IVAR we listen, and learn together

Health Inequalities through Community Eyes

Ten community-led research projects to reshape local health services

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Authorship and acknowledgements

This report has been written by Houda Davis and Lara Bautista, drawing on reports written by:

- Peter Bruce and Eleisa Sampson (Caribbean Lunch Club)
- Ridwan Morohunranti, Huda Albatash and Imade Edosomwan (Oxford Community Action)
- Joan St Clair, Jacqueline Mukono and Peris Njeri (Utulivu)
- Rehana Mirzada and Khwaja Noorullah Sidiqi (Community First)
- Laura Rook and Nadiya Al-Samerai (Portsmouth Mediation Service)
- Emily Burt and Roshni Barrass (SPARK)
- Anita David and Fatma Tuylu (Work Better Innovations)
- Swechchha Rai and Abesh Rai (Folkestone Nepalese Community)
- Tessa Ramrajsingh, Amy Marshall, and Catalina Gheorghe (Citizens Advice in West Sussex)
- Sara Fernee, Fatima Aliyu and Maha Mustafa (Trust for Developing Communities)

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People who design and deliver health services are under constant pressure to make the right decisions with limited time and resources. Voluntary, community and social enterprise (VCSE) sector organisations – working every day to support healthy communities – hold insights that statutory services cannot access alone. The Community Participatory Action Research (CPAR) programme, trains staff and volunteers from these organisations in community research. Researchers use their trusted relationships and lived experience to reveal how services are experienced, where they fall short, and how health inequalities manifest locally. This kind of grounded intelligence rarely appears in routine data, yet it often determines whether well-intentioned plans become services that actually work. And the legacy that CPAR leaves behind is a trained workforce, that can (with appropriate resource) continue their work in community research engagement, and participation.

This report aims to celebrate and amplify the work of the community researchers who took part in CPAR Cohort Three, showcasing what each project set out to understand, what researchers learned, and how organisations are already acting on insights. The research shines a spotlight on experiences that are often missing from formal decision-making – particularly among groups experiencing health inequalities.

From these rich research projects, a drum beat of similar messages emerged:

- ‘Digital by default’ and language barriers are creating significant roadblocks for the most vulnerable in our communities.
- A lack of cultural sensitivity has eroded trust in statutory services.
- Physical and mental health cannot be treated in silos – marginalised groups experience complex, multiple conditions where social stressors manifest physically.
- When basic needs – housing, food, and safety – are unmet, people struggle to prioritise preventative health or chronic condition management.
- Trauma, relocation, and interpersonal conflict is affecting mental and physical health.

The overall recommendations reflect shared insights from across this research. For GPs and primary care, they call for human, non-digital routes to access, whole-person approaches, culturally aware practice, and relational referrals. For commissioners and funders, they emphasise investing in access, prevention, co-design, and collaboration across sectors. For voluntary and community organisations, they highlight the importance of trusted spaces, advocacy, cultural translation, and sustainable partnership working.

Follow-up action is already underway. Organisations are building new partnerships (for example, with Integrated Care Services, housing teams and other local VCSE organisations), adapting and expanding community-based support (such as women's groups, ESOL and digital skills classes, wellbeing spaces, and peer-led health activities), and improving communication and cultural accessibility through multilingual and person-centred support. They are also planning preventative initiatives – from dance groups for hypertension to early language support – and using creative outputs to amplify lived experience to decision makers. These activities are strengthening organisational capacity, informing local strategies, and generating new opportunities for influence and funding.

Community research is valuable because it is led by insiders rooted in the communities they serve, it uncovers cultural, social, and practical realities that traditional research or public-health approaches often miss – from the nuances of digital exclusion to the role of stigma, trauma, and cultural norms in shaping health behaviours. This proximity builds trust, enables disclosure on sensitive issues, and produces evidence that is both more accurate and more actionable. As a result, community-led research generates insights that can reduce stigma, shift behaviours, and lead to practical changes that reflect how people actually live.

Together, the findings in the case studies in this report demonstrate why community research should be treated not as a peripheral activity but as a core resource for understanding inequality, designing services, and improving outcomes. When people rooted in their communities lead the research, deeper partnerships can form which are better able to meet everyone's needs.

Insights and recommendations

For GPs and primary care providers

1

Keep access human, not digital-by-default

Offer phone, face-to-face, and written options as standard, not exceptions. Use simple systems to record individual access needs and act on them consistently, especially for older patients and those facing language or confidence barriers.

2

Take a whole-person approach

Build routine questions about safety, stress, housing, and social isolation into consultations where appropriate. Work closely with mental health, social care, and specialist services so wider causes of ill health can be addressed.

3

Create safe spaces for disclosure and trust

Use trauma-informed, culturally aware approaches in everyday practice, not just in crisis moments. Where possible, signpost or host women-only or culturally specific support spaces in partnership with community organisations.

4

Act as navigators, not just clinicians

Proactively refer patients to social prescribing, community groups, rights advice, and peer support. Make referrals warm and relational, not just a leaflet or a link.

For commissioners and funders

1

Fund access, not just activity

Commission services that preserve non-digital routes, interpretation, and personalised access planning.

2

Shift investment upstream

Prioritise community-based prevention, social prescribing, and early intervention delivered in trusted local spaces. Fund programmes that reduce isolation and stress, not just those that respond once people reach crisis.

3

Invest in co-design

Require funded services to involve community members, peer researchers, and advocacy groups in design, delivery, and evaluation. Pay people for their time and expertise.

4

Incentivise joined-up working

Use contracts and outcomes to encourage collaboration across health, housing, education, and voluntary sectors. Support partnerships that address root causes, not just service throughput.

For voluntary, community and social enterprise organisations

1

Create trusted, safe spaces

Continue to offer welcoming environments where people can share experiences, build confidence, and feel heard, especially women-led, and culturally specific spaces that statutory services struggle to replicate.

2

Strengthen advocacy and rights education

Continue to support individuals to understand their health, legal, and social rights through peer support, workshops, and tailored materials. Help people prepare for appointments and navigate systems with confidence.

3

Act as cultural translators

Look for opportunities to bridge gaps between communities and health services by feeding back lived experience, barriers, and emerging needs. Support health providers to adapt their approaches, language, and assumptions.

4

Partner without being overstretched

Work with commissioners and primary care as equal partners. Be clear about capacity, sustainability, and what good collaboration actually requires avoiding burnout and mission drift.

Introduction

About the Community Participatory Action Research (CPAR) programme

The research projects in this report are part of the third cohort of the Community Participatory Action Research (CPAR) programme led by the South East School of Public Health in collaboration with the Office for Health Improvement and Disparities South East. CPAR aims to build a skilled workforce to enable people and communities to have an equal voice in how health and care priorities and services are informed. Since 2022, the programme has supported sixty-nine community researchers from VCSE organisations working with communities adversely affected by health inequalities, by training and mentoring their workforce on participatory research methods.

Researchers receive participatory action research methods training from the University of Reading; mentoring support to plan, deliver and reflect on their projects from the Scottish Community Development Centre (SCDC); and support to communicate their research, think about action and connect to stakeholders from the Institute for Voluntary Action Research (IVAR).

What is community participatory action research?

Community Participatory Action Research (CPAR) is an approach to research which empowers and enables communities to identify and better understand their needs through their lived experience. It equalises power relationships in research by placing control of the research topic and delivery in the hands of those who are experiencing the issues – or close to those that are experiencing the issues – that are being explored. It situates knowledge generation at the local level, breaking down barriers between communities and service providers to effect lasting social change. Crucially it links inquiry and investigation with action to achieve positive change in communities.

About this report

This report brings together the stories and findings from ten community-led research projects across the Southeast. It provides an overview of the CPAR programme, presents each project's motivations, methods, and key insights, and shares practical recommendations shaped by lived experience aimed at local strategic decision makers, funders, and service providers capable of implementing change. Throughout, the report also shows how organisations have begun putting their research into action – strengthening partnerships, adapting services, and influencing local systems – to improve health and wellbeing in their communities.

This work comes at a time of significant public sector reforms across Department for Health and Social Care, NHS England, Integrated Care Boards and Local Government. Community Participatory Action Research approaches are critical to ensure that communities are not only engaged and heard, but are actively shaping and informing the design and delivery of services during this period of transformation.

About the community researchers

VCSE organisations from across the Southeast were invited to apply for CPAR Cohort Three. Twenty-four staff and volunteers were selected, forming a diverse cohort drawn from Kent, Sussex, Hampshire, Oxfordshire, Buckinghamshire and Berkshire. Each brought deep motivation rooted in community stories and their own lived experience, with backgrounds spanning community development, advocacy, mediation, wellbeing support, and lived-experience leadership across a wide range of local communities. Many were motivated to become community researchers because they were already supporting people facing barriers, seeing first-hand the gaps, injustices, or unmet needs in local systems. They wanted the skills, confidence, and platform to turn those insights into meaningful change.

