a familial-type manner was evident. For instance, in a discussion about slenderness and health:

> Voice 1: It is about image because if you're slim they assume that you're healthy, because obviously, you've got no fatty tissues around. It's weight that you're carrying in the wrong places so they class it as unhealthy, so that's down to what you eat and your lifestyle, so technically to be slim and be toned.

V 2: Slim is not always healthy [serious tone].

V 1: No, it is healthy [serious tone].

V 2: No just because you are slim and toned does not mean you're healthy.

V 1: Well it's more healthy than carrying all that weight [all laugh]

V2: I just don't agree.

(Saturday morning exercise group)

From conducting research in the community groups, where the women had the space to explore their own understandings of health and those of others who they are well acquainted with, it gave the opportunity to capture the knowledge as produced in an almost family-type space. In such spaces, the personal is shared with others who have knowledge of others' circumstances and how this then shapes perspectives for all in the group in a way that can transcend ethnic background and affiliations.

Research phase three

Focus groups

Three focus groups, each with six African Caribbean women were conducted in community venues in Birmingham, average age was 35. With regard to recruitment for this research phase, it was the intention of the researcher to advertise the focus groups through posters in community venues, however this proved unnecessary. During phases one and two of the research, a number of women expressed their interest in taking part in phase three and that they would be happy to tell others of the research and invite them to take part. Thus, through word of mouth, a snowball method of recruitment was employed. Similarly to the previous research phases, no written consent was required from the participants and the researcher read from a prepared script to detail the nature of the research and its process and each participant was given an information sheet. Unlike in the previous phases, the focus groups were actively led by the researcher, who had developed a focus group guide to inform the discussions and to prompt further examine the research area.

Additionally, the researcher employed PowerPoint as a visual aid to assist in keeping the conversation concentrated on the topic area, (see figure five, page 154). Through use of the pictures, the researcher was able to focus on particular points related to the pictures that could probe the participants for further detail and as a tool to move the conversation on if necessary by changing the picture or focussing on another aspect of the picture. Each focus group lasted approximately an hour and was facilitated by the researcher and audio recorded. As is characteristic of the focus group method, participants are able to explore the topic as a group in a way that can often lead away from the research area, and it is the role of the facilitator to re-direct discussion. However, it became apparent during the first data collection phases that the ways of exploring knowledge collectively often takes off-shoots into directions that initially may appear to be unrelated to the topic but yet returns to the point, in a way that seeks to offer clarity to the perspective offered. As such, the role

of facilitating the focus groups in a manner that allowed extra time for participants to develop ideas was of much importance as attempting to follow a rigid discussion schedule would have possibly restrained the depth of the discussion. Interestingly, the importance of affording space to participants in the research process was commented upon:

> Voice 1: We can't be hemmed in to like – can we have a consultation on diabetes? You've seen how these conversations have gone.
>
> V 2: It's too broad.
>
> V 1: No, you can't have a conversation on diabetes, but global politics, world economics, this, this and that. We'll talk to you about this, that and the other, but we can't be confined down to just to one thing you know When you're asking us to talk about diabetes we want to then expand that out to even our view of health, we want to talk to you about faith and spirituality and prayer.
>
> V 3: And the mind
>
> V 1: They're like, 'God, I don't wanna know about that stuff I wanna hear about diabetes

V3: Yeah, like [in a sarcastic tone] ‘can we get back to question seven’? [all laugh] Well no, we can’t really.

V 2: No, because we don’t just look at our world like that, limited. We’re not prepared to be forced to give views in that way. Just let us speak and we will give you what you want.

(Focus group 3)

Such acknowledgement that people develop health understandings by drawing upon a range of different repertories does then suggest that a similarly flexible approach, such as thematic analysis is used so that the finely grained details are not missed.

Conclusion

This chapter has offered an evaluation of the novel method that was developed for this research. Exploration of each research setting was conducted that considered the benefits and limitations of using such a community based approach for applied health research. The following chapter applies a theoretical lens to the data gathered to further probe issues that seek to address how discursive constructions of health may influence how African Caribbean women relate to healthcare professionals and receive public health promotion more broadly and; with particular focus on body weight and weight management.

Chapter Eight

Post Memory and Health in African Caribbean Communities

Introduction

This chapter applies a theoretical perspective to the data gathered in this research process. Owing to the interdisciplinary nature of this project and the depth of the data gathered, the approach taken to applying theory is dynamic in nature to develop understanding. This chapter starts by offering a perspective on the discourse observed in this research does not exist in an antagonistic relationship with biomedical and mainstream discourses of health. Rather alternative views of health and health practices serve as ways of preserving culture. The concept of post memory that explores how memories are passed from generation to generation (Hirsch, 1992, 2008) is then used as a vehicle to understand how culture as enacted through health, becomes important to understanding African Caribbean communities and relationships to health and health information.

The importance of culture in alternative discourse

Research that has explored the health behaviours of African Caribbean communities in the UK has often used participants that have already been diagnosed with particular health conditions such as work by Brown et al (2007); Edge and MckKian (Edge and MacKian, 2010) and Higginbottom (2006). This data offers a retrospective view on understandings of health, pre diagnosis, which may have contributed to such outcomes and draws upon current realities of living with or being affected by particular health conditions. For instance, the work of Brown et al (2007) presents the health beliefs of African Caribbean people living with type 2 diabetes and refers to the ways in which

personal histories, as told by participants, can be related to their current understanding of their present health status. However, findings from such research it limited in how much it can offer to understanding how to guide discussion and intervention about prevention of obesity related chronic illnesses.

From the limited body of work that has been conducted with African Caribbean women who have not been recruited due to health-related criteria, there is expression of confidence in understanding the risks for types 2 diabetes and the lifestyle changes that may reduce the risks (Shoneye et al., 2011). The concept of the 'prevention paradox' (Davison et al., 1991), provides a theoretical understanding to this reality that was found during research conducted with African Caribbean communities. This term describes the contradiction that occurs when public health awareness campaigns succeed in raising health awareness but simultaneously highlighting the reality that not everyone who engages in particular behaviours will or will not experience particular outcomes, for instance not all overweight people will develop type 2 diabetes. It is then essential to understand the dynamics of how discourses of health are constructed and circulated through beliefs and practices within communities. Without such insight, there then exists a lack of understanding of what people know about health and then how patients relate to healthcare professionals and public health messages. Without context of patient's perspective may lead to further contribute to negative judgements of certain groups being 'hard-to-reach' and that they don't understand the health information being given to them (Brackertz, 2007).

Thus, research such as this that seeks to explore the finely grained nuances of discourses of health not only identify the elements of understanding, but also how that may influence health outcomes for patients and relationships with healthcare professionals in Primary Care, where there may be

issues on both sides of the consultation desk. On one side of the desk, the healthcare professional may be wondering why the management plan that was negotiated with the patient does not appear to be effective; whilst on the other side may be a patient whose understandings of health takes strands from multiple discourses, maybe offering an alternative interpretation of managing health.

The decision to suggest that alternative discourses of health may operate a as 'parallel' to biomedical perspectives rather than as 'competing' understandings is a perspective that has emerged from the data gathered in this investigation. At the inception of this research, the concept of an alternative discourse of health in African Caribbean communities was conceived by the researcher to be one that operated in largely in an antagonistic form; whereby perceptions of health and health behaviours differed from biomedical and mainstream conventions was rooted mainly in histories of distrust and suspicion of healthcare services and professionals. Whilst findings from this study do suggest that these are important issues, they only make up part of the discourse and that there is much value in exploring the cultures that shape health discourses that run alongside with, rather than in opposition to, biomedical and mainstream perspectives which this research study has done.

Napier et al (2014) make the case for health investigations and the subsequent interventions based upon research findings, to take a more nuanced view of health behaviours through locating the dynamics of culture within understandings. By doing so, this may enable for health behaviours to be further understood and action to improve health outcomes be developed. Traditional scientific discourses that can tend to offer a definitive standard of human nature, whereas biological wellness is the measure of health and wellbeing without acknowledging the influence of cultural systems of health for outcomes.

Against the backdrop of increasing diversity in the UK (Javraj, 2012); changes in experiences of health and illness are locally and globally and; in the ways that the health services must operate, the need to understand the relationship between health and culture is of heightened importance. This is especially true with regard to the prevention of obesity related chronic illness. As such, Napier et al (2014) propose that 'the time has come to revise common views of culture as overtly shared and largely unscientific ideas and practices' and propose the following definition of culture for understanding contemporary society:

> 'The shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artefacts that sustain conventions and practices, and make them meaningful' (Napier et al., 2014, p. 1610).

Appropriating such a perspective into understandings of health encourages views that appreciate how culturally influenced thought processes and actions may affect encounters with healthcare professionals and health promotion messages. When alternative ways of affirming knowledge of health and illness are acknowledged, health behaviours that may have initially seemed 'foreign and exotic might seem less so once one understands how complex beliefs and practices overlap to produce coherent and consistent forms of meaning' (Napier et al, 2014, p. 6). By encouraging a shift in how understandings of culture and alternative discourses of health shape perspectives, it further illustrates the need to continue developing research methods that give voice to seldom heard communities. Additionally, Napier et al (2014) that 'culture is made up not merely those variable behaviours and practices that a group understands itself to possess and articulate daily, but those that are covertly and taken for granted' (Napier et al., 2014, p. 1069), it also challenges health research to move beyond what is seen and recognised as culture and cultural acts by those in a

particular group and those outside of it. From this perspective, overt elements of culture such as food and food practices, religious practices and; traditional norms are only a small part of understanding the dynamics of the culture and its relationship to health. Rather research should seek to excavate what is not so visible, yet may be shaping the health of individuals and communities.

