

# Health and social care services for minority ethnic communities in the United Kingdom: a review of the literature on access and use

Lisa Arai and Seeromanie Harding



**MRC Social & Public Health Sciences Unit**

**Occasional Paper No 9**

**June 2002**

MRC Social & Public Health Sciences Unit,  
University of Glasgow,  
4 Lilybank Gardens,  
Glasgow, G 12 8RZ.  
Tel: 0141 357 3949  
<http://www.msoc-mrc.gla.ac.uk/>

**MRC**  
Medical Research Council

## Contents

<u>Acknowledgements</u>	2
<u>Section one: background, method and summary of results</u>	3
<u>Background</u>	3
<u>Method: search strategy and results</u>	4
<u>Summary of the literature reviewed</u>	8
<u>References</u>	11
<u>Section two: the research literature</u>	16
<u>Layout of the review</u>	16
<u>2.1) General and miscellaneous health and social care services</u>	16
<u>2.2) Asthma</u>	55
<u>2.3) Cardiovascular health</u>	59
<u>2.4) Children</u>	64
<u>2.5) Dental service use</u>	70
<u>2.6) Diabetes and hypertension</u>	73
<u>2.7) Disability</u>	75
<u>2.8) Ethnic elders</u>	78
<u>2.9) Eye conditions</u>	89
<u>2.10) HIV/AIDS</u>	90
<u>2.11) Head injury</u>	94
<u>2.12) Hospice and palliative care</u>	95
<u>2.13) Mental health</u>	97
<u>2.14) Renal care</u>	121
<u>2.15) Sickle cell and thalassaemia</u>	123
<u>2.16) Substance use and abuse</u>	129
<u>2.17) Travellers</u>	130
<u>2.18) Women's sexual and reproductive health</u>	131

*Acknowledgements*

The authors would like to thank Mary Robins and Kennedy Cruickshank for their help and advice during the writing of this review.

## **Section one: background, method and summary of results**

### *Background*

In this literature review, we present details of research on access to, and use of, health and social care services among minority ethnic communities in the UK. There are two principal reasons why such a review is necessary.

Firstly, though there is a large body of research on disease patterns among migrant ethnic groups—mainly the Irish, south Asians and West Indians (Balarajan and Bulusu, 1990; Davey Smith et al., 2000; Harding and Maxwell, 1997; Marmot, Adelstein and Bulusu, 1984; Modood et al., 1997)—less is known about the cause of these patterns. For example, excess cardiovascular disease mortality among south Asians, excess hypertensive-related mortality among Black Caribbeans and excess mortality from a range of causes among Irish people is well documented. Yet the cause of the excess mortality in these groups has not been established, and much research is targeted at attempting to quantify the effects of social, biological or genetic factors on mortality.

Many authors observe that environmental and risk factors relating to social disadvantage, diet and lifestyle play an important role in explaining the patterns of chronic disease mortality and morbidity among ethnic groups (Modood et al., 1997). Social and economic disadvantage, as measured by labour market participation rates, occupational class and standard of living, is greater among Pakistanis, Bangladeshis, Black Caribbeans and Irish compared with the general population in England and Wales (Berthoud, 1999; Modood et al., 1997). Health-seeking behaviour and use of health and other services may also be an important factor. Differential access to, and use of, health and social care services may help explain the pattern of mortality and morbidity in some minority groups.

Secondly, although minority ethnic populations have lived in the British Isles for many centuries, it is only in the last twenty or so years that attention has been given to their health needs (McNaught, 1988, 1985) though there is a need for further research in this area. After the large-scale, post-war migration of many minority groups, a consideration of their health needs did not begin until the late 1970s. McNaught (1988, 1985) provides an account of the development of health and other services for minority communities. He maintains that, initially, the National Health Service (NHS) was colour blind, except when it came to ‘exotic’ diseases. In a similar vein, though speaking

specifically of social service care for minority groups, McFarland, Dalton and Walsh (1987) remark that:

It is striking that it was not until the early 1970s, after more than twenty years of settlement, that commentators tried to assess social service provision for ethnic minorities. The subsequent material mirrors the reaction of British society generally to migration, intertwined with a specific social work emphasis on individual cases and ‘problem’ clients’ (p.1).