Community Participatory Action Research – at a glance

10 community-led projects

24 community researchers

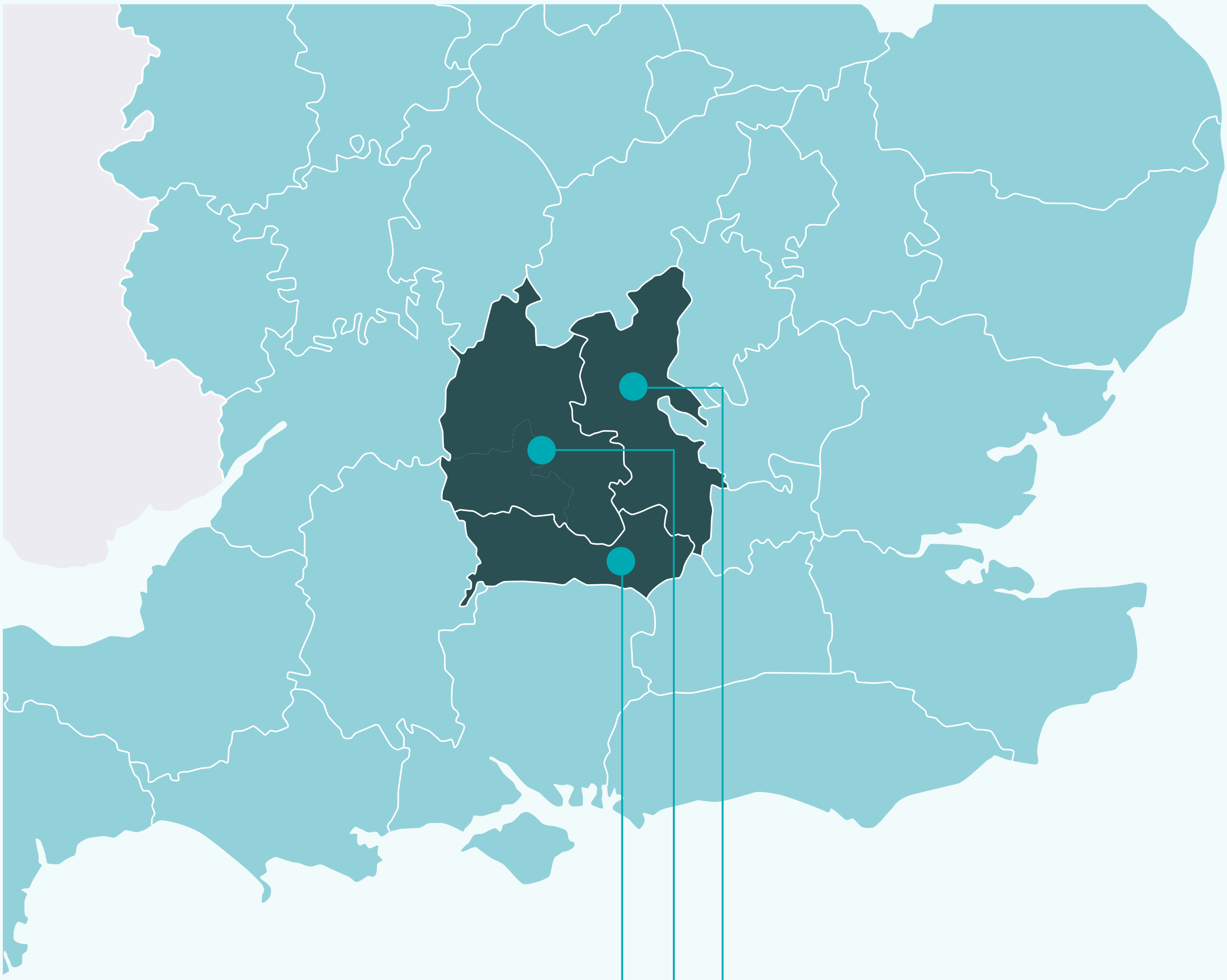
- Trained and mentored in participatory action research
- Supported by academic, VCSE and research partners
- Lived experience driving action on health inequalities

How CPAR responds to policy and statutory expectations

CPAR embodies the cultural shift toward partnership, equity, and shared leadership between systems and communities. This directly supports the NHS cultural ambition to embed *"nothing about us without us"* approach to decision-making, as well as current policy and legal frameworks which make clear that engaging communities is not optional, but a core requirement across the health and care system. Community research offers a practical way for commissioners and system leaders to meet these expectations by generating the kind of grounded, community-led insight described in policy and guidance frameworks. By embedding community researchers within local VCSE organisations, approaches like CPAR can enable systems to identify unmet need, understand overlooked groups, and design services that more effectively reduce inequalities and improve outcomes.

For a more information about policy and guidance frameworks that support community engagement and research see the 'Further Reading' section at the end of this report.

Journeys in research: Berkshire, Oxfordshire, and Buckinghamshire



Exploring the reasons behind high blood pressure among the Afro-Caribbean community

The impact of poor housing on racially minoritised families with low incomes in Oxford

Mental health and health inequalities: Understanding the impact of domestic violence on hormonal issues

Exploring the reasons behind high blood pressure among the Afro-Caribbean community

About the research

The **Caribbean Community Lunch Club (CCLC)** in Aylesbury provides weekly meals and a trusted social space for older Afro-Caribbean residents. Peter Bruce and Eleisa Sampson led research into the drivers of high blood pressure among the users of the lunch club, exploring whether medical evidence matched local lived experience and how cultural norms, diet, stress, and service access shaped health. They used a mixed-methods approach, combining questionnaires with focus groups involving predominantly older (60+) participants to understand lifestyle, dietary patterns, barriers to care and perceptions of health. Both Peter and Eleisa reflected that conducting the research within a familiar, culturally rooted setting enabled unusually open conversations. They emphasised that participants were especially candid because the researchers were trusted members of the community.

Elisa Sampson talking about findings at the CPAR 2025 showcase

Key findings

The findings highlighted the long-term impacts of lifestyle, access to care, and service design:

- **More than half of participants reported high blood pressure**, reflecting both long-term health patterns and experiences common in older Afro-Caribbean communities.
- **Cultural dietary habits were a key factor**, since traditional Caribbean dishes -often rich in salt, seasoning blends, and fried foods – were an important contributor to risk, with many participants unaware of hidden salt in familiar ingredients.
- **There was low engagement with formal exercise but strong preference for social movement**. Although 86% did not meet recommended activity levels, many expressed enthusiasm for activities such as dancing, which they viewed as enjoyable and community-building.
- **People experienced barriers in accessing healthcare**. Digital-first GP systems excluded many older adults, who struggled with online booking and inconsistent follow-up. Participants emphasised wanting more relational, face-to-face care.
- **Many described stress** – including financial pressures, caregiving, and the wider impact of discrimination – as a major contributor to their high blood pressure.

Insights and recommendations

The research presented a series of culturally specific recommendations aimed at improving prevention, management, and engagement:

1. **Train NHS staff to provide culturally relevant advice**, including realistic ‘food swaps’ for traditional Caribbean dishes.
2. **Use tailored health information** including tools like the Caribbean-specific ‘health wheel’ or traffic-light system to clearly show salt and fat content in familiar foods.
3. **Promote community-based exercise**, for example replacing gym referrals with social, enjoyable activities, such as dance classes held within trusted spaces like the Lunch Club.
4. **Carry out more youth engagement**, using social media and youth-focused approaches to reach younger generations before unhealthy habits become entrenched.
5. **Provide clear, consistent advice and training** on how to use home blood pressure monitors effectively.

Putting the research into practice

The findings are already shaping action. Through a partnership with Pump It Up, members now have access to blood pressure monitors and peer support to use them confidently. The Lunch Club is seeking funding to run dance classes as a culturally relevant form of physical activity. Plans are also underway to share findings with younger community members through social media and youth-friendly formats want to promote healthier behaviours early and encourage positive change within families.

Read the full research report here →

The impact of poor housing on racially minoritised families with low incomes in Oxford

About the research

Oxford Community Action (OCA) works with Black and minoritised communities in Oxford to tackle structural inequalities like labour market exclusion and ethnic health disparities. Researchers Ridwan Morohunranti, Huda Albatash and Imade Edosomwan explored how poor-quality housing in OX4 postcodes affects racially minoritised families on low incomes, investigating links between damp, mould, heating problems, and physical and mental health. They used a mixed-methods, participatory approach involving surveys, in-depth interviews, and observation of housing conditions.

The project was rooted in lived experience sparked by a conversation between women who all realised they were living with damp walls and broken heating. Participants spoke openly about the real impact of their homes on health.

Ridwan Mohohunranti talking about findings at the CPAR 2025 showcase

Key findings

The research revealed a clear and consistent link between poor housing quality and negative health outcomes, particularly for socially and economically marginalised groups.