This research investigation has sought to understand issues of health and wellbeing with regard to body shape and size for African Caribbean women and this discussion chapter will present the discursive threads that elements of a discourse of health and wellbeing by this particular group. While it cannot be claimed that positions maintained by this investigation are definitive of the whole discourse and represents all African Caribbean women, the findings are useful for developing targeted services and approaches to offering healthcare advice to this particular group who are at an increased risk of obesity related chronic illnesses. What follows in this chapter is the telling of a complex story, rooted in the data and emerging from the analysis using evidence from within and across themes. The voices of participants are used to create an analytic narrative that goes beyond description of data and gives validity to the answers offered to the research questions (Braun and Clarke, 2006).

Health as remembering: culture, behaviours and preserving the past

As expressed in the findings chapter of this research investigation, the initial idea that an alternative discourse of health held by African Caribbean women may be largely antagonistic in nature has been shown to not offer a wholly useful insight into how health and health behaviours are shaped. Rather, the concept of the oppositional gaze has to be rearticulated in this research as one that provides a view of health that runs alongside, biomedical and mainstream perspectives rather than

in conflict with and exists with an alternative purpose. One such purpose is that understandings of health and subsequent behaviours are vehicles of cultural preservation and remembering that can transcend issues of wellness and illness, consciously or unconsciously by those enacting it. For those who may have grown up in other countries before migrating to the UK, it is understandable that memories of 'home' may influence health understandings (Redwood et al., 2012). This perspective would explain why some diabetic patients, typically elders, may choose traditional herbal medication when spending time in the Caribbean; at 'home', where memories can be practiced rather than continue taking prescribed medication (Lowe et al, 2012).

Interestingly, this research has found that women of African Caribbean heritage who have been born and have grown up in the UK also voice such memories of 'home' through health and health practices and attach importance to them:

> Sometimes, I just wish that we could take it back. I don't want to live there [laugh] I'm fine here thanks [all laugh] but it's the way that you can live in tune like harmony with nature. You can have all the technology if you want, but if you want to live natural you can [group agreement] I try to have and keep that midset so that I still keep a piece of home in my home you get me [group agreement] You have to think, 'what would you do about this if you lived in like Grenada?' You can can't run down to the GP, so you have to think more deeply. That's what you get in the West Indies, at home. I means a lot to me that I try to think like that.
>
> (Community Sisters group)

> We folks come over here and loose ourselves [laugh] We need to remember where we come from and what we do at home, the Caribbean, Africa. You don't go to your friend's house and forget what you do in your house because they do it different in their place. Health is where home is, that is how we always used to do it [laugh]. That's all I have to say really [laugh].
>
> (Community Radio Programme)

Curiously, such sentiments are also echoed by women who have never been to the Caribbean:

> I think that back home, it's better like the traditional stuff that works and it's still what we need. I know lots of people use it over there and here. I mean, I've never been [to the Caribbean] but I still know it, you know.
>
> (Black student group)

Thus, how can such memories be placed into the context of understanding health for these women in contemporary society in the UK? How do these memories, which do not directly *belong* to the individual influence health behaviours and responses to health messages?

The interdisciplinary nature of this project allows space for interpretations of findings to be drawn from perspectives outside of conventional health studies. For understanding this phenomenon, the Cultural Studies concept of 'Postmemory', coined by Hirsch (Hirsch, 1992, 2008) is especially useful. When explained at length, this term is a living connection that:

> Describes the relationship that the generation after those that witnessed cultural or collective trauma bears to the experiences of those that came before, experiences that they "remember" only by means of the stories, images and behaviours among which they grew up. But these experiences were transmitted to them so deeply and affectively as to *seem* to constitute memories in their own right. Post memory's connection to the past is thus not mediated by recall but by imaginative investment, projection, and creation. To grow up with such overwhelming inherited memories, to be dominated by narratives that preceded one's own birth or one's consciousness, is to risk having one's own stories and experiences displaced, even evacuated, by those of a previous generation. It is to be shaped however, even indirectly, by traumatic events that still defy narrative reconstruction and exceed comprehension. These events happened in the past, but their efforts continue into the present (Hirsch, 2008, pp. 106-107).

Whilst the concept of postmemory was developed regarding the Jewish diaspora using the Holocaust as the scaffold from which memories are based, Hirsh notes that this way of understanding memories of trauma. can be applied to subsequent generations. Marquis (2012) applies this understanding to the African Caribbean experience, taking into account the pain of enslavement, colonialism and migration to the UK through the literary work of Andrea Levy[17]. Through her interpretation of these works, Marquis suggests that 'for those growing up in Britain, through the visual and narrative histories, the Caribbean becomes a post memorial space' where narratives of history inform understandings of history through acts of remembering. For Cultural

[17] Andrea Levy is a Black British writer, whose work is features the experiences of Black Caribbean communities in post World War 2 Britain (Levy, 2014).

Studies, acts of remembering can be performed through the arts[18] and for Health Studies it is understood that overt expressions of culture such as food choice and preparation styles are rooted in historical experiences. To further expand this area of knowledge, this research suggests that through understandings of health and health practices, for African Caribbean communities the body also becomes a vehicle through which individual and communal acts of remembrance as performed:

> Well this body is more than just me, you know. This skin, this hair, this thick waist, this big bottom, these boobies. They all tells a story that is bigger than me. Well bigger than all of us. Parts of that story are parts that I know and parts that I don't. But it is there all the time, you know what I mean?
>
> (Hairdressing salon 3)

Interestingly, participants expressed how it was important to preserve African Caribbean culture through food, food practices and health understandings as conscious acts of retaining heritage:

> Lots of people can't cook, like, proper Caribbean food and think that all our food is just rice and peas and chicken. Nah, you have to have the knowledge of the vegetables and the herbs, cook up a pot of stew peas and rice, fully ital [vegan]. That has like kept us for generations. You can't leave that behind you have to bring this with you. We can't loose that, we all have

[18]The work of Vanley Burke, who is renowned as the UK's leading Black British Photographer and Artist, is an example of this. His most recent exhibition entitled 'At Home with Vanley Burke' featured artworks, books and other cultural artefacts of Black British Caribbean life since the 1960's (Ikon Gallery, 2015).

to make more of an effort to keep it alive, the history in the kitchens, that's healthy I think. And then your body shows that health.

(Book group)

Good food is always healthy food, and our food is good food. So it is healthy food. But all the frying and salt, I don't know where this has come from because it is not what we used to eat all when I was growing up. No no, that is not our food. I try to cook with the grandkids, to show them how to eat well and learn well, and I can teach them about home you know. I show them, 'you know what this is?' and they say 'no Nanny' and I tell them 'it's breadfruit' and 'you know where it grows?' And they say 'no Nanny' so I tell them it grows back home and I ask if they know why it grows back home and they say 'no Nanny' so I tell them it was brought to Jamaica to feed the slaves. So I can teach them to cook and a history same time. They need it because I will not be around for ever, but I can leave them a history you know. So when them cooking when them grown, they can think of Nanny and home.

(Saturday morning exercise group)

I know that when my nan was growing up, like back home there wasn't a lot of money because her dad died. So that didn't have much, so when they were sick, her mom would use the bush to cook up a medicine cos there was no money. And anyway the bush is better and she had a good life. She studied all of the ways to use natural like herbs and plants to make medicine. So even now my baby has eczema and I rub the aloe plant on his skin. The doctor at the hospital is asking why would I want to do that and I told him there is power in the plants [laugh] and even if it doesn't work for my baby it's what we do. It's in us like and it

works anyway [laugh] So even though my nan isn't even here, I still have a bit of her you know and no doctor can take it [voice tails off] It's my nan.

(Focus group two)

Voice 1: Everyone grew up with pimento on the window sill [laugh].

V 2: [Laugh] And a piece of lemon [all laugh] You weren't really Black Caribbean if you didn't see that on the window [all laugh; group agreement] Shows that you can cook, clean and heal [all laugh].

V 3:For real, that pimento in white rum is the cure for everything like 'Mommy I've got a cold' 'Go get the pimento', 'Mommy, look at my neck' 'run go fi di pimento'[laughter].

V4: I can't breathe [laughing] this is so true. To be honest, I have pimento and white rum in my kitchen to remind me of Miss Milly [laugh] I keep it for her.

V 1: Yeah, it look good pon di window sill. I don't use it really, to be honest. But it's there if I need to fall back, I know it's there.

V 4: Yeah need to keep it, memories and that. But I use the lemon though [all laugh].