*Method: search strategy and results*

A research item was selected for inclusion here if:

1. It uses the term and/or concept of access to and/or use of health and/or social or other services in a *significant* way in the title and/or body of item.
2. And is British research.
3. And is focused wholly or partly on the experience of minority ethnic groups.
4. And dates from 1980 on.
5. And is written in English.

As noted above, there is a growing body of research on the health of British minority ethnic populations. Though not dealing specifically with issues around access to and use of health care and other services, many research items include some consideration of these issues. Details of these items do not appear here. The research items reviewed here are ones where access to, and use of, services is considered in a prominent way (i.e. is the main or the substantial focus of the article). Some of the items below might appear not to satisfy this inclusion criterion; where this is the case, it is made clear in the review. There is a large body of research that looks at lay health beliefs and conceptualisations of illness in minority communities. Details of this research has been included *if* it substantially deals with access to and use of services. Where service access and use is not the main point of the research, it has been excluded or only brief details are provided below.

The services considered here are those relating to health, social and welfare care. Within the social care literature, we excluded research items that explored access to housing services, child care and adoption services. The focus in this review is on health care and associated or related social welfare services, such as the ‘home help’ or ‘meals on wheels’ services.

*Description of databases, catalogues and websites*

A variety of databases, catalogues and websites were searched. Where possible databases and catalogues were searched from 1980 on. The databases searched were:

**AgeInfo** - an information service about old age and ageing provided by the Library and Information Service of the Centre for Policy on Ageing (UK). Includes a bibliographic database based on written material in the library catalogue.

**ASSIA** - Applied Social Sciences Indexes and Abstracts (USA).

**CareData** - abstract database of relevant social work and social care literature. Developed by the National Institute of Social work (UK).

**Community WISE** - contains seven databases on social policy and welfare issues worldwide, from data provided by Barnardo's, Community Development Foundation, National Centre for Volunteering and the National Youth Agency (UK).

**EMBASE** - Excerpta Medica database, renowned for its international coverage of drug-related research literature. It covers all aspects of human medicine and related biomedical research with an emphasis on European-based research.

**IBSS** - International Bibliography of the Social Sciences via BIDS (USA).

**ISI Web of Science (Social Sciences Citation Index)** - the Social Sciences Citation Index is a multidisciplinary database indexing more than 1,725 journals spanning 50 disciplines.

**MEDLINE** - corresponds to three printed indexes: Index Medicus, International Nursing Index, and Index to Dental Literature. Accessed via the NLM's PubMed portal and including PreMedline. (National Institute of Medicine, USA).

**PsychInfo** - American Psychological Association database, which underpins the printed Psychological Abstracts.

Two library catalogues were searched: The Centre for Research in Ethnic Relations (at Warwick University at: <http://www.warwick.ac.uk/CRER/search.html>) and The British Library catalogue (at: <http://blpc.bl.uk/>)

A number of journal websites were searched. This was done using the BMJ website's multiple journal search facility (<http://bmj.com/all.shtml>). Too many journals were searched to give full details here. Some research items were found in the bibliographies of existing literature. This review includes papers published before June 2002.

### *Search terms*

The following terms (which were adapted to suit the database or catalogue being used) were used in the review:

Primary search terms: access OR use OR services; ethnic\*

Additional terms (concepts, conditions and population groups-will not be shown in table 1.): accident\*; admission; adolescent; alcohol; alternative; Asian; asthma; Black; cancer; children; Chinese; complementary; consult\*; deaf\*; dent\*; diabetes; diet; disease; doctor; drugs; elder\*; emergency; genetic; GP; hearing; heart; HIV/AIDS; hospice; information; injury; immunisation; mental; minorit\*; opt\*; palliative; prescribing; provision; referral; renal; schizophrenia; screening; sex\*; sickle cell; substance; travellers; welfare; women.