- **More than half of survey respondents rated their housing as average, poor or very poor**; none rated it very good.
- **Damp, mould, poor insulation and overcrowding were widespread**.
- **Respiratory problems, poor sleep, and worsened asthma were common**. Parents were particularly concerned about persistent coughs, colds, and fears that poor housing was affecting their children's development and educational progress.
- **Housing-related stress, anxiety, and depression were widely reported**.
- **Families feared eviction or retaliation for raising complaints**, reinforcing inequality. Landlords were reportedly dismissive or 'nonchalant,' with people being told to simply *'open the window.'*

Insights and recommendations

Grounded in residents lived experiences and focused on accountability, prevention, and rebuilding trust between tenants, landlords, and public institutions, the report's recommendations reflect the clear need for both practical action and structural change to improve housing conditions:

1. **Ensure stronger enforcement and accountability** by committing to proactive enforcement of housing standards, including regular local-authority inspections, completion of essential repairs before tenants move in, and rapid responses to maintenance issues so minor problems do not become serious health risks.
2. **Support greater fairness, redress, and legal protection** by providing financial compensation or rent relief where people have lived in unsafe conditions, apply penalties for non-compliance, and ensure access to dedicated legal and advocacy support when landlords fail to act.
3. **Ensure local representation** by supporting/working with those that provide trusted locally informed support, who can help ensure fair access to shared facilities to prevent discrimination within blocks or estates.
4. **Build greater transparency, trust, and delivery on commitments** by using housing data transparently, communicating clearly about actions taken, and maintaining a visible follow-through on promised repairs and improvements to rebuild confidence among residents.

Putting the research into practice

The research team reflected that trust, proximity and follow-through were essential. Without action, one respondent warned, *'this research… will just die.'* This shaped the team's commitment to remain engaged and ensure findings translated into meaningful change.

The research has already been used to drive advocacy, systems engagement, and practical change. The team shared findings at national and regional forums, including the Public Power Workshop and Oxfordshire Marmot discussions, reframing housing as a root cause of health inequality. The work has informed involvement in the Oxfordshire Care Co-op and is shaping a planned stakeholder event with the Buckinghamshire, Oxfordshire, and Berkshire West ICB to create direct dialogue between residents and commissioners.

They are also working with the Agnes Smith Advice Centre to translate housing advice materials and have proposed a community-led cleaning and minor-repair initiative to address problems quickly and locally.

Reflecting on the process, the researchers described CPAR as both a warning and a roadmap. Testimonies revealed urgent realities, but also clear solutions rooted in lived experience. They emphasised that trust, responsiveness, and visibility are essential if systems are serious about addressing housing-related health inequality.

Read the full research report here →

Huda Albatash presenting on housing related health inequalities in Oxford at the CPAR 2025 Showcase

Mental health and health inequalities: Understanding the impact of domestic violence on hormonal issues

About the research

Utulivu is a specialist organisation supporting women and girls across diverse communities in Reading and surrounding areas, providing safe, supportive spaces, advocacy, and practical assistance, often in partnership with other local groups.

This project – led by Jacqueline Mukono, Peris Njeri, and Joan St Clair – arose from a critical, cross-cutting theme in Utulivu's work: women's voices not being heard in healthcare. Using mixed methods and targeted outreach with women from BAME backgrounds, refugees, asylum-seekers and low-income households, the team explored how hormonal imbalances affect mental wellbeing, the compounded effects of domestic violence, and the accessibility and quality of existing services.

The research specifically sought to address a 'silence' surrounding the link between women's hormonal issues and mental health struggles – an issue that many participants recognised but felt was overlooked or dismissed.

The team describe the work as deeply transformative, noting that listening directly to women was one of the most powerful aspects of the project and that insights from lived experience prompted them to re-imagine support models with dignity and safety at their core.

Participants and community leaders at The Story Within Retreat, Black History Month 2025 – a celebration of women's wellness, heritage and empowerment in Reading

Key findings

The research revealed a ‘vicious cycle’ in which trauma and biology are inseparably linked:

- **The biological toll of trauma:** the chronic stress of domestic abuse can flood survivors’ bodies with cortisol and adrenaline, disrupting hormonal balance and intensifying emotional instability.
- **Systemic failures and misdiagnosis:** A recurring theme was women feeling ‘unheard and dismissed;’ their symptoms (such as depression or mood swings) were often misinterpreted as character flaws, or trivialised as ‘just hormones,’ rather than biological responses to prolonged stress.
- **Barriers to care:** 80% of participants reported facing cultural or language barriers when accessing health and social care, with many unaware of where to go for domestic abuse recovery services.
- **Experiences of care:** Key themes identified included women feeling ‘unheard and dismissed,’ a lack of safe spaces, and the presence of ‘deep systemic misogyny’ within existing treatment frameworks.

Insights and recommendations

The research identifies a clear need for integrated, trauma-informed care to break the vicious cycle of trauma and hormonal disruption. Key recommendations include:

1. **Support women-led wellbeing support hubs** which create spaces where women can feel safe to speak openly, with the confidence that they will be heard and taken seriously.
2. **Make screening holistic** by conducting health assessments which ask about a patient’s living conditions, safety, and stress.
3. **Increase collaboration between GPs, specialised medical practitioners, and mental health professionals** to address the biological tolls of abuse.
4. **Invest in specialised professional training** for healthcare professionals which helps them to ask compassionate, non-judgmental questions about domestic abuse history and chronic stress, ensuring that both bodily and mental recovery are supported.
5. **Ensure services have multilingual and culturally competent staff** to reach the 80% of women currently facing barriers to accessing care.

Putting the research into practice

The findings have already shaped service evolution. Utulivu strengthened its partnership with Project Salama (an organisation supporting individuals live a life free of abuse), integrating hormonal and mental-health awareness into domestic-abuse drop-ins, and expanding existing Chai and Chat sessions into tailored wellbeing spaces.

They also created a weekly Women-to-Women Peer Support programme to provide safe, non-judgemental connection.

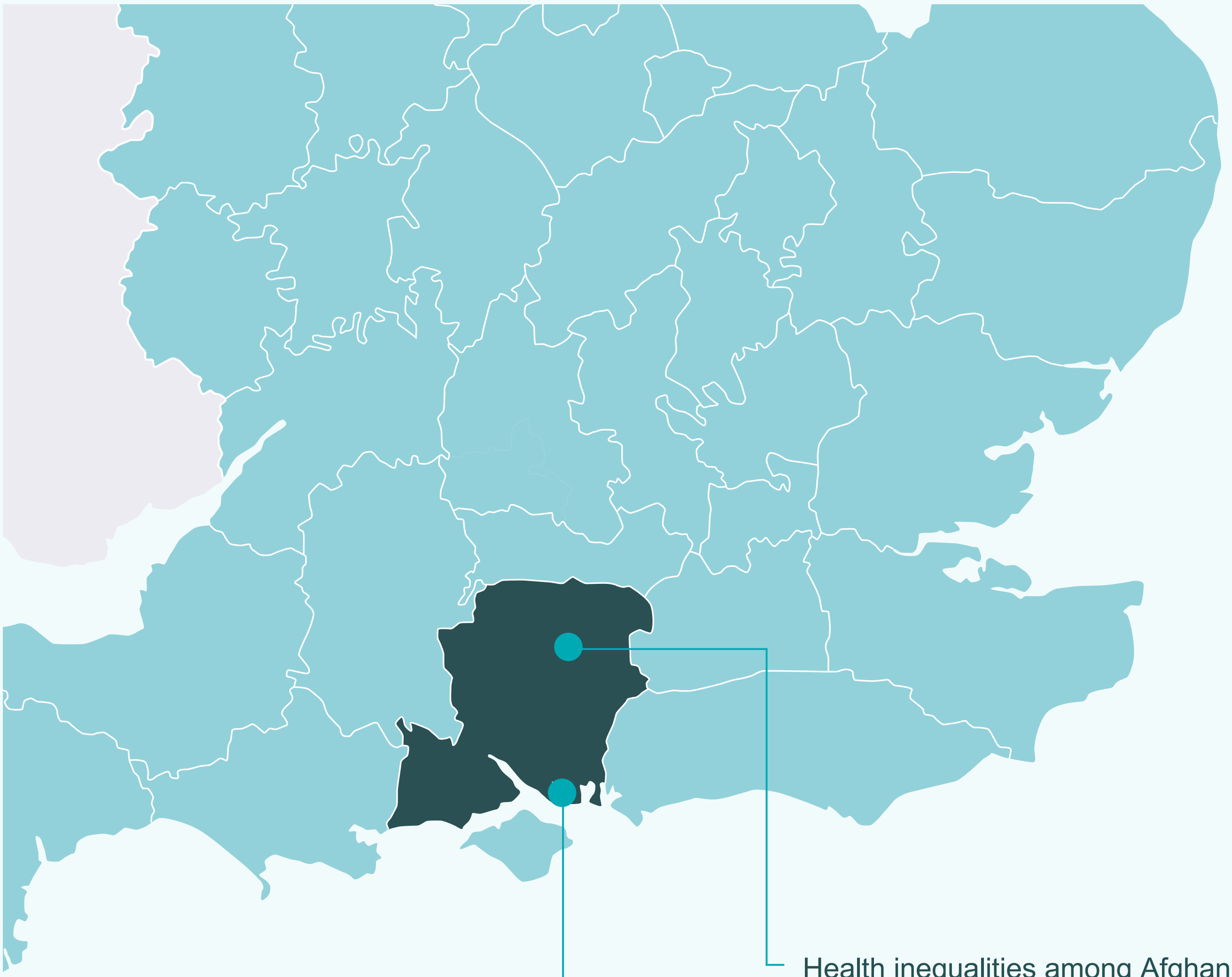
To address language barriers, Utulivu now works with multilingual volunteers from diverse communities.