(Hairdressing salon 1)

As such, why is this concept of post memory important when raising the issue of weight management with African Caribbean female patients for whom the conversation may be

appropriate? Hoffman (2004, p. 25) suggests that postmemory also results in the 'paradoxes of indirect knowledges' whereby the 'relationship to [postmemories] has been defined by our very 'post-ness' and by the very powerful but mediated forms of knowledge that have followed from it'. Memories, by nature are subjective and do not always reflect the social realities from which they emerge. In the process of locating understandings of the healthy body in memories that are subjectively drawn from realities of life in the Caribbean, constructing the larger female body in this way is actually an expression of inequality rather than empowerment. The following transcript is taken from a discussion that stated after listening to the radio vox pops:

> Vox pop: It means that you are eating good, eating well
>
> Voice 1: Yeah but like back home the big woman was the healthy one you know she was eating good, living nice, yeah she was doing ok
>
> V 2: Yeah but that's the point because when you inna Jamaica no body is big and fat like you see over here. There are big body people like dem bones is bigger, the frame the body is bigger but nobody is fat and wobbly [laugh]. It is people when they come to England they get that jiggle. In Jamacia if you don't work you don't eat, so you must get up and do something. When you've got no car and you have to walk miles fi go a work, then you can't be so big and fat. You can be big but the fat is very different.
>
> V 3: Yeah man a true, true.

V 2: Yeah it has always been like that. Only the woman with money can be fat, not the woman who has to work hard. Even when you come to England back in the days or even now, the woman dem that have to work hard don't have botty big so [spreads out hands]. Nah man, we have to look at it properly and separate out big body woman from big fat woman. When you have to go a market to sell what you grow you, just so you can eat, nobody is fat. Remember you know Jamaican people, we don't have a heap of money, that's how the systemis set up. We poor, but we proud.

V 1: I never thought of it like that.

V 4: Yes that's because you're from here you were born here [in the UK] and never had to see real hard life.

V 2: And we come a England and some of we still poor [laugh] the story just carry on. You English woman [gesturing to the younger participants], need fi know dem history and not use it to keep themselves down. You can't know certain things until you live it. Mi cyan stand to hear people say that Black women is supposed to be bigger. You need to understand the whole picture before you say that.
(Book Group).

Interestingly, Hoffman (2004, p. 25) refers to the existence of this paradox of indirect knowledge as one that can 'haunt many of us who came after'. In the case of understandings of health and the larger female body for African Caribbean communities this legacy exists to legitimate a body size and shape that is 'remembered' and legitimated when in fact may be the opposite.

In taking the analysis further, it is also interesting to explore how far these *memories* of the Caribbean are reflective of the reality of health in the region. Rising rates of obesity in the Caribbean are linked to increased rate of obesity related chronic illness and; reported poorer health outcomes for those living with such conditions. Rates of obesity are higher for women and research that has explored the barriers to weight management describes issues related to an obesogenic environment very like that in UK (Alvarado, Murphy, and Guell, 2015).

It is important to understand this in relation to understanding how health is discursively constructed, regarding health and wellbeing with regard to preventing obesity related chronic illness. Such a perspective gives a way for exploring the dynamics of trust between African Caribbean communities and Primary Care healthcare professionals and healthcare services.

Conclusion

This chapter has applied an interdisciplinary approach to understanding the relationship between discourses of health, culture and health practices. Health as a process of preserving memories is especially interesting as it allows for understanding of how alternative discourses of health with regard to body shape and size may be referred to by different generations of African Caribbean women. The following chapter discusses how conceptions of health and wellness for African Caribbean women that may be rooted in an alternative discourse which may influence relationships with healthcare professionals and public health information.

Chapter Nine

Rethinking Trust and Healthcare Services

Introduction

This chapter will detail how discourses of health that may be held by African Caribbean women can shape relationships with healthcare professionals and public health messages, with particular regard to improving health. Trust, as a central concept to developing effective and meaningful dialogue with patients when raising the issue of weight management will be the basis for this interrogation.

Understanding alternative discourses of health

Through the analysis of the data collected though this research, the issue of African Caribbean women, healthcare services and trust emerged as an important area to further probe. Trust is an essential element of the relationship between patient and professional and increased levels of trust between both parties has been linked to more positive health outcomes for the patient. For healthcare professionals who are working with African Caribbean women who are at increased risk of obesity related chronic illnesses, a good relationship is essential for discussions of weight management to be of value and be a catalyst for change. At the start of this investigation, the researcher held the thought that it was the legacies of medical abuse experienced by those of the African diaspora and; the importance of traditional perspective and healthcare practices that may exist in parallel to Western biomedicine. Thus, leading to understandings that mistrust of healthcare advice and treatments is a cultural issue. However, the findings of this investigation show that issues of trust are much more complex than first thought. Rather than there being an antagonistic

relationship between conventional biomedicine, mainstream perspectives and African Caribbean conceptions of health and the body, there is a hybrid of understanding for African Caribbean women that straddles all three, producing both similarities and contradictions. Therefore, it is important to re-visit how issues of trust and mis-trust for African Caribbean women have been articulated not just in the existing literature but indeed at the start of this research.

By viewing mistrust of biomedical healthcare as a cultural issue, linked to the shared histories across the African diaspora, it can lead to a conflation of experiences that do not always consider the varying socio-political healthcare environments in which circumstances emerge. This is especially true between US and UK Black populations. This is a rabbit hole that this research project had initially gone down by placing shared experiences of historical medical abuse as a focal point of mistrust. Whilst this history is extremely important and much be acknowledged, it is questionable how much these abuses, many committed outside of the UK, really influence the health behaviours of African Caribbean women in the contemporary UK setting:

> I know it's bad but like does that [history] stop people from doing what the GP says? I doubt it. Something else is going on really.
> (Black students group)

> Yeah we're like a family, global cos we all come from the same place. Our origins are the same even if there are still people who can't understand that they got African in them [laughs]. We a family but we live different like we don't live the same way. It's different for us here, you know what I mean.,
> (Focus group one)

From the quotes, there is the understanding that while common experiences keep the Black diaspora connected, it is the realities of health and nuances of healthcare systems that make understanding the issues of trust very much geographically specific.

Engaging in healthcare services

Due to the nature of healthcare provision in the US, issues of engaging with healthcare services are not just about trust, but also about finances. US census data showed in 2014, 11.9% of those catergorised as Black in the US had no health insurance (Smith and Medalia, 2015). In circumstances where there may be access to free healthcare services, there may be limited care and treatment options. As such, issues of trust and biomedicine are not necessarily just linked to culture, but rather to the realities of institutional racism, poverty and poor options of healthcare. It this lack of access to biomedical healthcare for many African Americans that may influence relationships with healthcare professionals and how power dynamics between professional and patient may require a different view of analysis. For instance, in her work into the health activism of the Black Panther Party, Nelson (2011) explains that the tradition of biomedical authority and the powerful symbolism that accompanies it which may foster mistrust in mainstream US, actually manifests differently in poor Black communities, promoting a sense of trust of the professional:

> The white coat of medical science could have a different connotation in Black communities. Because the Party worked with populations that historically had not had regular contact with medical professionals, the white coat, worn by trusted experts, could be a welcome sign of long sought access to quality healthcare as well as an emblem of the potential excesses of medical power (Nelson, 2011, p. 84)

For the Black Panther Party volunteers, both healthcare professionals and lay people, providing healthcare services in community settings to poor communities in the US as part of this activism, all wore white coats. If contemporary analysis of trust only referred to the histories of medical abuse, then the importance of these late nineteenth century lab coats, that have evolved to be symbols of Western biomedical science, cannot be located as the acceptance of such images suggests a level of belief in the model of healthcare offered to address health conditions (Nelson, 2011).

It is then especially interesting to contrast such issues of trust in the UK, where the same symbol of biomedicine, the white coats, is being phased out (Burd, 2010). The chasm between the NHS system of providing healthcare to UK citizens versus the US model means that different lenses of analysis of trust and Black communities need to be applied. In the particular case of African Caribbean communities in the UK, the direct history between the Caribbean and the UK with particular regard to post World War 2 migration to the UK and the NHS as a major employer means that for many families, there is a direct link to the practice of healthcare:

> Everyone has someone working the NHS [all laugh] everybody has [laugh] could be your Mum, Auntie, Grandma, sister you must have someone who's a nurse or a midwife or something [laugh]. We all grew up ironing those bloody uniforms [all laugh]. You ain't for real if you ain't got someone in a uniform rushing to work at the hospital for the night shift [all laugh].
>
> (Focus group two).

It is this unique relationship with health and healthcare systems that African Caribbean communities in the UK have warrants a particular attention to how relationships with healthcare professionals are shaped. The issue of trust is a central concept to this relationship, especially in Primary Care when issues of weight management and preventing obesity related chronic illnesses are to be raised. From the data, it has emerged that there are a number of strands that can be explored within the context of trust and how this relates to improving health outcomes for African Caribbean women.

This chapter will leave the theoretical discussion of post memory to discuss issues of trust, with focus on relationships between African Caribbean communities and healthcare professionals and public health information. It will start by looking at the concept of *health*, through the dimensions of wellbeing and illness and where there are observed similarities and tensions between different bio medical, mainstream and Africa Caribbean discourses of health. It will then move on to explore how the role of the NHS in African Caribbean history in Britain influences trust in primary and secondary care.

Wellness versus illness

From the details explored in the literature review, there does exist a range of perspectives of health that vary between biomedical, mainstream and cultural ontologies; with particular focus on female body shape and size there many conflicting positions. However the term *health* is a broad one and through the research process, it became apparent that to explore the discursive construction of health for African Caribbean women this concept must be looked at in terms of wellness and illness.