Geographical limits: UK OR United Kingdom OR Britain OR British OR England.

Details of the results of the search are shown in table 1.

Table 1: the results of the literature search

Order in which accessed	Database name	Results	
		Using primary search terms only.	Using primary search terms & geographical limits
1	MEDLINE	777	93
2	IBBS	303	22
3	Embase Psychiatry	192	Not used
4	ASSIA	303	195
5	PsycINFO	1831	105
6	CareData	909	Not used
7	AgeInfo	142	Not used
8	CommunityWise	29	Not used
9	ISI Web of Science	1298	119
10	Centre for Research in Ethnic Relations	150	Not used
11	British Library catalogue	187	Not used
12	Journal websites	433	22

A large number of items were located using this search strategy (especially so in the case of the literature on mental health). Many of these were not in academic journals, or were unpublished ('grey' literature) and were often reports of surveys conducted by community groups in specific geographic locations (this was the case with many of the research items found in the British Library catalogue). Some of this grey literature could not be found, but, if located, was included if it fulfilled the inclusion criteria. The emphasis in this review is on the academic literature published in peer reviewed journals and every effort was made to locate papers whose titles or abstracts appeared to fulfill the inclusion criteria.

*Summary of the literature reviewed*

Ethnic differences in mortality could reflect differences in survival, in morbidity or both. Studies in the US have demonstrated the existence of potential barriers, at various stages, to health care for African Americans (Chen, 1999). These barriers could contribute to the high cardiovascular-related mortality of African Americans through differential survival.

As indicated above, our knowledge about the health of minority ethnic populations in the UK has grown in recent years, but knowledge about access to health and other care services by minority individuals is less developed in comparison. The existing research suffers from many methodological limitations, making the interpretation of results difficult. Much of this research examines access and utilisation issues and patient/provider interactions such as health-seeking behaviour, frequency of service use, satisfaction and the cultural appropriateness of services. There are few studies that examine the *quality of medical management*, that is, type of treatment at the primary and secondary level (including referral patterns to specialist care).

There are consistent themes in relation to health and social care access and health-seeking behaviour that are noteworthy in spite of methodological problems (one of which is the inability to adjust for need/level of morbidity or differences in socio-economic circumstances). South Asians appear to use primary health services more than Whites (Chaturvedi, Rai and Ben-Shlomo, 1997) but they appear to report higher dissatisfaction in relation to factors such as lack of access to female doctors, language barriers or the lack of staff from minority backgrounds in primary care reception areas (Campbell, Ramsay and Green, 2001). Linguistic difficulties appear to be less of a problem for younger south Asians, but ethnic elders continue to use relatives as interpreters, which may reflect some level of unmet need (Ebden et al., 1988; Free et al., 1999). Link workers can be used to address difficulties with communication in some areas and are thought to be successful. For example, in the Hackney Multi-ethnic Women's Health Project, this advocacy approach was thought to result in a reduction in caesarian rates, rates of induction and changes in length of antenatal stay (Ahmad, 1993).

Black Caribbeans use services less than expected, report high levels of mistrust in doctors (particularly among Black Caribbean men) and sometimes use private health care (Donovan, 1986; Scott, 1998). There is high usage of natural remedies—bush teas, evening primrose oil and

laxatives—in this population, and non-compliance with prescribed medication may be related to the poor management of conditions such as hypertension, diabetes and sickle cell disease (Cappuccio et al., 1997; Scott, 1998; Shaw et al., 1999). Adherence to prescribed drugs among African Caribbeans is influenced by traditional beliefs about the long-term harmful effects of drugs and religious values, but also by lack of communication between them and their general practitioners (GPs). Scott (1998) argues that most practitioners are concerned with clinical features of conditions rather than with the health beliefs and practices of this group. Cultural and education issues are also important for Asian asthmatic patients. They have an increased risk of admission to hospitals and poor self-management of asthma which may be associated with passive control and a lack of understanding about the role of drugs in the management of the condition (Griffiths et al., 2001; Moudgil and Honeybourne, 1998). The evidence on usage of home remedies is consistent, but there are few initiatives that have assessed its health impact (Chen, 1999).