The research evidence is supporting funding bids and efforts to establish a Women's Wellbeing Support Hub, covering staffing, premises, and therapeutic support.

Researchers described the project as personally transformative. Jacqueline noted that *'speaking directly with women during the research was one of the most powerful and transformative aspects of this work.'* By acknowledging the often-overlooked link between body chemistry, trauma, the researchers hope to move away from dismissal of women's health issues, instead offering women scientifically backed compassion and validation.

Read the full report here →

Journeys in research: Hampshire



Health inequalities among Afghan women in Hampshire

The hidden impact of conflict on health and wellbeing in Portsmouth

Examining the alienation of older adults due to increasing digitalisation and the challenges in accessing personalised healthcare

Migrant women's barriers to accessing menopause care: Insights from Portsmouth

Health inequalities among Afghan women in Hampshire

About the research

Drawing on their insider knowledge and lived experience within the community, Rehana Mirzada and Noorullah Sidiqi's research explored how social, cultural, and linguistic barriers shape the mental health and wellbeing of Afghan women resettled across Hampshire.

Rehana and Sidiqi were volunteers at Community First Hampshire, an independent membership organisation supporting the voluntary and community sector in Hampshire to make a difference in their communities. They were hosted by Hampshire County Council's Public Health Team where they received regular support throughout. They used mixed-methods design – surveys, one-to-one/telephone interviews and focus groups with **21 Afghan women** from varied backgrounds and lengths of residence (many arriving under Afghan Relocations and Assistance Policy) to examined language barriers, gender roles, isolation, and access to care.

As insiders, the researchers note that shared lived experience reduced power imbalances and enabled unusually open, honest conversations, which they describe as validating and transformative. Rehana and Sidiqi reflected that the research felt not just like a professional task, but a moral responsibility to their community and emphasised the resilience and ambition of the women who took part. Despite experiences of trauma, displacement, and ongoing barriers, participants demonstrated strong aspirations for education, employment, and integration. The researchers highlighted that empowering Afghan women through education and inclusion benefits not only individuals, but also families and wider communities.

Rehana Mirzada at the 2025 CPAR Showcase

Key findings

- **Language barriers** were the most significant limitations to accessing healthcare. Participants described difficulties understanding GP correspondence, booking appointments, using self-check-in machines, navigating the NHS app, and communicating with healthcare professionals.
- **Employment and financial dependency** limited women's independence and confidence, with limited English skills, childcare responsibilities and a lack of suitable employment opportunities acting as constraints. Participants highlighted employment as a potential route to improving language skills, social integration, and independence.
- **Traditional gender roles and misinterpretations of religion** were found to reinforce male dominance within households, restricting women's autonomy and decision-making.
- **Feelings of stress, depression, and loneliness** were commonly reported alongside limited opportunities to engage outside the home.
- **Afghan women demonstrated resilience and ambition** expressing aspirations for education, employment, and community involvement. They identified practical needs such as ESOL classes with bilingual tutors, flexible schedules, childcare support, and vocational training in areas like tailoring, cooking, and hairdressing.

Insights and recommendations

1. **Expand education** by providing ESOL classes with bilingual tutors and integrated childcare support.
2. **Develop inclusive employment pathways** and work opportunities accessible to women with varying levels of literacy, language proficiency, and formal qualifications.
3. **Improve healthcare access** by ensuring consistent availability of interpreting services within healthcare settings.
4. **Invest in digital literacy support** to deliver targeted workshops to help women navigate online systems, including booking appointments.
5. **Invest in rights education** to increase awareness of gender equality, domestic abuse protections, and UK social and legal rights.
6. **Create new roles to reflect the community** by employing Afghan community workers to build trust and act as bridges between communities and public institutions.
7. **Increase coordination and culturally competent responses** across services.

Putting the research into practice

Although completed in October 2025, the project is already informing local practice by offering a credible insider perspective for policymakers and providers through the strengthened partnership with Hampshire County Council.

For Rehana and Sidiqi, the project opened new opportunities to get involved with International Rescue Committee (IRC) UK, first as volunteers and subsequently as staff members within the Resettlement, Asylum, and Integration programme. This role supports Afghan communities across Hampshire and enables continued, direct engagement with the populations central to the research. Sidiqi noted that: *‘yesterday we were the ones advocating, today we are the ones bringing change.’*

CPAR has equipped them with skills in stakeholder engagement and raised their professional profile. CPAR was just the beginning of a longer journey – one that has already begun to translate community-led research into meaningful and wider change.

Read the full research report here →

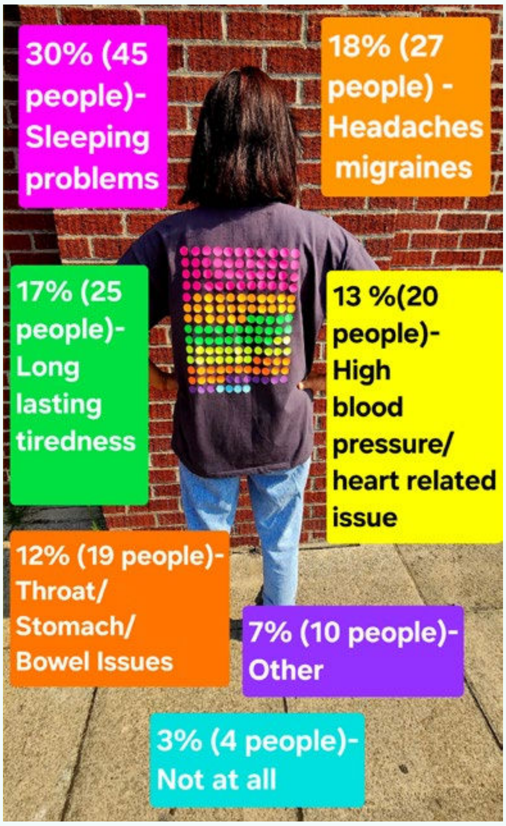
The hidden impact of conflict on health and wellbeing in Portsmouth

About the research

Portsmouth Mediation Service (PMS) works with a restorative approach to help people move from dispute to dialogue and working in partnership with local entities to address the broader social impacts of conflict. Laura Rook and Nadiya Al-Samerai's research explored how unresolved interpersonal conflict acts as a driver of health inequality and barriers to healthcare access.

Using quantitative postcode mapping, alongside qualitative and creative methods, they gathered 'real life stories' focused on three questions: the impact of conflict on wellbeing, the structural barriers to resolving disputes, and the role of partners in preventing conflict from escalating into health crises. Nadiya and Laura drew on PMS's strengths in relationship-building and respectful dialogue, noting that their restorative practice background helped them engage residents in an *'extremely relational'* way.

Portsmouth Mediation Service is a charity dedicated to resolving conflict and repairing relationships within the community. The service operates with a restorative approach, aiming to help individuals move from dispute to dialogue, and working in partnership with local entities to address the broader social impacts of conflict.



Key research findings illustrate the effects of conflict on health

Key findings

While conflict is a universal phenomenon, the research suggests it disproportionately affects communities already facing disadvantage. In Portsmouth, a city with pockets of both affluence and deprivation, high levels of social isolation and entrenched disadvantage correlate directly with higher reported levels of conflict and poorer health outcomes. Crucially, the research findings confirm that conflict is not merely a personal issue, but left unresolved on a wider scale, can escalate into a public health crisis.

- **Conflict profoundly damages emotional wellbeing:** Participants described feeling "*robbed of joy*" and "*emotionally not present*," particularly following unresolved disputes. Anxiety, frustration and hopelessness were common, with emotional strain lingering long after incidents occurred.
- **Chronic stress manifests physically and keeps the body in 'fight or flight':** Residents described skin reactions, neck pain and dangerous levels of fatigue. The report draws on the phrase "The Body Keeps Score" to illustrate how prolonged conflict embeds itself in the nervous system.
- **Conflict significantly disrupts daily functioning and social connection:** 44% of respondents said conflict affected their social life, and 24% reported negative impacts on work or studies. Isolation was a recurring theme, with individuals cut off from the support networks needed to resolve issues.
- **Communities show strong appetite for skills and agency, not just intervention:** Residents were open about trauma and actively requested training on how to raise issues constructively. This signals demand for capacity-building support rather than purely external resolution.

Insights and recommendations

1. **Implement community restorative learning** to equip residents with the practical skills to raise and respond to conflict constructively, helping to shift community reactions from 'flight or fight' to resolution.
2. **Increase visibility of services** by launching awareness campaigns to ensure residents know exactly where to turn for help, addressing the finding that a lack of knowledge is a primary barrier to resolving disputes.
3. **Establish 'Community Circles'** as facilitated, safe spaces for restorative dialogue where residents can share experiences, build mutual understanding, and foster connection.
4. **Secure sustainable investment** and move beyond short-term fixes by securing long-term funding to make conflict mediation and restorative approaches permanently accessible

Putting the research into practice

PMS is working toward its vision of Portsmouth as a “Restorative City,” where relationships are strengthened and conflict is handled with compassion. A creative writing workshop helped identify a street with particularly high levels of conflict, prompting a pilot Restorative Road project offering whole-street mediation and restorative training.