The importance for doing so comes from the research findings which suggest that it is in the discursive construction of wellness where the nuances are more pronounced when compared to concepts of illness. During discussions of illness, especially those illnesses that had been medically diagnosed, participants would use medical terminology, refering to the expertise of healthcare professionals. For some, they describe how lifestyle changes suggested by healthcare professionals since diagnosis have been incorporated into everyday life:

> Well, I cut down on the sugars, you know the ones that they call refined sugars but also them ones that are in the other food, like in the potato. I take it easy with it all now, my doctor told me that I would feel the difference and I do once.
> (Elders group)

This willingness to place knowledge authority with the healthcare professionals after diagnosis is not a new finding. The dynamics of trust in biomedical healthcare discourse for those living with chronic illness has been explored and the ways that illness may shape perceptions of self and relationships with healthcare professionals (Bury, 1982; Williams, 2000). However, what did emerge from this research is that it is in the concept of *wellness* where difference in discourse exists, contributing to the alternative perspectives that are held by some with regard to health. In contemporary society where public health discourse is rooted in discussion of wellbeing as prevention of illness (Kickbusch and Payne, 2003), this point is of particular importance. Where the concept of wellness and maintaining wellbeing is understood differently, this is where issues with trust can be identified. This explicitly stated by a participant:

> Different people have different ways to keep healthy like keeping well. Our bodies and our cultures is different and people have been keeping well for centuries so I think that we know what we're doing. But obviously when you're sick you're sick, you have to trust them. Doctor knowledge is for illness, we can do wellness ourselves, thank you very much. (Focus group three)

From this, health for the African Caribbean as a discursive construction of wellness and illness is both a verb and a noun. Wellness becomes an active state of *doing*, where actions are influenced by culture as reimagined by post memory and; illness is a more reflexive state of *being,* more readily shaped by biomedical discourses of health. This then lends itself to providing insight into how the discursive construction health may influence the relationship between African Caribbean women as Primary Care patients and healthcare professionals in the clinic, especially with regard to raising the issue of weight management.

When the issue of weight management is raised in the discussion of preventing chronic illness is greeted with suspicion by African Caribbean women, it may be due to questions of what biomedicine deems as 'wellness':

> Listen, it is in their interest for us to be sick. Not all the time, but some times. It's not the NHS, the staff it's not them you know, they want us to be ok. But it is the drug companies the companies that are running the NHS. If we are all well, they have nothing to sell us. Me, I know how to take care of myself, thanks [laugh]. When I need you, I will ask, ok doc [laugh].
> (Black student's group*)*

When considering this issue with regard to discourses, it is also important to understand that this perspective of wellness and the role of healthcare systems is different to some mainstream critiques of societal intervention in the lives of community as 'nanny statism' (House of Commons Health Committee, 2004, p. 7). Rather, this perspective taken from the data is not one of rejection of intervention, rather it is questioning the authority of the advice that is given to keep well. The drive to make 'every conversation count' in Primary Care requires an alliance between GPs and Practice Nurses and patient so that they both have the same views of obtaining and maintain wellness. Yet, ironically it is this attempt to form agreement rooted in the pursuit of wellness where the issues may exist, compromising trust between professional and patient. The move from using illness as the vehicle to encourage lifestyle change to the purist of wellness is located within a larger shift to focus on wellness. This paradigm shapes public health interventions and commercial product marketing locally, nationally and globally (Kickbusch and Payne, 2003).

These research findings suggests that for African Caribbean communities, there is a need for this dynamic to be reversed and for targeted illness prevention to become the driver for health promotion, i.e. rather than focus on how to keep well, the emphasis should be on how not to get sick. Interestingly, this perspective also provides insight into why, during a range of discussions, that participants expressed more trust in the treatment and advice offered by healthcare professionals in Secondary Care. Hospitals were constructed as a site of treatment for illness more than surgeries in the community with regard to encouraging lifestyle change:

> I mean when you're in hospital there ain't no denying that you're sick. If the doctor says that you need to lose weight to get better, you would be a fool to question him [group

> agreement]. I mean you're in hospital because you are sick and it is not like they want you to get any sicker. So you have to listen and make things better for yourself.
>
> (Community Radio Programme)

Subsequently, this encourages consideration of how public health interventions and campaigns are shaped. Critiques of previous public health campaigns that used negative imagery depicting undesirable consequences of health behaviours exist to scare patients does little to improve health outcomes. Instead, focusing on lifestyle change and managing health is a more effective approach (Kickbusch and Payne, 2003). However, perspectives given by those that were sampled as part of this study challenge this perspective:

> I prefer to just hear the truth. We Black people, Caribbean people like to talk di tings [laugh] You might not like it but here it is. Your Mom tells the truth, your Dad tells the truth, your kids tell the truth, so I don't expect my doctor not to tell me the truth, like tell it how it is. I think some of our people need that. Bring back the pictures of the fat dripping out the arteries and the black lungs and them things. We need to see. Show them that you can lose your legs, your sight, with this diabetes business. Show people the truth.
>
> (Focus group 1)

On a number of occasions in the data, the importance of *truth telling* was expressed as being an important aspect of the discursive construction of health and; *whos*e truth held value and was to be respected. The conscious avoidance of the consequences of particular lifestyle choices that may negatively impact on health exist to delegitimise regimes of truth as offered by healthcare professionals and public health interventions. Thus, impacting upon the values given to the

information presented by healthcare professionals and the level of trust placed upon it to improve health outcomes.

Further, how could this alternative approach to public health be utilised for African Caribbean women when investigation confirms a cultural normalising of larger bodies? While this research would support claims of increased acceptance of bigger bodies, this is not to deny that there is not a perspective of what an 'ideal' larger body would look like, which as expressed by some is for a toned and fit body. Thus, while mainstream and African Caribbean discourses of body shape and size may differ in aesthetic aspect, they are similar in the desire for wellbeing. In reviewing the literature the risk for developing obesity related chronic illnesses, the risks can be measured more accurately by the hip-to-waist ratio the BMI scale (Lear et al, 2010). Understanding that reduced fat distribution around the stomach is embedded within concepts of desirability for African Caribbean women, a sematic change that than moves from weight management to body fitness may be more effective; focus on body shape rather than size for increased effectivity.

Relationships with healthcare professionals

For those African Caribbean women who took part in this research, the ethnicity of healthcare professionals was also explored within the context of trust, which lends further insight into why there was an observed increase trust in Secondary Care. As presented earlier, the NHS was a major employer of African Caribbean nurses in the post Windrush era and as such has a particular importance to the African Caribbean community, with a particular familiarity with hospital spaces that have been important to the dynamic of individual families and the community more broadly (Kramer and Bernard, 2006). Since the 1950's, African Caribbean women have continued to have a

large presence in secondary care sites; importantly this presence is often visible when going to hospital sites:

> It's not a shock seeing Black people in hospital, you know working like but I'm not being funny but I've never met a Black woman doing a PhD so I wasn't too sure about you at the start [all laugh] but really it's true. But we all know a nurse and it's not a surprise. Even if I go to hospital and don't see a sister, I still feel ok about being there. Sounds silly but it's true.
>
> (Community sisters group)

From this perspective, it is understandable why advice and treatments offered in secondary care may be more trusted by African Caribbean patients and their families; in contradiction to the emphasis on local services offered through Primary Care. From those in the study, it was regularly remarked that the lack of Black GPs, particularly of African Caribbean heritage was a factor in issues pertaining to trust. In the following quote, this reality with particular regard to raising the issue of weight management was discussed:

> Voice 1: I mean it's not so bad if you're Punjabi or got a Asian background, because at least you can see a GP that understands like gets it and you can trust what they are telling you more. Because there's that link kinda [group agreement]
>
> V 2: Hmmm, like it's more than that the language, like if you can speak English but if there is something that you can like connect too. I mean my doctor is a nice guy but it's not the same [laugh]. Maybe if he was Black like Caribbean I might trust a bit more [laughs].

> Seriously I ain't gonna be happy with a Asian doctor telling me I'm fat. I would be so vex, that ain't for him to say
>
> V 3 (hairdresser): So only a Black person can tell you about your weight?
>
> Voice 2: Nah not like that. It's just that I would take it differently if it was someone Black like Caribbean cos they would have more understanding of what I'm eating, before having to even ask. When you gotta spend the whole time explaining, of course you're not gonna trust them. They don't have a clue and it's not their fault, but it's real.
> (Hairdressing salon 2)

These comments raised by the participants in this research illustrate the complexity in offering meaningful and effective health advice in increasingly diverse areas. Further comments about the physical GP surgery sites were also discussed as negatively impacting on relationships with healthcare professionals in Primary Care[19].

Whilst issues of ethnic concordance and lack of African Caribbean GPs is a symptom of larger social issues and; aesthesis of local community surgeries may be issues that can be address with financial investment, within the context of trust they are important. This research has illustrated the

[19] Having conducted research in a range of primary care settings across the city of Birmingham in another research capacity, I can understand this comment. A number of surgeries, especially those in areas of increased deprivation and/or large numbers of Black and minority ethnic patients do feel like hostile places. Some are very dark, others with bars on the windows and grills between staff and patients. While they meet clinical standards, some feel very dated and unwelcoming.

importance of physical spaces and; how different locations allow for the cultivation of knowledge, in this case for African Caribbean women. It is then feasible to suggest that tying the emphasis on wellbeing to Primary Care cannot work for all communities.

