Mile in My Shoes: Charles' story

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My name is Charles Kwaku-Odoi. I'm a Ghanaian father, brother, uncle. I've lived in Manchester since 2002.

So, Chief Exec for the Caribbean & African Health Network, which is a Black-led national charity working with the Black community, but also policymakers, service providers. Then I'm a church leader, a senior pastor for Common Prayer Centre Ministries International. So, it means I get to sit on a couple of regional boards that are in relation to population health. I'm a patient and public voice partner for NHS England. You know, different hats, different roles, but I turn up because someone's voice needs to be heard on behalf of other people.

When I set up a food bank, that has been running for 10 years plus, and we are an independent food bank run by Christian volunteers. We don't turn people away. We look at how we can support and signpost people beyond the food. In the last year we've seen a lot more demand for food parcels, even higher than we saw during the peak of the COVID-19 pandemic. But with the cost-of-living crisis, where you have people actually in work, but you still need food parcel to survive. And it's really biting, and we see that firsthand where people can't quite cope.

We've had cases where someone is in work, gets injured, but because for all these years they've never been able to put life insurance in place or illness cover, then everything comes crumbling down.

I was born in Ghana, schooled in Ghana, came over in 2002 to do a Master's. On the journey, someone advised me, 'If you want to get a job then volunteer.' So volunteered with a British Red Cross. And whilst volunteering, went freelance, did lots of interfaith work, community health development. And I remember in 2012, receiving a phone call from someone working with Terrence Higgins Trust – in the leading national organization on HIV. Went along to training, and on the back of that did two, three years of engagement. We've seen decreasing transmission in the… white gay community, but not so much in the Black African community. They said they thought church leaders could help.

And then fast forward, working across Greater Manchester, our chair, who was doing a PhD running focus groups, people ask her what she was going to do with the data. And she said, 'Oh, you know, she's going make sure that it didn't sit on the shelf because people said they get consulted and nothing happens.' Ten of them came together set up as a CIC and after a month or two I joined. And I just believed in the vision and something that was focused on the Black Caribbean African community because faith is a key part, so even if people don't go to church there's that recognition.

When we were set up, we were knocking on doors trying to say, 'Black people have really poor health outcomes.' Our women unfortunately four times more likely to die during childbirth with complications. We're twice more likely to have stroke, high rates of hypertension, obesity, lupus, fibroids, you name it. And we weren't getting the traction. And the pandemic struck – data shone a light on that. The elephant in the room is usually the resource. This is all we've been seeing, the data year in, year out, but we don't know quite where to start from. And sadly, the other frustration is usually when people say, 'Oh well, if we start this for the Black Caribbean and African community, then the South Asian communities are gonna say what about the Chinese community?' And what we say is, 'When you do something for one group, it's really important to monitor, evaluate, pick the learning, and then you explore how that can be applied to other groups. Because we will never have enough resource to do everything at the same time. So, you've got to start from somewhere.'

So, for the Caribbean & African Health Network, we've had to really evolve over the last seven years, having started without any legacy, money or investment. And at the moment, we place the work we're doing in three buckets. So, one is working with sectors and systems. The other is working with our community. And then the other element is lots around influencing and policy and research. And one of the challenges within public sector and other spaces is people sometimes don't know where to start and how to start. When it comes to your social value or it comes to your corporate social responsibility, what are the things that are important to you, how might we work with you? When it comes to our community, it's about improving health literacy and raising awareness. But then also, how do we equip people to know, in quotes, 'They are right'.

We came up with things that were the problem, why we needed to exist. First was lack of trust. The messenger is as good as the message because of the historic lack of engagement, lack of a sense of value for our people and what really matter to us. Then people are like, 'I will never trust you; you never have my vote.' So, we run trainings for GPs, for example. And we say to them, 'If you want to get better outcomes from your Black patients. If someone has high blood pressure, you prescribing them on tablets and ask them, "Do you have herbal remedies? Is there any other thing else you take?"' And these are the things that make people think, 'Oh, you know me. Yeah, you've taken interest in me rather than just, "Oh, it's 10 minutes, out of the door and go away".' When you begin to address the historic stuff and then you bring in – okay, it's a faith that is in the way or needs addressing. Or is it your cultural norms and belief that we need to talk about. It makes huge amounts of difference.

Every Saturday morning would have a Black Caribbean or African doctor that presents on Zoom, live stream to YouTube, Facebook and LinkedIn and they will pick one of those health conditions which we know has stark inequalities or outcomes for our community and they present on that and they can take questions from the general public. And all the stuff around the policy research and influence it, so we will support various university research to make sure Black people's experiences is fed into that research, whether via focus group or interviews.

What we had to do right from the outset was to make the case that we can't have someone else coming to save our community. We've got to take responsibility. Historically, the community has been described as hard to reach, which we know is not true. And I say to people, 'You want low hanging fruits, on a Sunday just look in your neighbourhood. There will be a Black majority church that you could go in and engage with 40, 50 people.' There are sections within our community that feel there's an agenda to westernize them. And I say, 'It's not that they have a problem but psychologically, especially for migrants who may have spent 20, 30, 40 years in a country where they pay for healthcare just because they are here.'

There has to be that engagement, there has to be that education, there has to be that awareness.

What we need is for you to say, 'This is a slice of cake in terms of the national funding and the resource out of the taxes we all pay.' We do three, four jobs to pull through and to survive and we are capable, proven over the decades. We've contributed to various spheres. You know, why don't we have senior Black people in the leadership in the NHS across the country? Whereas we, Windrush, arrive two weeks before the start of the NHS. So, it has to start from trust. Stop giving us middlemen and middlewomen, you know, who are not from the community, as saviours. You will sit around the table and value us as equal players and say, 'This is the financial envelope we have. What do you think you could do to improve XYZ?' There's more work to be done. We're making progress We're not short of data. But we are here. We're not going anywhere. We will not vanish.