The team used a Community of Inquiry not just to present findings, but to co-design solutions with stakeholders in Community Circles, grounding recommendations in lived experience and collaborative learning.

Their work has catalysed new partnerships with the Health Determinants Research Collaboration (HDRC), the Integrated Care System (ICS), and the University of Portsmouth, leading to joint bids for future research and embedding PMS’s approach within the wider public health landscape. They have also secured funding for a follow-on project – Conflict, Health Impact and Restorative Interventions – to co-design community-wide restorative approaches and deepen understanding of how conflict shapes health over time.

Researchers reflected that their restorative practice skills were a *‘unique selling point’*, helping them build trust, hold sensitive conversations, and engage participants in deeply relational ways – strengthening both the research and PMS’s future work.

Read the full research report here →

Watch videos made for this project on Portsmouth Mediation Service’s website →

Examining the alienation of older adults due to increasing digitalisation and the challenges in accessing personalised healthcare

About the research

SPARK Community Space is a Portsmouth-based charity, with a vision of providing 'a place for anybody who feels like a nobody to be a somebody,' by tackling isolation and loneliness and supporting people navigating through significant life changes. First founded during the Covid-19 pandemic as an online gathering space, SPARK now operates physical spaces which support both community members and volunteers to 'get their spark back'.

Roshni Barrass and Emily Burt's research explored how increasing digitalisation within healthcare systems is contributing to feelings of exclusion, anxiety, and isolation among older adults, and affecting their ability to access the health system. They used a mixed methods approach involving suggestion boxes and questionnaires. They also collected seven personal stories which were compiled into a short film, allowing participants to share their experiences in their own words.

Spark Community Space volunteers and research participants, who shared experiences about the effects of digitalisation on older people

Key findings

As health services increasingly rely on digital systems for appointments, communication, and information, older adults can face significant access barriers, with broader implications on mental and social well-being. The research revealed widespread frustration and feelings of exclusion among older adults when navigating digitally driven healthcare systems:

- **Negative experiences:** Of the 26 questionnaire respondents, 16 reported negative feelings about their healthcare experiences.
- **Alienation and confusion:** Participants described feeling displaced by technology. One respondent remarked, *'It's like you're an alien,' while another admitted, 'I get confused with the phone… I don't know how.'*
- **Systemic pressure:** Many felt responsibility was shifted onto individuals rather than systems adapting to their needs. As one participant explained, *'The onus is on the person not the system. It's frustrating.'*
- **Perceived judgement:** Participants reported feeling judged by staff for lacking digital skills, noting assumptions that *'everyone does internet' and that staff can 'look at you like you're stupid if you don't have technology.'*
- **Stoicism and lowered expectations:** The researchers observed a stoic or passive approach to healthcare among older adults, influencing how much difficulty they tolerate and what level of care they expect.

Insights and recommendations

The report sets out a clear strategy focused on recognition, representation, and accessibility:

1. **Recognise digital inequality** by formally acknowledging the inequalities created by increasing digitalisation within healthcare systems.
2. **Strengthen representation** by ensuring older adults have advocacy and representation in healthcare decision-making processes.
3. **Preserve non-digital access routes** so that older people are not excluded.
4. **Improve personalised access** plans within GP surgeries and other healthcare settings.

Putting the research into practice

By producing recorded personal stories in a short film format, the research team created a powerful resource to communicate lived experiences directly to GP surgeries, the NHS, local councils, and wider health and care stakeholders.

Intended to support presentations and discussions with those ‘who have the power and passion to influence change,’ the film serves as a visceral and deeply human means to capture and project older adults’ voices, ensuring that their perspectives and experiences are heard within conversations about service design and accessibility.

The film has been shared publicly online, and in November 2025 was also screened at a Portsmouth-focused CPAR showcase, hosted by SPARK (in partnership with Portsmouth Mediation Service and Work Better Innovations). While the showcase was a chance for residents to learn about the organisations’ community-focused CPAR projects, it also provided a valuable forum for discussion and feedback from community members.

Overall, the project reinforced the value of community-led, creative approaches in capturing nuanced experiences and translating them into compelling, accessible evidence for change. The researchers emphasised the importance of centring accessibility throughout the research process itself, ensuring that participation did not replicate the very exclusions under investigation. They also highlighted the need to be attentive to different interpretations of concepts such as ‘inequality,’ and to understand the particular tolerance levels and expectations of care held by older generations.

View slides about this research here →

Migrant women’s barriers to accessing menopause care: Insights from Portsmouth

About the research

Work Better Innovations (WBI) is a community interest company dedicated to delivering community-based solutions to global challenges affecting vulnerable populations. Founded by minority women with lived experience of migration in Portsmouth, WBI strives to drive transformative change from the community level with a focus on tackling health and employment inequalities.

Initially inspired by stories shared at a community event on difficulties accessing menopause care, Anita David, and Fatma Tuylu’s research examines how cultural silence, stigma, and language barriers act as hidden drivers of medical isolation and health inequality for migrant women.

The research took a mixed method, community-led approach, centred on the lived experience of women from a wide range of migrant backgrounds, focusing on those voices often underrepresented in health research. The researchers wanted to understand how migrant women experience menopause within the UK healthcare system, and why many remain unsupported despite significant physical and emotional symptoms.

Anita David at the CPAR 2025 Showcase

Key findings

The research revealed that barriers to menopause care for migrant women are shaped by the interaction of cultural norms, language barriers, and healthcare systems that are not designed with diverse experiences in mind. Together, these factors contribute to delayed care, unmanaged symptoms, and feelings of invisibility.

- **Cultural silence and stigma:** Menopause was widely described as a taboo topic, contributing to what researchers called "psychological denial," where women minimise or suppress symptoms to avoid associations with ageing or loss of femininity. Many therefore endure significant discomfort without seeking help.
- **Barriers to healthcare access:** Over half of participants (53.8%) had never spoken to a healthcare professional about menopause, despite experiencing symptoms. Language barriers were central – 64% reported difficulty communicating with doctors. Many felt their symptoms were 'not serious enough,' reflecting cultural expectations and limited information about care options.
- **Confusion and mistrust around treatment:** Women often received generic, 'one-size-fits-all' advice lacking cultural sensitivity or clear explanation. Some were prescribed HRT without adequate information, leading to fear, uncertainty, and in some cases discontinuation, reinforcing mistrust in healthcare services.
- **Reliance on informal networks:** Family and community networks were the most common source of menopause information (52%), while only 25% relied on healthcare professionals. These networks provided reassurance but also perpetuated misinformation and normalised suffering, contributing to delays in accessing effective care.

Insights and recommendations

Improved access to menopause support needs a multifaceted approach, including community engagement, inclusive communication, and culturally competent care.

1. **Develop more culturally sensitive healthcare services**, including cultural awareness training for healthcare providers, tailored and culturally appropriate information resources and female healthcare professionals to increase comfort and engagement.
2. **Improve community-based education and awareness**, including community-led support and discussion groups, incorporating menopause education in existing health services, and targeted health workshops in community centres where women feel safe to discuss menopause-related issues.
3. **Improve language accessibility and ensure clear communication**, including NHS resources on menopause available in multiple languages; offering interpretation services for menopause-related queries through NHS helplines and clinics; developing video explainers and infographics in different languages to simplify medical explanations for women with low literacy.
4. **Engage families and work towards changing social norms**, including information sessions for male family members; educational sessions where mothers and daughters learn about hormonal health together; use of platforms like WhatsApp, Facebook, and community radio broadcasts to share menopause education in a culturally accessible way.

5. **Improve healthcare access and care**, including specialist menopause clinics in areas with high-migrant populations; social prescribing and GP-initiated referrals to menopause education and support networks; flexible appointment scheduling; regular check-ups and systematic routine appointments (e.g. cervical screening) for women over 30 or 35; and technology-based support (e.g. multilingual mobile apps where women can record symptoms, track changes and prepare for appointments).

Putting the research into practice

The findings have already contributed to dialogue and advocacy surrounding migrant health and wellbeing at both local and international levels. In February 2025, WBI participated in the review of the UK's implementation of the International Covenant on Economic, Social and Cultural Rights at the United Nations in Geneva. Anita David and Fatma Tuylu joined civil society organisations to highlight health inequalities affecting migrants, asylum seekers, and refugees.