Conclusion

This chapter has shown the importance of understanding the role of culture in the discourse of health for African Caribbean communities. It shows that conceptions of wellness and illness can be shaped in ways that do not reflect biomedical discourse, resulting in a discursive construction of health that offers alternative views to preventing obesity related illnesses. Issues of trust and healthcare professionals, linked to constructions of health, relationships to secondary care and; ethnic difference in Primary Care all contribute to the dynamics between patient and professional in the clinic when raising the issue of weight management.

Chapter Ten

Discussion

Introduction

This thesis has presented the qualitative sociological research conducted into the study of discourses of health in African Caribbean communities in the UK, with focus on women's body shape and size. This research was primarily concerned with discursive analysis of understandings of health in African Caribbean communities and developing a research method that encourages the participation of the target group, enabling for rich data to be gathered.

This final chapter offers a discussion of the research presented in this thesis and the implications of the findings and recommendations for future research. The chapter starts by giving an overview of what the research set out to do and how this was accomplished. It then moves on to discuss the findings with regard to the research questions and the existing literature. Implications for practice are then offered, with particular regard to raising the issue of weight management with African Caribbean women in Primary Care and developing qualitative research methods when working with seldom heard communities. The limitations of the research are then presented and a concluding reflection on the investigation closes the chapter.

The research process

The study set out to explore issues pertaining to how issues of weight management can be raised and explored effectively in a culturally sensitive and appropriate way with African Caribbean women by Primary Care healthcare professionals. It sought to offer understanding into how issues of body shape and size are understood with regard to health and wellbeing and how this may influence health behaviours and responses to health promotion messages. The importance of addressing this issue is illustrated by the continued rise in the rates of excess weight and diagnosis of obesity related chronic illnesses in the UK which disproportionately affect African Caribbean women (Tillin et al, 2013; Forouhi et al., 2006).

For healthcare professionals, the task of initiating and exploring issues of weight management with patients is complex task shaped by biomedical discourse, but also influenced by mainstream and discourses of health, body shape and size. When working with diverse patient groups there is the additional complexity of varying cultural discourses of health that gives different meaning to body shapes and sizes. This research was concerned with the discursive construction and discourses of health that African Caribbean women may refer to that may or may not reflect mainstream perspectives and how such knowledge could be used to improve health outcomes for this community.

As such, it was imperative for this research to be designed and conducted in such a way that engaged with African Caribbean communities so that richly detailed data could be captured. As a seldom heard community, it was also the aim of this investigation to develop a community based research method to increase participation from African Caribbean communities in Applied Health Research. Rooted in a Black feminist epistemological framework, the Big Talk Project used an interdisciplinary approach to research design so that data collection methods reflected the dynamics of the target communities. Conducted over three distinct research phases and two cycles of data analysis, this research utilised both novel and conventional research methods in a way that was rigorous in its design and execution. Through the use of Black feminism as the theoretical framework, this study was grounded in a defined set of principles that could reflect the participant group while also meeting the standards of knowledge validation required by academic inquiry. The study was designed over three phases with two distinct aims. Phases one and two sought to capture the discourse through a novel community based research method that used the concept of liminality to identify spaces for data collection. Through the first cycle of thematic analysis of the data from these two phases, the contours of the discourse of health for African Caribbean women emerged. Phase three sought to explore the observed discourse further using focus groups and this data analysed in the second cycle of thematic analysis contributed to the understanding the wider contexts in which the discourse may be lived and experienced by African Caribbean women.

As such, the findings generated from this study lift a curtain on discourses of health, body shape and size for African Caribbean women that offer a real insight into the alternative ways that health and wellbeing are conceptualised. Illumination of nuances between biomedical, mainstream and cultural discourses between different groups in society further show that a *one size fits all* approach to discussing weight management is problematic for both patient and professional.

Research findings in context

The thematic findings and the critical discussion chapters of this thesis have presented answers to the research questions:

i. What are the discursive constructions of health, wellness and the body that exist for African Caribbean women?
ii. How do these discursive constructions influence the ways in which African Caribbean women relate to healthcare professionals and receive public health promotion messages with regard to body weight and weight management programmes?

In addressing the first research question, six themes that emerged from the data that gave insight into the discursive construction of health, wellness and the body:

- Diasporic influence.
- Biomedical/ alternative discourses.
- Experiences of illness.
- Keeping 'healthy'.
- NHS healthcare.
- Weight and weight management.

Understanding the importance of intersectionality in the shaping of the context of discourses of health for African Caribbean women, themes that constituted the interpretive framework of the discourse were identified as being:

- Ethnicity.
- Gender and sexuality.
- Femininity.
- Socio-politics.

Through this method of data analysis, a multi-layered perspective into how alternative discourses of health influence health understandings and behaviours, at times complementing or contradicting biomedical discourse. In addressing the second question, critical discussion of the observed themes in the context of relations with healthcare professionals and health promotion was offered. Concepts of post memory, trust, and views of wellness arose during the research process and they have provided the lens through which issues of weight management for African Caribbean women could be approached.

The themes that have been found to form the discursive construction of health in African Caribbean communities does reflect what has been found in previous research with African Caribbean communities that was discussed in the Literature Review chapter. The influence of diaspora and links to the Caribbean through the practice of culture, particularly through food and food preparation was expressed to be an important aspect of maintaining a relationship with the local and global African Caribbean communities in this study and in the studies conducted by Scott and Rajan (2000a; 2000b); Sharma and Cruickshank (2001). Similarly, the use of traditional Caribbean herbal treatments as alternatives to Western biomedical medication was also found by Brown et al (2007) who also report that participants in their study also expressed distrust regarding the prescription of drugs and the role of pharmaceutical companies in this. The findings of this study also echo those published by Shoneye at al (2011) who found that the women in their study understood very well

the health risks associated with excess body weight, but still expressed a cultural preference for a larger body size and shape. With regard to experiences of illness and relationships with NHS healthcare, the participants in this study gave similar views to those reported in research conducted by Edge et al (2005; 2010; 2011) in that they felt that the healthcare system lacked understanding of Caribbean communities, which they felt impacted on their care.

The addition of the findings of this study to the existing body of literature is that it pieces together the various elements of the discourse of health that have been explored in previous research with African Caribbean communities and locates the discourse within a wider social context. As separate pieces of research data, the complex picture of alternative discourses of health is difficult to understand in the context of improving health outcomes. This research gives real insight into the 'pre swallowing domain of behaviour, culture, society and experience' (Crotty, 1999, p. 109) for African Caribbean women with regard to weight and weight management.

Limitations of the study

As a characteristic of qualitative research, knowledge produced is not generalisable and it would not be accurate to posit that all African Caribbean women draw upon the discourses of health as presented in this thesis. As discussed in the literature review chapter, there is much diversity within African Caribbean communities in the UK and this research could only be concerned with a small number of women from this ethnic background and findings could be reflective of the unique characteristics of the particular participants. This particular aspect is of particular importance for this research as the novel method employed is also reflective of particular participants in that the locations that were used as sites of data collection in phases one and two. Chapter eight, which

explores the realities of conducting research in community based liminal spaces offers, details the dynamics how the various data collection sites were distinctive each with its's own characteristics. These data collection sites, as spaces defined by those who created and maintain them and, those who chose to participate in the phase three focus groups, may have resulted in a particular uniqueness of the data collected that may not reflect views and perspectives held by others in African Caribbean communities.

An additional issue that could be explored as a limitation of the study is the ethnic concordance between the researcher and the participant group. As explored in the methodological approach chapter, there are positive and negative aspects of being an African Caribbean woman for the development and conduct of the study. However, the reality of conducting applied health research does require a degree of critical distance so that personal knowledges, biases and perspectives during the research process can be recognised and managed. To address this, a reflective diary was kept and was used during the data collection and analysis stages of this research and its details shared with supervisors during supervision meetings. Through the diary and regular in-depth discussions with supervisors, it became easier to untangle the researcher from the research, but as with all qualitative investigation there will be evidence of researcher subjectivity in the findings and conclusions made.

Recommendations

From this research, there are two strands to the offered recommended implications for practice. The first concerns recommendations with regard to addressing issues of weight management with

African Caribbean women patients in Primary Care as part of reducing likelihood of developing obesity related illnesses such as type 2 diabetes, hypertension and stroke. The second strand concerns recommendations for the development of novel research methods in applied health research that reflect the dynamics of seldom heard communities when seeking to engage meaningfully with them. In view of re-thinking community engagement, health research and improving health outcomes, it also encourages thought of how community based interventions could be shaped and delivered.

Raising the issue in Primary Care

The Royal College for General Practioners (RCGP) curriculum (2016) outcomes for those undertaking GP training emphasises that a patient-centred approach to consulting must form the basis of interaction in the clinic. The RCGP offers three key areas for patient-centred care during consultations and findings from this research offer recommendations that relate to working with African Caribbean women patients when raising the issue of weight management for the prevention of obesity related chronic illness.