Studies focusing on specific conditions have provided some information about differences in referral patterns and in severity of disease at presentation. Black Caribbeans with schizophrenia are more likely than Whites to be admitted to services via contact with the police, with little involvement from a GP and more frequently under a section of the Mental Health Act (McGovern and Cope, 1991; Singh et al., 1998; Thomas et al., 1993; Davies et al., 1996). The reasons for higher compulsory admission rates in this group are not clear. Prejudicial stereotyping by the police and mental health practitioners (Lewis, Croft-Jeffreys and David, 1990), an increase in severity of illness because of delay in seeking treatment, poor compliance with medicines, and social isolation have been considered as likely factors (Davies et al., 1996). Differential routes of referral to mental health services is also an issue for Black children with psychosomatic and medical illness; Black children being more likely than White children to be referred by education services and mixed race children by social services (Daryanani et al., 2001). Other work suggests that there may be inequity at the referral level from GPs (Cooper, Smaje and Arber, 1998; Smaje and Le Grand, 1997). For example, there is high use of primary care services but low use of secondary care services by minority children and young people.

Whites are more likely than Indians to attend hospital diabetes clinics and GP clinics, which is at odds with the higher rates of diabetes and diabetic mortality in Indians (Goyder and Botha, 2000). Asians are more likely to receive renal replacement therapy because of end stage renal failure

believed to be associated with diabetes (Rodderick et al., 1999; Roderick et al., 1996). This could reflect poor control of diabetes and associated high blood pressure but whether this is due to health-seeking behaviour at the individual level, or organisational issues of poor access to specialist care, remains unclear. Retinopathy can result from diabetes and late presentation at services is a significant risk factor for blindness; African Caribbean patients are more than four times more likely to present with advanced loss of vision from glaucoma than Whites after adjusting for referral source (Fraser, Bunce and Wormald, 1999).

South Asians also have a greater risk of coronary disease than Whites but appear to wait twice as long for coronary angiography (Shaukat, de Bono and Cruickshank, 1993). In this study, however, referral bias was not thought to be major problem. Diagnosis of heart attacks in south Asians might be missed as they are less likely to present with classic symptoms (Lear et al., 1994). A recent study of invasive management of coronary disease, however, found no differences in clinical presentation, previous investigations and interventions between south Asians and Whites who had coronary angioplasty and coronary artery bypass grafting, but south Asians were more likely to be younger, male and non-obese (Feder et al., 2002).

Minority ethnic communities tend to live in poor urban areas and often face the prospect of seeking care from health and other care facilities with fewer resources. Structural and organisational issues could limit access to quality care. For example, the uptake of cervical screening in deprived areas (and where there are large proportions of minority ethnic populations) is low (Majeed et al., 1994). GPs are unevenly distributed across England and some areas do not have enough GPs for the needs of their population (Benzeval and Judge, 1996). We know that higher levels of satisfaction are reported if the ethnic origin of the patient is concordant with that of the provider of services, but little is known about whether or not this means that they receive a high quality of care. An early study noted that the GPs of Asian mothers were less likely to be on the obstetric list than the GPs of White mothers and that this was associated with poorer peri-natal outcomes (Clarke and Clayton, 1983). Some authors suggest that discrimination in the health care setting might also compromise the quality of care (Anionwu and Atkin, 2001; Ahmad and Atkin, 2000; McNaught, 1988; Webb, 2000). This is particularly relevant to haemoglobinopathies, such as sickle cell anaemia, which could be seen as a 'Black disease', with health professionals attributing illnesses to some aspect of minority culture (Maxwell, Streetly and Bevan, 1999).