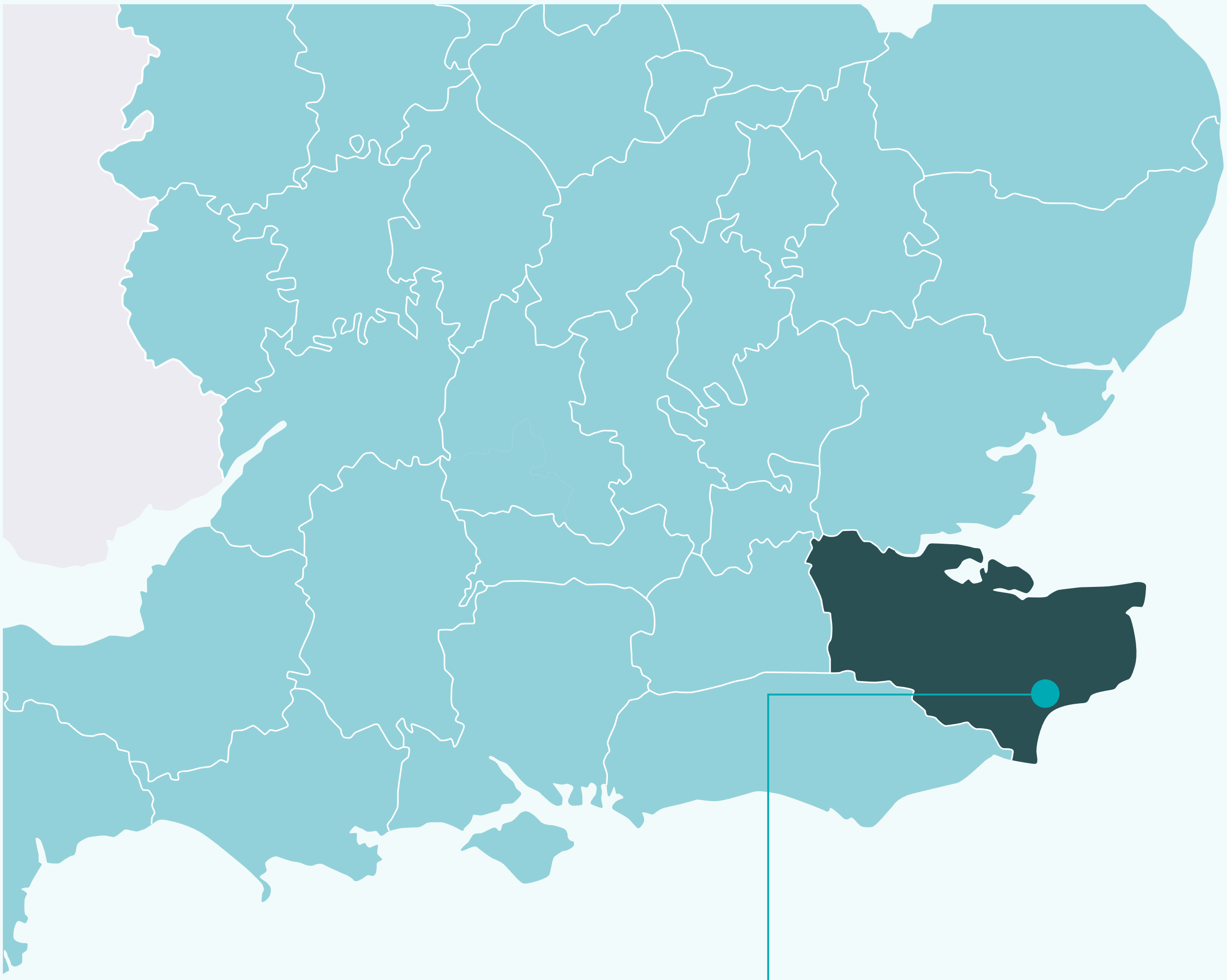
Anita and Fatma have also presented their findings at the NHS England Southeast Women's Forum, the Southeast Communities of Practice and the Learning and Improvement Network event (focussing on Women's Health and Gynaecology).

Locally, WBI shared the findings through its *Food with Friends* forum, bringing together research participants, stakeholders, and community members in Portsmouth and creating space for shared reflection, validation of lived experience, and discussion about how services can respond more effectively.

Anita reflected that, *'one of the most fulfilling aspects of the project was seeing participants transform — from initial hesitation to confidently sharing their stories.'* As a migrant woman herself facing many of the challenges expressed in the research, she felt that her lived experience allowed her to accurately represent the voices of women often overlooked in mainstream research. For Fatma, in addition to developing new research skills, hearing other women's stories prompted her to seek specialist care and begin HRT, significantly improving her quality of life. Both researchers reflected on the 'power of community research to drive real change' highlighting how lived experience, building trust, and sharing stories are not only powerful research methods, but essential tools for enabling lasting, meaningful positive outcomes.

Read the full research report here →

Journeys in research: Kent and Medway



Folkestone Nepalese community:
Barriers to health service access

Folkestone Nepalese community: Barriers to health service access

About the research

Folkestone and the surrounding areas of Kent are home to one of the largest Nepalese communities in the county. Long-standing links with the British Army, particularly the settlement of former Gurkha soldiers and their families, have resulted in a well-established population. It is a population with distinct health needs. Around two-thirds of Nepalese people in Folkestone are aged 55 or over, and nearly half live with two or more long-term health conditions.

As volunteers for The Folkestone Nepalese Community, Abesh Rai and Swechchha Rai, had first-hand experience of some of the issues affecting people's access to care, having supported many individuals with appointments, translating NHS communications and health education. They chose to focus their research on the barriers to health service access for Nepalese residents in Folkestone. The study specifically focused on health inequalities affecting individuals with multimorbidity: the co-existence of two or more long-term health conditions.

Abesh and Swechchha used a mixed methods approach involving focus groups, a survey (receiving 100 responses), and in-depth interviews. They actively assisted community members to take part in the research process by helping complete surveys, ensuring the voices of those with lower literacy were captured. They found linguistic and cultural factors led to significant barriers to healthcare.

Research participants from Folkestone Nepalese community

Key findings:

This report isolates data on the subgroup of people with more than two conditions to highlight the specific challenges:

- **Digital exclusion:** The shift to 'digital by default' in the NHS has created new barriers. 81% of participants with multiple conditions cited online booking systems as their biggest challenge. One participant noted: *'I don't know how to use e-consult. I don't have the digital skills.'*
- **Language barriers:** 72% of people with multimorbidity reported that they 'never' or 'only sometimes' had access to translation services.
- **Worsening health:** 49% of the multimorbid group felt their health had worsened due to access difficulties. One participant expressed the toll this takes: *'I can't sleep well at night.'*
- **Systemic delays and impact:** Long wait times led some residents to seek care abroad. One interviewee stated: *'I had to wait for many months, so I had to go to Nepal to have my treatment.'* Another focus group participant shared: *'I was so tired of waiting so I have to go back Nepal for the treatment. Upon returning provided all the medical reports, [and] finally, was given an appointment.'*

Key recommendations:

The participants overwhelmingly endorsed specific solutions to improve accessibility:

1. **Address language barriers and culture differences**: 100% of multimorbid participants recommended enhanced language support services, and 98% called for cultural awareness training for health professionals.
2. **Adapt to peoples' communication preferences** and acknowledge the strong preference for non-digital communication which allows for community support. Participants stated: *'Our preferred mode of communication with GPs are letters. We can show the letter to someone who know English to translate it for us.'*
3. **Maintain face-to-face interactions to build and maintain trust**. As one participant explained: *'I would like to see doctors face to face as I feel more assured.'*
4. **Go out to where communities gather**. 96% of the multimorbid group supported increased community outreach initiatives.

Abesh and Swechchha concluded that the lack of translation services for multimorbid patients is 'alarmingly' high. They observed that for this community, medical interactions are not just transactional but relational. They noted that seeing doctors face-to-face 'carried cultural significance, as it fostered greater trust and reassurance,' allowing for a sense of 'being genuinely cared for' that was missing in remote consultations.

They emphasised that addressing these issues requires a 'coordinated response from local health authorities, community organisations, and policymakers' to ensure this vulnerable community receives the support it deserves.