Key area 1:

'Understanding the wider context of the consultation: this means perceiving that your patient is a person; a belief that the sick patient is not a broken machine; and that 'health' and 'illness' comprise more than the presence or absence of signs and symptoms. A constant willingness,

therefore, to enter your patient's 'life-world' and to see issues of health and illness from a patient's perspective, considering social, educational and cultural differences' (RCGP, 2016).

Recommendation:

Concepts of health and illness and how these relate to the body with regard to shape and size differ between groups in society. It is important to have an understanding of this when discussing issues of weight management. For African Caribbean women, this understanding takes elements of biomedical, mainstream and alternative discourses that shape heath understandings. The importance of post memory, trust, and views of wellness as give a complex discursive construction of health through body shape and size that is intersected by gender, sexuality and race for women of this ethnic group. While it cannot be expected that all health professionals have a good working knowledge of the health understandings of their patients, acknowledging the presence of such differences and allowing space for them to be explored as part of health discussions may open up spaces of liminality in the clinic. This is not to place biomedical and alternative discourses of heath into an antagonistic relationship, rather it would seek to meet patients *where they are at* with regard to health narratives; honouring their perspectives whilst giving health advice. Whilst real and genuine attempts are made by the RCGP to redress the traditional doctor-patient knowledge authority in Primary Care relationships, blanket approaches to perspectives of health when consulting can lead to the silencing of important aspects of discursive health constructions that may reduce the value of health discussions.

An example of such blanket recommendation would be in the reconsideration of RCGP curriculum guidance that purports that 'understanding the epidemiology of illness presenting in general practice requires a normality-orientated approach, as opposed to the disease-orientated approach in

Secondary Care' (RCGP, 2016). Whilst this guidance recognises that a holistic approach to health must be taken during consultation, it does not acknowledge that for some patients, it is the disease-orientated approach that might be more effective than focus on wellbeing. As found in this research, for African Caribbean women, it is in the different conceptions of wellness rather than illness *and* a particular relationship with secondary care that could potentially make a disease-orientated approach more valuable. It would be the recommendation of this research to avoid one-size-fits-all models of consultation that contradict the aims of understanding the wider contexts of the consultation and importance of the life world of patients.

Key area 2:

'Recognising that patient-centered medicine depends on an understanding of the structure of the consultation – in particular that good consultations are often associated with particular consultation styles and skills. However, the expectations and preferences of your patients will vary, so that as a patient-centered doctor you must be able to select from a range of styles and skills' (RCGP, 2016).

Recommendation:

The practicalities of consulting effectively in Primary Care are often compromised by the time constraints placed on patient appointments. During what is a relatively short time, Primary Care healthcare professionals are required to explore the health issue that is the reason for the appointment, offer appropriate action to address the issue, and initiate conversations about other lifestyle factors that may influence health outcomes for the patient. When raising the issue of weight management with patients, fear of upsetting patients as a result of mainstream discourses of the

larger body may shape the style of the approach with the patient. However, not all patients ascribe to this particular view in the same way and can critique biomedical and mainstream measures of health and beauty with regard to weight. This research would suggest that when raising the issue of weight management with African Caribbean women, rather than focus on medical definitions of overweight and obesity the style of approach should explore body shape and link to wellness and wellbeing. This style of approach may give way to a discussion where the patient feels that they can *trust* the healthcare professional to disclose how they view their body. From this research, issues such as biological differences between racial groups and body shape and size and the range of ideal body types are important factors of understanding health with regard to weight and weight management. In establishing a relationship of trust with the African Caribbean female patient, the healthcare professional may find it more comfortable to discuss how losing weight from particular parts of the body which does not challenge Black femininity, rather it acknowledges it by discussing body size and shape and how reducing health risks. For example, discussion that explores the benefits of losing abdominal fat rather than losing weight may prove to be a more effective approach for African Caribbean women.

Key area 3:

'Being committed to an ethical, reflective attitude that enables you to understand and monitor your practice, and develop it to the benefit of your patients' (RCGP, 2016).

Recommendation

This research has shown that stereotyping of patients, especially those from seldom heard communities has a negative impact on the relationship between patient and professional. Although the process of reflexive practice encourages healthcare professionals to assess how they view themselves as professionals and their relationship to patients (RCGP, 2015), it is important to acknowledge that patients themselves pick up when they are being viewed through an archetypical lens in the clinic, which negatively impact on health outcomes (Green et al., 2007; Laird et al., 2007; Sabin et al., 2008). The issue of stereotypes is especially important when they may be viewed as positive attributes which may in fact mask the real health issue for patients. The image of the strong Black woman, both physically and emotionally, actually may silence the realities of health issues by both healthcare professional and the patient herself. This research would suggest that as part of reflective practice, an honest engagement with stereotypes that may be held about patients is essential for developing trust and creating the space in the clinic to explore issues of weight management effectively.

In Primary Care, where work load and patient diversity is increasing, there is an increased likelihood for GPs and practice nurses to draw upon stereotypes when working with patients (Burgess, 2010; Van Ryn and Fu, 2003). In such highly pressured environments, opportunities to raise the issue of weight and engage in meaningful conversation about may be missed.

Further research

This investigation has shown that is possible to develop novel approaches to applied health research when seeking to engage with seldom heard groups. This investigation has shown that a multi-disciplinary novel approach to research design can be developed and executed. It is possible to push the boundaries of data collection in ways that that meets ethical standards and university regulation

so that research can be effective in gathering finely grained data from under represented, seldom heard groups in applied health research. This research has also shown the necessity of placing communities at the centre of research and developing the research methods around them; as opposed to the more orthodox approaches to qualitative research that place the research processes at the centre and expect communities to fit into them.

With regard to developing services, novel approaches may also be effective. In considering the demands upon Primary Care, it could be too much of an expectation to place on healthcare professionals to be able to unpick the range of complex health discourses with regard to body shape and size in relatively short consultations. Rather, targeted community health interventions that reflect the particular communities that they seek to serve may be better placed to explore issues of weight and weight management in ways that feed into Primary Care. This research has shown that African Caribbean women are not distrustful of healthcare professionals and the healthcare system per say. Rather they reject the authority of biomedical discursive constructions of wellness. A community intervention that could deliver health promotion that was sensitive to this dynamic may have success is addressing issues of weight management for African Caribbean women.

Conclusion

This final chapter has offered a discussion of the research presented in this thesis. It started by giving a research overview and then went on to detail how the findings addressed the research questions and the limitations of his investigation. Further, a dual approach to recommendations for practice were then offered for improving health outcomes for African Caribbean women with

regard to reducing the likelihood of the onset of obesity related chronic illness. The first recommendations are made with regard to improving the value of discussions of weight and weight management with African Caribbean patients. These recommendations relate to the key areas of consultation as presented by the RCGP curriculum for best practice in GP consultations. The second recommendations are given with regard to the development of research methods that seek to meaningfully engage with underrepresented seldom heard communities.

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Appendices

Appendix One: Verbal Consent

Phase 1

My name is Nicole Andrews and I am a student at the University of Birmingham. I am conducting a research study called the Big Talk Project in Birmingham.

Before we begin, I would like to take a minute to explain why I am inviting you to participate and what I will be doing with the information you provide. Please call the contact the station during the programme if you have any questions about this research. After I've told you a bit more about my project, you can decide whether or not you would like to participate.

I am doing this research as part of my studies in the School of Health and Population sciences and I will use the information gathered for the basis of my PhD research. For this project, I am interested in how African Caribbean women understand 'health' with a focus on body shape and body size.

I am using a community based research method to encourage members of the African Caribbean community to take part. The knowledge gained from this study will be used to inform GPs and other health professionals about the ways that the African Caribbean community understand health with relation to body shape and body size. This information will help GPs and health professionals to be able to raise issues relating weight and weight management appropriately with African Caribbean women patients.

This study is going to be taking place in three stages and this is stage 1 of the study. During this radio show, I would like to listeners to present their views on this topic. All members of the community are invited to take part in this phone-in, not just African Caribbean women. This radio show, emails and text messages will be recorded.

I am really interested in interested in your opinions, so please feel free to speak openly.

There are no risks involved in this study and anyone who takes part in the study will be kept confidential. Please be aware that if you do contribute the show, your contribution may or may not be used as research data and you would be unable to withdraw your data from the research. Specific quotes may be used and attributed to the name that you choose to give to the researcher. African

Caribbean women are also invited to participate in stage 3 of the study. If you would like to take I would need to take some contact information so that I can give you further details. All personal information and information collected will be secured securely in line with the university regulations and the Data Protection Act.

Please feel free to take part, your participation will be much appreciated.

Phase 2a

My name is Nicole Andrews and I am a student at the University of Birmingham. I am conducting a research study called the Big Talk Project in Birmingham.

You should have already been given a participant information sheet about this research but I would like to take a minute to explain why I am inviting you to participate and what I will be doing with the information you provide. Please stop me at any time if you have any questions. After I've told you a bit more about my project, you can decide whether or not you would like to participate.

I am doing this research as part of my studies in the School of Health and Population sciences and I will use the information gathered for the basis of my PhD research. For this project, I am interested in how African Caribbean women understand 'health' with a focus on body shape and body size.

I am using a community based research method to encourage members of the African Caribbean community to take part. The knowledge gained from this study will be used to inform GPs and other health professionals about the ways that the African Caribbean community understand health with relation to body shape and body size. This information will help GPs and health professionals to be able to raise issues relating weight and weight management appropriately with African Caribbean women patients.