In summary, the empirical evidence on access to health care among minorities is patchy but there is sufficient basis to be concerned about the cultural appropriateness of health care provision, whether or not there is equitable access to quality care and whether these impact on health outcomes.

### References

1. Ahmad, W.I.U. (ed.) (1993). *'Race' and health in contemporary Britain*. Buckingham: Open University Press.
2. Ahmad, W. and Atkin, K. (2000). Primary care and haemoglobin disorders: a study of families and professionals. *Critical Public Health* 10 (1), 41-53.
3. Anionwu, E. N. and Atkin, K. (2001). *The politics of sickle cell and thalassaemia*. Buckingham: Open University Press.
4. Balarajan, R. and Bulusu, L. (1990). Mortality among immigrants in England and Wales, 1978-1983. In M. Britton (ed.), *Mortality and geography: A review of the mid-1980s*. OPCS Series DS No. 9. London: HMSO.
5. Benzeval, M. and Judge, K. (1996). Access to health care in England: continuing inequalities in the distribution of GPs. *Journal of Public Health Medicine* 18 (1), 33-40.
6. Berthoud, R. (1999). *Young Caribbean men and the labour market. A comparison with other groups*. York: York Publishing Services for the Joseph Rowntree Foundation.
7. Cappuccio, F.P., Cook, D. G., Atkinson, R. W. and Strazzullo, P. (1997). Prevalence, detection and management of cardiovascular risk factors in different ethnic groups in south London. *Heart*, 78 (6), 555-563.
8. Campbell, J.L, Ramsay, J. and Green, J. (2001). Age, gender, socioeconomic and ethnic differences in patients' assessments of primary care. *Quality in Health Care* 10 (2), 90-95.
9. Chaturvedi, N., Rai, H. and Ben-Shlomo, Y. (1997). Lay diagnosis and health-care-seeking behaviour for chest pain in south Asians and Europeans. *The Lancet* 350 (9091), 1578-1583.
10. Chen, M.S. Jr (1999). Informal care and the empowerment of minority communities: comparisons between the USA and the UK. *Ethnicity and Health* 4 (3), 139-151.

11. Clarke, M. and Clayton, D. G. (1983). Quality of obstetric care provided for Asian immigrants in Leicestershire. *BMJ* 286, 621-623.
12. Cooper, H., Smaje, C. and Arber, S. (1998). Use of health services by children and young people according to ethnicity and social class: secondary analysis of a national survey. *BMJ*, 317, 1047-1051.
13. Daryanani, R., Hindley, P., Evans, C., Fahy, P. and Turk, J. (2001). Ethnicity and use of a child and adolescent mental health service. *Child Psychology and Psychiatry Review*, 6 (3), 127-132.
14. Davey Smith, G., Chaturvedi, N., Harding, S., Nazroo, J. and Williams, R. (2000). Ethnic inequalities in health: a review of UK epidemiological evidence. *Critical Public Health* 10 (4), 375-408.
15. Davies, S., Thornicroft, G., Leese, M., Higgingbotham, A. and Phelan, A. (1996). Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *BMJ* 312, 533-537.
16. Donovan, J. (1986). We don't buy sickness, it just comes. Health, illness and health care in the lives of Black people in London. Aldershot: Gower.
17. Ebdon, P., Carey, O.J., Bhatt, A. and Harrison, B. (1988). The bilingual consultation. *The Lancet* 1 (8581), 347.
18. Feder, G., Crook, A.M., Magee, P., Banerjee, S., Timmis, A.D. and Hemmingway, H. (2002). Ethnic differences in invasive management of coronary disease: prospective cohort study of patients undergoing angiography. *BMJ* 324, 511-516.
19. Fraser, S., Bunce, C. and Wormald, R. (1999). Retrospective analysis of risk factors for late presentation of chronic glaucoma. *British Journal of Ophthalmology* 83 (1), 24-28.
20. Free, C., White, P., Shipman, C. and Dale, J. (1999). Access to and use of out-of-hours services by members of Vietnamese community groups in South London: a focus group study. *Family Practice*, 16 (4), 369-374.