Putting the research into practice

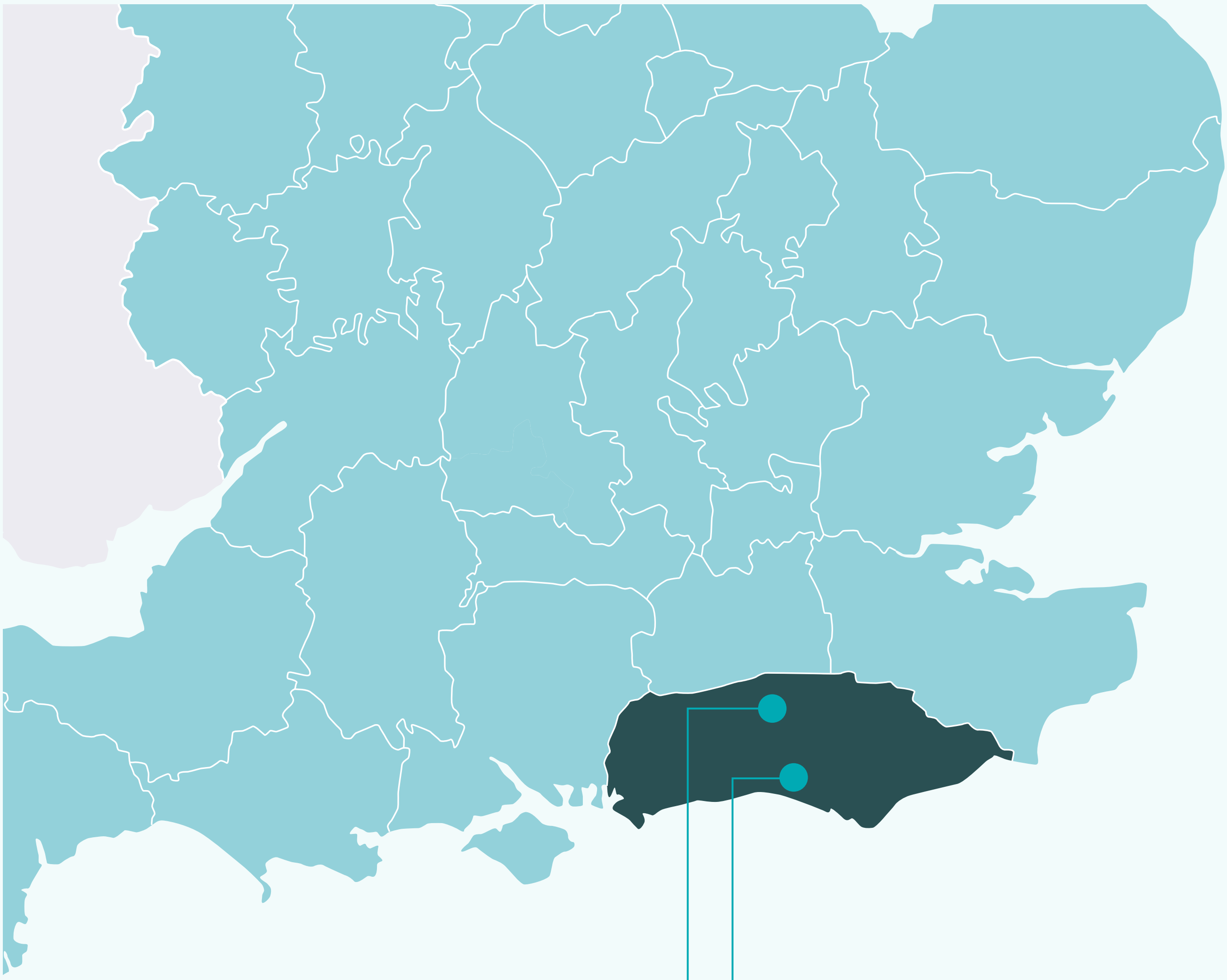
Since completing the research, the Folkestone Nepalese Community has been taking forward new relationships and opportunities shaped by their findings. They are working with a local Armed Forces Champion to support Gurkhas and their families – for example, encouraging people to register as armed forces family members on their medical records so that NHS staff are aware of their circumstances and can refer them to specialist care when needed. They are also in discussion with the Patient Participation Group to encourage local GPs to register as armed forces champions, and the community centre will host Carers Support East Kent to increase awareness of available support.

The research findings are also being used to strengthen new funding applications. The project had a significant impact on the researchers themselves. Abesh described gaining confidence, skills, and a deeper understanding of ethical, community-based research. Training and mentoring helped him see research as a collaborative process and reinforced the importance of keeping community voices central to decision-making. Being connected to wider networks broadened his perspective on partnership working, trust and shared ownership, and motivated him to take on new responsibilities, support others to share their stories, and explore future research and community development roles.

Both Abesh and Swechchha noted feeling more confident contributing ideas, sharing personal experiences and taking initiative in work centred on community voice. The programme encouraged them to pursue further learning and opportunities. Reflecting on the overall experience, Abesh highlighted how listening to “hidden stories” and turning them into meaningful evidence strengthened his belief in the power of community-led research: even small shifts in confidence and practice, he noted, can create lasting impact for individuals, organisations, and communities.

Read full research report here →

Journeys in research: Sussex



Community voices: Barriers, strengths and actions

Health and accessibility needs of the Chagossian community: Improving local services and health outcomes following demographic change

Community voices: Barriers, strengths and actions

About the research

The **Trust for Developing Communities (TDC)** is a community-focused organisation based in **Brighton and Hove**. The organisation is committed to inclusion, equality, and community empowerment, and put together a research team with extensive lived experience to engage residents facing social, health, and structural inequalities.

The primary aim of the project was 'to ***understand hidden barriers experienced by marginalised communities in accessing services and support, and to identify community-led actions that can strengthen wellbeing, belonging, and equity.'*** The research focused on residents from racially minoritised communities, migrants and refuges, LGBTQ+ residents, neurodiverse residents, disabled residents, and those on low incomes. Other participants also engaged in the research including people with multiple health conditions, carers and people experiencing isolation or mental health challenges.

Over 12 months, Maha, Fatima, and Sara engaged over 110 participants through interviews, focus groups, surveys, and extensive participatory observation through their roles as community engagement and development workers. They documented the lived realities and everyday challenges residents faced when navigating health, social care, and public services, with the aim of amplifying voices and coproducing local solutions.

Left: TDC walking group. Right: Researchers Maha, Sara and Fatima

Key findings

Findings reveal hidden barriers related to language and communication, digital exclusion, discrimination, fragmented systems, and insufficient outreach, which restricts people's ability to access services, understand their rights, and thrive:

- **Accessibility and digital exclusion:** The increasing reliance on digital-only access (e.g., apps, online booking) excludes those with low digital skills or limited data. Furthermore, the language used by services was often "full of jargon," making it inaccessible to many residents.
- **Racism and discrimination:** Participants reported incidents of discrimination in healthcare settings, on public transport, and in public spaces. These experiences were compounded by a lack of clear reporting routes and insufficient bystander intervention, which significantly impacted residents' mental health and willingness to access support.
- **The Power of community connection:** In contrast to statutory services, local community groups were identified as essential sources of safety. Mixed-identity groups (varying ages, cultures, and abilities) fostered belonging and trust, acting as a bridge to help residents overcome system barriers.
- **Lack of representation:** A lack of diversity in staff teams often led to mistrust and miscommunication. The findings highlighted that poor cultural awareness contributed to misdiagnosis and inadequate follow-up care. Conversely, culturally appropriate, women-led support was described as "transformative".

Insights and recommendations

1. **Improve accessibility** by reducing jargon, simplifying written materials, and – crucially – increasing alternatives to digital-only access (e.g., face-to-face or phone options).
2. **Support community connection** by strengthening localised provision by investing in long-term funding for neighbourhood-based community groups and health support.
3. **Increase awareness about their rights**; resource peer support and co-produce education materials tailored to specific communities.
4. **Tackle racism and discrimination** by strengthening anti-racism infrastructure and developing accessible reporting pathways for discrimination and ensuring transparent follow-up; support campaigns addressing racism on public transport and in public spaces.
5. **Mandate cultural awareness and trauma-informed practice training** for service providers to reduce the distress caused by "lack of empathy" in interactions; embed community voice in service design and create systemic feedback mechanisms.
6. **Invest in diversity and cultural competence within services**, involving community researchers in the co-design of future programmes.

Putting the research into practice

Maha, Fatima, and Sara's research highlights the protective role of community connection, peer support, advocacy, and culturally responsive, neighbourhood-based provision. Local groups act as lifelines for belonging, confidence and improved wellbeing, and the research has already led to new multicultural women's groups, more accessible walking programmes, and voluntary digital support services. It has also helped strengthen cross-organisational collaboration, including partnerships with mental health charities and a neighbourhood health hub. Maha has since secured a place at Sussex University to complete a PhD.

The researchers reflected that working together was one of the most rewarding aspects of the process. Comparing experiences across different communities helped them deepen their understanding of inequality, challenge assumptions and build confidence as researchers. They described how training and ongoing support strengthened both their skills and self-esteem, positioning their organisation to grow and advocate for change. A key outcome, they noted, was gaining deeper insight into the breadth of experiences across Brighton & Hove: despite diverse backgrounds, many residents benefited from the same actions around accessibility – making a strong case for services to pay attention and act. They were also struck by how willing and passionate people were to share their stories, reinforcing the value of trust and safe spaces in community-led research.

Read the full research report here →

Health and accessibility needs of the Chagossian community: Improving local services and health outcomes following demographic change

About the research

Citizen's Advice West Sussex (CAWS) is an independent local charity and member of the national Citizen's Advice Network. While its primary function is to provide accessible information to help individuals resolve problems, CAWS also identifies as a 'learning organisation,' using community voice and insight to influence systems change in and around West Sussex.

Amy Marshall, Catalina Gheorghe, and Tessa Ramrajsingh's research explores the health inequalities and barriers faced by the Chagossian community in Crawley.

Crawley is home to the UK's largest Chagossian population, a community with roots in the Chagos Archipelago, with over 3,500 individuals settling in the town since the introduction of a new UK citizenship route in 2022. The community faces significant health inequalities, with 56% of participants disclosing a health condition or disability. Through a mixed method, participatory approach, researchers sought to understand if changes to migration and demographics creates new accessibility or service needs.

During the research process, Amy, Catalina, and Tessa reflected on how essential it was to build relationships with the community in culturally sensitive ways. They realised early on that typical research methods were unlikely to work, and that more informal, trust-building approaches often led to greater engagement and richer insight. To strengthen this relational approach, Tessa – who has lived experience of the community's challenges – was recruited, helping to create the safety and trust needed for meaningful participation.