This study is going to be taking place in three stages and this is stage 2a of the study. I have visited your group to find out how body shape and size is spoken about by African Caribbean women and how this influences our understandings of health. I am here today to ask if you would be interested in taking part in this study. I would like to invite you to take part in a discussion about African Caribbean women and body shape and size and health. Your group may present this discussion in any way that you choose and I would like to record these sessions.

I am really interested in interested in your opinions, so please feel free to speak openly.

There are no risks involved in this study and anyone who takes part in the study will be kept confidential. No personal information is required, but I would like to make a note of your age range and your ethnic background. Specific quotes will be used and attributed to the name that you choose to give to the researcher. If you would like to take part in the stage 3 of the study, I would need to take some contact information so that I can give you further details. All personal information and

information collected will be secured in line with university regulations and the Data Protection Act.

If you decide to take part in the study, I must let you know that you are free to withdraw from the study at any time during the session. If after the session you would like to withdraw your contribution to the research, you must contact the researcher within six weeks of the data collection session. From today's date, that would be [insert date six weeks from data collection session here].

I am going to give you an information sheet with all of the details about this study. If you have any questions, you are free to ask them now. If you have any questions later, you can contact me on the details that are on the information sheet. There is no pressure to take part in this study, so please feel free to decline if you wish.

Would you be interested in taking part in this study?

Phase 3

My name is Nicole Andrews and I am a student at the University of Birmingham. I am conducting a research study called the Big Talk Project in Birmingham.

You should have already been given an information leaflet about this research but I would like to take a minute to explain why I am inviting you to participate and what I will be doing with the information you provide. Please stop me at any time if you have any questions. After I've told you a bit more about my project, you can decide whether or not you would like to participate.

I am doing this research as part of my studies in the School of Health and Population sciences and I will use the information gathered for the basis of my PhD research. For this project, I am interested in how African Caribbean women understand 'health' with a focus on body shape and body size.

I am using a community based research method to encourage members of the African Caribbean community to take part. The knowledge gained from this study will be used to inform GPs and other health professionals about the ways that the African Caribbean community understand health with relation to body shape and body size. This information will help GPs and health professionals to be able to raise issues relating weight and weight management appropriately with African Caribbean women patients.

This study is going to be taking place in three stages and this is stage 3 of the study. In this group I would like to present the findings of the previous research stages for your feedback. I would also like your views on how the ways that African Caribbean women understand their health affect relationships with health professionals regarding weight management. I would like to record these sessions.

I am really interested in interested in your opinions, so please feel free to speak openly.

There are no risks involved in this study and anyone who takes part in the study will be kept confidential. No personal information is required, but I would like to make a note of your age range and your ethnic background. Specific quotes will be used and attributed to the name that you choose to give to the researcher. All personal information and information collected will be secured in line with the university regulations and the Data Protection Act.

If you decide to take part in the study, I must let you know that you are free to withdraw from the study at any time during the session. If after the session you would like to withdraw your contribution to the research, you must contact the researcher within six weeks of the data collection session. From today's date, that would be [insert date six weeks from data collection session here].

I am going to give you an information sheet with all of the details about this study. If you have any questions, you are free to ask them now. If you have any questions later, you can contact me on the details that are on the information sheet. There is no pressure to take part in this study, so please feel free to decline if you wish.

Would you be interested in taking part in this study?

Appendix Two: Participant information
Phase 2a

The "Big Talk" Project

Participant Information Sheet Data Collection Stage 2a

Researcher Name: Nicole Andrews

Research Supervisors: Dr S Redwood Dr S Greenfield Dr W Drever

Address: School of Health and Population Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT

You are invited to take part in a research study. Before you decide if you would like to take part, you need to understand why this research is being done and what it would involve for you. Please take the time to read this information carefully and feel free to ask the researcher any questions that you may have.

What is the purpose of the study?

The purpose of this study is to explore how African Caribbean women understand 'health' with a focus on body shape and body size. The research is being conducted using a community based method to encourage participation from the African Caribbean community. The knowledge gained from this study will be used to inform GPs and other health professionals of the cultural understandings of health within the African Caribbean community so that they may be able to raise issues relating weight and weight management appropriately with African Caribbean women patients. This study has been authorised by the University of Birmingham and has been approved by the University of Birmingham Research Ethics Board.

Who will be taking part in the study?

Women from the African Caribbean community will be invited to take part in this study. However, as the research is taking place in the community, women from other ethnic groups will not be excluded if they wish to take part.

What will happen in the study?

The study will be conducted in three data collection phases:

1. Talk radio, BBC radio and other local radio stations
2. Community settings, such as faith groups, women's groups and hairdressing salons.
3. Small group sessions in the community

   This is phase 2a of the study.

In this phase, the study will aim to understand how body shape and size is spoken about by African Caribbean women and how this influences understandings of health. The researcher is interested in your opinions, so please feel free to speak openly.

The researcher will invite your group to take part in a discussion about African Caribbean women and body shape and size and health. Your group may present this discussion in any way that you choose. These sessions will be recorded using a voice recorder. It is important that in consenting to take part in this research, that you understand that no personal references to any person other than yourself are made during the conversation. This is to observe confidentiality. Also, all participants are asked to make no negative comments about or towards any individual.

Will I need to give any personal information?

No personal information will be required for this stage. If you would like to take part in phase 3 of the study, the researcher will require contact information so that you can be given more details about the small group sessions that will be taking place.

Will my taking part in this study be kept confidential?

Only the name you choose to use with the researcher and the date of data collection will be stored by the researcher with regard to this session. Any personal contact information given to the researcher will be kept confidential. All research data and personal information will be stored lawfully by the researcher with limited access to the information only by the research supervisors.

Are there any risks involved?

No. However, for some people, talking about overweight and obesity is a sensitive topic. So please will all participants bear this in mind during the research as the aim of this study is not to upset or offend anyone. If at any point you feel uncomfortable with the discussion, please inform the researcher who will stop the discussion.

What will happen with the results of the study?

The recordings of the sessions will be transcribed and analysed to understand the meaning of health, body shape and size for African Caribbean women. Specific quotes from participants will be used and attributed to the name that you choose to give to the researcher. The results of the study will be written up by the researcher and presented to the University of Birmingham as a thesis. The findings of this research may also be presented at conferences and published as journal articles.

Can I change my mind if I decide I do not want to take part in the study?

You may withdraw from the study at any point during the sessions.

If after the session you would like to withdraw your contribution to the research, you must contact the researcher within six weeks of the data collection session.

Date of session [insert date of session here] Last date for withdrawal [insert date six weeks from date of session here]

If I have any more questions, who should I contact?

If you have any questions about this research, please contact the researcher using the contact details supplied.

If you would like any further information or support related to weight management and health issues, you should contact your GP. Below are details of local and national support agencies and information that may be useful:

- Change 4 Life (National) Tel: 0300 123 4567
  Web: http://www.nhs.uk/change4life/Pages/change-for-life.aspx

- B-Eat (National) Tel: 0845 634 1414

Web: http://www.b-eat.co.uk/Home

- Lighten Up Weight Management and Support Service (Local)

Web: https://www.sbpct.nhs.uk/your-services/lighten-up.aspx

Phase 2b

The "Big Talk" Project

Participant Information Sheet Data Collection Stage 2b

Researcher Name: Nicole Andrews

Research Supervisors: Dr S Redwood Dr S Greenfield Dr W Drever

Address: School of Health and Population Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT

You are invited to take part in a research study. Before you decide of you would like to take part, you need to understand why this research is being done and what it would involve for you. Please take the time to read this information carefully and feel free to ask the researcher any questions that you may have.

What is the purpose of the study?

The purpose of this study is to explore how African Caribbean women understand 'health' with a focus on body shape and body size. The research is being conducted using a community based method to encourage participation from the African Caribbean community. The knowledge gained from this study will be used to inform GPs and other health professionals of the cultural understandings of health within the African Caribbean community so that they may be able to raise issues relating weight and weight management appropriately with African Caribbean women patients. This study has been authorised by the University of Birmingham and has been approved by the University of Birmingham Research Ethics Board.

Who will be taking part in the study?

Women from the African Caribbean community will be invited to take part in this study. However, as the research is taking place in the community, women from other ethnic groups will not be excluded if they wish to take part.

What will happen in the study?

The study will be conducted in three data collection phases:

1. Talk radio, BBC radio and other local radio stations
2. Community settings, such as faith groups, women's groups and hairdressing salons.

3. Small group sessions in the community

This is phase 2b of the study.

In this phase, the study will aim to understand how to body shape and size is spoken about by African Caribbean women and how this influences understandings of health. The researcher is interested in your opinions, so please feel free to speak openly.

The researcher will invite you to take part in a one-to-one discussion about the topic in a private section of the salon. These sessions will be recorded using a voice recorder.

It is important that in consenting to take part in this research, that you understand that no personal references to any person other than your self are made during the conversation. This is to observe confidentiality. Also, all participants are asked to make no negative comments about or towards any individual.

Will I need to give any personal information?

No personal information will be required for this stage. If you would like to take part in the focus groups in stage 3, the researcher will require contact information so that you can be invited to take part in one of the small group sessions and given the details.

Will I need to give any personal information?