21. Gillam, S. J., Jarman, B., White, P. and Law, R. (1989). Ethnic differences in consultation rates in urban general practice. *BMJ* 299, 953-957.
22. Goyder, E. C. and Botha, J.L. (2000). Inequalities in access to diabetes care: evidence from a historical cohort study. *Quality in Health Care* 9 (2), 85-89.
23. Griffiths, C., Kaur, G. Gantley, M., Feder, G., Hillier, S., Goddard, J. and Packe, G. (2001). Influences on hospital admission for asthma in south Asian and White adults: qualitative interview study. *BMJ* 323, 962-966.
24. Harding, S. and Maxwell, R. (1997). Differences in mortality of migrants. In F. Drever and M. Whitehead, *Health inequalities: decennial supplement ONS series DS no. 15*. London: The Stationery Office.
25. Lear, J.T., Lawrence, I.G., Pohl, J.E. and Burden, A.C. (1994). Myocardial infarction and thrombolysis: a comparison of the Indian and European populations on a coronary care unit. *Journal of the Royal College of Physicians of London* 28 (2),143-147.
26. Lewis, G., Croft-Jeffreys, C. and David, A. (1990). Are British psychiatrists racist? *British Journal of Psychiatry* 157 (9), 410-415.
27. Majeed, F. A., Cook, D. G., Anderson, H. R., Hilton, S., Bunn, S. and Stones, C. (1994). Using patient and general practice characteristics to explain variations in cervical smear uptake rates. *BMJ* 308, 1272-1276.
28. Marmot, M., Adelstein, A. and Bulusu, L. (1984). *Immigrant mortality in England and Wales: 1970-1978 OPCS studies on population and medical subjects: no. 47*. London: HMSO.
29. Maxwell, K., Streetly, A. and Bevan, D. (1999). Experiences of hospital care and treatment seeking for pain from sickle cell disease: qualitative study. *BMJ* 318, 1585-1590.
30. McFarland, E., Dalton, M. and Walsh, D. (1987). *Personal welfare services and ethnic minorities*. Scottish Ethnic Minorities Research Unit Research Paper no. 4. Glasgow: Research Unit, Glasgow Caledonian University.

31. McGovern, D. and Cope, R. (1991). Second generation Afro-Caribbeans and young Whites with a first admission diagnosis of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology* 26 (2), 95-99.
32. McNaught, A. (1988). *Race and health policy*. London: Croon Helm.
33. McNaught, A. (1985). *Race and health care in the United Kingdom*. London: Health Education Council.
34. Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S. and Beishon, S. (1997). *Ethnic minorities in Britain. Diversity and disadvantage*. London: Policy Studies Institute.
35. Moudgil, H. and Honeybourne, D. (1998). Differences in asthma management between White European and Indian subcontinent ethnic groups living in socioeconomically deprived areas in the Birmingham (UK) conurbation. *Thorax* 53 (6), 490-494.
36. Roderick, P., Clements, S., Stone, N., Martin, D. and Diamond, I. (1999). What determines geographical variation in rates of acceptance onto renal replacement therapy in England? *Journal of Health Services Research and Policy* 4 (3), 139-146.
37. Roderick, P. J., Raleigh, V.S., Hallam, L. and Mallick, N.P (1996). The need and demand for renal replacement therapy in ethnic minorities in England. *Journal of Epidemiology and Community Health* 50 (3), 334-339.
38. Scott, P. (1998). Lay beliefs and the management of diseases among West Indians with diabetes. *Health and Social Care in the Community* 6 (6), 407-419.
39. Shaukat, N., de Bono, D.P. and Cruicksank, J.K. (1993). Clinical features, risk factors, and referral delay in British patients of Indian and European origin with angina matched for age and extent of coronary atheroma. *BMJ* 307, 717-718.
40. Smaje, C. and Le Grand, J. (1997). Ethnicity, equity and the use of health services in the British NHS. *Social Science and Medicine* 45 (3), 485-496.