CAWS research team with members of the Chagossian community

Key findings

Researchers asked community members how they manage their health, navigate daily responsibilities, and interact with local services, and found a close link between deprivation and health inequalities. Their findings reveal:

- **Immediate survival needs routinely take precedence over healthcare:** Urgent basic needs such as housing and food often overshadowed medical care, particularly for recent arrivals facing instability. This led to delayed treatment, missed medication, and deterioration of existing conditions.
- **System-level barriers prevent effective access to care for most participants:** 86% of people faced barriers including digital exclusion, language barriers, sociocultural misalignment and administrative delays ("failure demand"), resulting in unmet needs, prolonged uncertainty and growing distrust in services.
- **Limited knowledge and confidence restrict people's ability to navigate healthcare systems:** Individuals struggled to understand their rights, manage charges such as the immigration health surcharge, and complete administrative tasks like benefit applications or interpreting hospital letters. Many lacked confidence to self-advocate, relying instead on word of mouth, which contributed to misinformation.
- **Widespread housing insecurity directly undermines health outcomes:** 70% of participants experienced housing insecurity, including overcrowding, sofa surfing and temporary accommodation. Poor conditions such as damp, mould and lack of cooking facilities exacerbated asthma and respiratory problems.
- **Immigration and welfare bureaucracy creates persistent barriers and psychological strain:** Passports held by the Home Office, lack of a fixed address, and requirements for UK-based guarantors restricted access to services. Prolonged waits for housing and benefit decisions intensified uncertainty and negatively affected mental health.

While the community is resilient, many are 'slipping through the cracks,' due to systems that assume a level of stability, literacy, or accessibility. Despite the systemic failures and lack of trust, research participants were keen to contribute to positive change, offering thoughtful recommendations, largely focused on building capability and confidence.

Insights and recommendations

The report's findings make clear the need for more person-centred, responsive, and culturally sensitive healthcare systems. The team advocates for an **empowerment-based approach** to service design, which increases accessibility, promotes prevention, and supports self-advocacy, at the individual, neighbourhood, and system levels.

1. **At the individual level**: Build individuals' knowledge, confidence, and skills to navigate systems independently and take greater control over their lives, for example by expanding access to language classes to support self-advocacy and bolster confidence.
2. **At the neighbourhood level**: Enhance how information and support are delivered. For instance, through establishing neighbourhood health centres as trusted spaces for learning and engagement, using plain language and visual tools to explain rights, available support and how systems work.

3. **At a systems level**: Adopt a holistic approach where housing, education, and health services work in partnership to address the root causes of inequality, bringing community organisations and statutory services into greater alignment.

Putting the research into practice

By deepening understandings of individual experiences and unmet needs, the research project enhanced CAWS' work with the Chagossian community, informing service design, accessibility, and impact on wider health outcomes. Staff training in the CPAR approach has enabled lasting impact for the organisation by *'laying the foundation for a sustainable legacy of inclusion, learning, and system change.'* The deep community engagement undertaken in this research has provided an invaluable platform for individuals facing these challenges to share their experiences and help shape future solutions.

Since completing the fieldwork CAWS has seen an uptake in Chagossian participants in their beginner's English language classes, where participants can learn language skills and build their capacity to navigate UK systems independently. Since CPAR, over half of the participants in these classes are now Chagossian, effectively acting as an 'upstream preventative measure' for improving access to healthcare.

The project has helped raise the profile of CAWS as a trusted entity, reducing friction between local services and making inter-agency referrals. The process also strengthened relationships with key advocacy groups such as Chagossian Voices and the Chagos Action Alliance Committee, strengthening partnerships that can inform future service design and delivery.

The team has also shared their findings with the local council team responsible for addressing temporary accommodation issues and is keen to feed into national conversations following the prominence of temporary accommodation in the most recent Autumn Budget.

The researchers described CPAR as a *'validating'* experience. It provided a platform to build confidence, particularly in public speaking and presenting findings to large groups. For Amy, the process revealed a strong interest in research, sparking a desire to pursue research opportunities.

Read full research report here →

Conclusion

This CPAR cohort has demonstrated that when inquiry is rooted in lived experience and embedded in cross-sector partnerships, it produces insight that systems can act on quickly and credibly. It helps statutory organisations test assumptions, adapt services, and retain flexibility under pressure while maintaining quality, value, and shared responsibility. This work comes at a time of significant public sector reforms across Department for Health and Social Care, NHS England, Integrated Care Boards and Local Government. A Community Participatory Action Research approach is critical to ensure that communities are not only engaged and heard, but are actively shaping and informing the design and delivery of services during this period of transformation.

At its core, CPAR shifts involvement upstream, from feedback after decisions towards intelligence that shapes them in real time. This aligns with current policy emphasis on prevention, patient empowerment and care closer to home, positioning community researchers as a standing resource for system learning.

Because it is led by insiders – people trusted within their communities – this work surfaces realities that routine data misses: the mechanics of digital exclusion, the health impacts of damp housing, the interplay of trauma and hormonal health, the cultural meaning of face-to-face care, and the public-health consequences of unresolved conflict. In doing so, it reduces stigma, supports behaviour change, and generates practical, culturally grounded solutions.

The case studies in this report demonstrate action already underway, for example:

- **Encouraging prevention and self-management:** From Caribbean blood pressure peer-monitoring and culturally resonant dance exercise activities to women-led wellbeing hubs and menopause support, community researchers are translating insight into local, preventative action.
- **Highlighting access and inclusion issues:** Projects in Folkestone and Portsmouth highlight the costs of 'digital by default' and language barriers for older adults and migrant communities – prompting new ESOL and digital skills classes, clearer non-digital routes, and advocacy to maintain human, relational access.
- **Highlighting the link between housing and health and making the case for greater accountability:** Oxford research reframed poor housing as a root cause of ill-health, catalysing engagement with ICBs, advice services and local initiatives focused on enforcement, redress, and rapid repair.
- **Developing restorative models for mental wellbeing:** Portsmouth's work links interpersonal conflict to health inequality, moving from findings to Restorative Road pilots, Community Circles, and multi-agency partnerships with HDRC, ICS and the university – backed by follow-on funding.
- **Enhancing neighbourhood-based support and representation:** In Brighton & Hove, trusted local groups and women-led spaces are strengthening belonging and access, while training and collaboration build capability across organisations.

- **Responding to demographic change:** In Crawley, CAWS' research with the Chagossian community has informed service design, boosted uptake of beginner's English classes as an upstream measure, and deepened partnerships to improve access and outcomes.

Across the programme, shared messages are clear: default-digital pathways exclude those with high need; language barriers and low cultural sensitivity erode trust; health and wellbeing are inseparable from housing, safety, and social connection; and people engage best through trusted, relational, community spaces.

Crucially, CPAR also builds leadership. Researchers describe gains in confidence, skills, and credibility – moving into employment and advocacy roles, brokering partnerships, and influencing local strategies. This strengthens organisational capacity and sustains impact beyond the life of individual projects.

What this means for partners

- Primary care and providers: Keep non-digital access open, adopt whole-person, trauma-informed practice, and make warm, relational referrals to community supports.
- Commissioners and funders: Resource access as well as activity; invest upstream in prevention, co-design, and cross-sector collaboration; and create outcomes that reward partnership working.
- VCSE organisations: Continue to offer trusted spaces, advocacy, and cultural translation – partnering confidently while protecting capacity and mission.

The CPAR approach offers a great resource to those wanting to design and deliver services that address health inequalities. By maintaining community-led inquiry alongside commissioning and service design, partners can spot emerging needs, act sooner, and measure what matters to people. The results are already visible across this cohort: stronger partnerships, improved access, early-intervention offers, a more confident and empowered workforce, and new routes for influence and funding – laying the foundations for better health and wellbeing for everyone.

Further reading

Current policy and guidance that highlight the need for more community engagement:

- UK Policy Framework for Health and Social Care Research, which requires the involvement of patients, service users, and the public in setting research priorities and shaping design.
- Fit for the Future: the 10-Year Health Plan, which commits to designing services on people's own terms and co-creating Neighbourhood Health Plans with local authorities and VCSE partners.
- Inclusion Health Framework and ICS legal duties, which require ICBs to reduce inequalities in access and outcomes and recognise the importance of community-led insight in identifying groups that are often overlooked.
- Public Services (Social Value) Act 2012, which requires commissioners to consider social value, including trust, engagement, and community benefit.
- NHS England commissioning guidance on community health services, which emphasises the use of research and lived experience to avoid operational and access failures.
- Hewitt Review (2023), which argues for a shift toward prevention and tackling inequalities, noting that services designed with communities support greater self-reliance and reduced demand on public services.
- Fuller Stocktake (2022), which calls for integrated teams rooted in communities, drawing on VCSE expertise to understand local social, cultural, and demographic factors.
- Model Integrated Care Board Blueprint (v1.0, May 2025), which highlights the need to engage underserved communities to develop a dynamic understanding of population needs and generate actionable insight for service design.