No personal information will be required for this stage. If you would like to take part in phase 3 of the study, the researcher will require contact information so that you can be given more details about the small group sessions that will be taking place.

Will my taking part in this study be kept confidential?

Only the name you choose to use with the researcher and the date of data collection will be stored by the researcher with regard to this session. Any personal contact information given to the researcher will be kept confidential. All research data and personal information will be stored lawfully by the researcher with limited access to the information only by the research supervisors.

Are there any risks involved?

No. However, for some people, talking about overweight and obesity is a sensitive topic. So please will all participants bear this in mind during the research as the aim of this study is not to upset or offend anyone. If at any point you feel uncomfortable with the discussion, please inform the researcher who will stop the discussion.

What will happen with the results of the study?

The recordings of the sessions will be transcribed and analysed to understand the meaning of health, body shape and size for African Caribbean women. Specific quotes from participants will be used and attributed to the name that you choose to give to the researcher. The results of the study will be written up by the researcher and presented to the University of Birmingham as a thesis. The findings of this research may also be presented at conferences and published as journal articles.

Can I change my mind if I decide I do not want to take part in the study?

You may withdraw from the study at any point during the sessions.

If after the session you would like to withdraw your contribution to the research, you must contact the researcher within six weeks of the data collection session.

Date of session [insert date of session here] Last date for withdrawal [insert date six weeks from date of session here]

If I have any more questions, who should I contact?

If you have any questions about this research, please contact the researcher using the contact details supplied.

If you would like any further information or support related to weight management and health issues, you should contact your GP. Below are details of local and national support agencies and information that may be useful:

- Change 4 Life (National) Tel: 0300 123 4567
  Web: http://www.nhs.uk/change4life/Pages/change-for-life.aspx

- B-Eat (National) Tel: 0845 634 1414

Web: http://www.b-eat.co.uk/Home

- Lighten Up Weight Management and Support Service (Local)

Web: https://www.sbpct.nhs.uk/your-services/lighten-up.aspx

Phase 3

The "Big Talk" Project

Participant Information Sheet Data Collection Stage 3

Researcher Name: Nicole Andrews

Research Supervisors: Dr S Redwood Dr S Greenfield Dr W Drever

Address: School of Health and Population Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT

You are invited to take part in a research study. Before you decide of you would like to take part, you need to understand why this research is being done and what it would involve for you. Please take the time to read this information carefully and feel free to ask the researcher any questions that you may have.

What is the purpose of the study?

The purpose of this study is to explore how African Caribbean women understand 'health' with a focus on body shape and body size. The research is being conducted using a community based method to encourage participation from the African Caribbean community. The knowledge gained from this study will be used to inform GPs and other health professionals of the cultural understandings of health within the African Caribbean community so that they may be able to raise issues relating weight and weight management appropriately with African Caribbean women patients. This study has been authorised by the University of Birmingham and has been approved by the University of Birmingham Research Ethics Board.

Who will be taking part in the study?

Women from the African Caribbean community will be invited to take part this phase of study.

What will happen in the study?

The study will be conducted in three phases:

4. Talk radio, BBC radio and other local radio stations
5. Community settings, such as faith groups, women's groups and hairdressing salons.
6. Small group sessions in the community

This is phase three of the study.

In this phase, the researcher will present the findings of phases one and two of the study for feedback from the group. The researcher will also guide a discussion about how the ways that African Caribbean women understand their health influences relationships with health professionals. The researcher is interested in your opinions, so please feel free to speak openly. All conversations will be voice recorded by the researcher.

Will I need to give any personal information?

For this phase, the researcher will require contact information so that you can be invited to take part in one of the small group sessions and given the appropriate details. If you consent, your contact information will be stored securely so that you may be invited to a presentation of the research findings when the project is completed.

Will my taking part in this study be kept confidential?

Only the name you choose to use with the researcher and the date of data collection will be stored by the researcher with regard to this session. Any personal contact information given to the researcher will be kept confidential. All research data and personal information will be stored lawfully by the researcher with limited access to the information only by the research supervisors.

Are there any risks involved?

No. However, for some people, talking about overweight and obesity is a sensitive topic. So please will all participants bear this in mind during the research as the aim of this study is not to upset or offend anyone. If at any point you feel uncomfortable with the discussion, please inform the researcher who will stop the discussion.

What will happen with the results of the study?

The recordings of the sessions will be transcribed and analysed to understand the meaning of health, body shape and size for African Caribbean women. Specific quotes from participants will be used and attributed to the name that you choose to give to the researcher. The results of the study will be written up by the researcher and presented to the University of Birmingham as a thesis. The findings of this research may also be presented at conferences and published as journal articles.

Can I change my mind if I decide I do not want to take part in the study?

You may withdraw from the study at any point during the sessions.

If after the session you would like to withdraw your contribution to the research, you must contact the researcher within six weeks of the data collection session.

Date of session [insert date of session here] Last date for withdrawal [insert date six weeks from date of session here]

If I have any more questions, who should I contact?

If you have any questions about this research, please contact the researcher using the contact details supplied.

If you would like any further information or support related to weight management and health issues, you should contact your GP. Below are details of local and national support agencies and information that may be useful:

Change 4 Life National

Tel: 0300 123 4567

Web: http://www.nhs.uk/change4life/Pages/change-for-life.aspx

- B-Eat National

Tel: 0845 634 1414

Web: http://www.b-eat.co.uk/Home

- Lighten Up Weight Management and Support Service Local

Web: https://www.sbpct.nhs.uk/your-services/lighten-up.aspx

Appendix Three: Information and recruitment material
Phase 2a

Community Based Health Research

The 'BIG Talk' Project

UNIVERSITY OF BIRMINGHAM

African Caribbean Women: Health, Body Shape and Body Size

A Research Project

The purpose of this study is to explore how African Caribbean women understand 'health' with a focus on body shape and body size.

The knowledge gained from this study will be used to inform GPs and other health professionals of the cultural understandings health within the African Caribbean community.

The researcher will be visiting this hairdressing salon on the following dates and times to talk to African Caribbean women about body shape and size:

Dates and times to be listed here

There is no obligation to take part in this study

If you are interested in taking part of would like more information, please contact the researcher Nicole Andrews

Phase 3

Community Based Health Research

The 'BIG Talk' Project

UNIVERSITY OF BIRMINGHAM

African Caribbean Women: Health, Body Shape and Body Size
A Research Project

The purpose of this study is to explore how African Caribbean women understand 'health' with a focus on body shape and body size.

The knowledge gained from this study will be used to inform GPs and other health professionals of the cultural understandings health within the African Caribbean community.

African Caribbean women are invited to take part in this study.
The researcher would like to present the findings of the study in small groups of women to get your feedback of the findings. There will also be a discussion how the how the ways that African Caribbean women understand their health influences relationships with GPs and other health professionals.

Date and venues to be listed here

If you are interested in taking part of would like more information, please contact the researcher Nicole Andrews

Phase 3

If you are interested in taking part in this research please complete this form and return to the researcher.

You will be contacted with details of the research sessions.

Thank you

I consent for my information to be securely stored by the researcher in accordance with the Data Protection Act 1998 and the University Code of Practice. I understand that my contact information will only be used in relation to this research project.

Please tick to consent to the above: ☐

Name:

_____

Address including post code:

_____

_____

_____

_____

Telephone:

_____

Email:

_____

This research study has been authorised by the University of Birmingham and has been approved by the University of Birmingham Research Ethics Board.

If you have any queries or questions about this project, please feel free to contact the researcher:

Nicole Andrews

School of Health and Population Sciences,
University of Birmingham,
Edgbaston,
Birmingham
B15 2TT

Community Based Health Research

The 'Big Talk' Project

African Caribbean Women:

Health, Body Shape and Body Size

A Research Project

UNIVERSITY OF BIRMINGHAM

Phase 3

THE 'BIG TALK' PROJECT

You are invited to take part in a research study.

What is the purpose of the study?

The purpose of this study is to explore how African Caribbean women understand 'health' with a focus on body shape and body size.

The knowledge gained from this study will be used to inform GPs and other health professionals of how culture influences understandings health within the African Caribbean community.

Why is this study important?

African Caribbean women are disproportionately effected by obesity related illnesses such as type 2 diabetes, hypertension and stroke.

The findings of this study will help GPs and other health professionals to raise the issue of weight management with African Caribbean women patients to help prevent or to manage obesity related illnesses.

The Study

One of the aims of this research is to encourage the local community to be involved in health research and to talk about health issues concerning African Caribbean communities in the UK.

By getting involved health research, you could help to influence the services developed for the community. This study is being conducted in the community in 3 phases :

Phase 1: Community settings, such as faith groups, women's groups and hairdressing salons.

Phase 2: Talk radio

Phase 3: Small group discussion sessions in the community

This is an invitation to take part in phase 3 of the study.

In this phase, small groups of African Caribbean women will be presented with the findings of the previous phases and asked to give feedback.

Also the researcher will guide a discussion about how the ways that African Caribbean women understand their health may influence relationships with GPs and other health professionals.

The researcher is interested in your opinions, so you will be welcome to speak openly and freely.

There will be a number of these sessions taking place at various locations in the local area.

All African Caribbean women are invited to participate.

If you are interested in taking part, please complete your contact details overleaf and the researcher will contact you with details of the sessions.

Thank you.