41. Shaw, C.M., Creed, F., Tomenson, B., Riste, L. and Cruickshank, J.K. (1999). Prevalence of anxiety and depressive illness and help seeking behaviour in African Caribbeans and White Europeans: two phase general population survey. *BMJ* 318, 302-305.
42. Singh, S. P., Croudace, T., Beck, A. and Harrison, G. (1998). Perceived ethnicity and the risk of compulsory admission. *Social Psychiatry and Psychiatric Epidemiology* 33 (1), 39-44.
43. Thomas, C. S., Stone, K., Osborn, M., Thomas, P. F. and Fisher, M. (1993). Psychiatric morbidity and compulsory admission among UK-born Europeans, Afro-Caribbeans and Asians in Central Manchester. *British Journal of Psychiatry* 163 (7), 91-99.
44. Webb, E. (2000). Health care for ethnic minorities. *Current Pediatrics* 10 (3), 184-190.

## **Section two: the research literature**

### *Layout of the review*

The research literature on use of health and other care by minority communities is, very often, general in nature. That is, authors tend to look at access to a *variety* of services, so that use of primary care and secondary care (and use of social care services) is sometimes examined together in the same study. Authors also tend to explore the experiences of minority groups together, so that the use of services by south Asians is compared with use of services by, for example, Chinese individuals or people of West Indian origin (or the indigenous White population). For the purposes of this review, we have categorised the research according to which type of service is being used (e.g. diabetes, substance use and abuse) or which type of individual is using it (elders, children), as given in the title or main body of the item. Clearly, there is a great deal of overlap between these categories and this should be borne in mind when reading the review. The first category below is a general one, and contains details of research items from a wide variety of areas including general practitioner (GP) consultations, use of hospital services etc. If a research item is not specific enough about the type of individual using the service or the type of service being used, it is detailed in this category. The general nature of many of the research items in section 2.1 limits their usefulness here, and many of these have been only briefly described.

### ***2.1) General and miscellaneous health and social care services***

**Ahmad, W. I. U. and Atkin, K. (1996). *'Race' and community care*. Buckingham: Open University Press.**

All the chapters in this edited collection are relevant to an exploration of the provision and use of services by minority populations in the UK, though the chapters on family obligations and community care (Ahmad; Atkin and Rollings), disability (Stuart) and mental health (Watters) are especially useful here.

In Atkin and Rollings, there is some discussion of service provision for minority carers (about which very little is known); the same can be said for the provision of care to disabled Black individuals in the community (Stuart). Watters points out in his assessment of care provision for Black, mentally ill people, that the fact that so many Blacks are the subjects of compulsory admissions to psychiatric institutions means that they are not accessing services via the more

conventional route—by referral through a general practitioner (GP). The pathways to care are different for the Black population, and the role of the GP is crucial in determining if the Black mentally ill patient receives the care he or she needs. Many projects that aim to identify illness in minority ethnic populations are only short-term ones and are under-funded. Those that are innovatory often fail because they ‘...exist in institutional contexts in which Black people’s needs are marginalized’ (p.122).

**Ahmad, W. I. U. (ed.) (1993). *‘Race’ and health in contemporary Britain*. Buckingham: Open University Press.**

An edited collection which examines (more generally) the health of minority populations in the UK but is also concerned with health care provision. Several of the chapters are important here. One of these is provided by Anionwu on the experience of minority communities with sickle cell and thalassaemia (this issue is addressed more fully below). She maintains that the history of the development of services for sufferers of these conditions provides a useful example of how racism operates within health services, how inequitable services can be challenged by sufferers’ families and others, and how better services can be developed for affected families and groups.

In the chapter by Parsons and colleagues (‘Pregnancy, Birth and Maternity Care’), the authors describe the problems that many minority ethnic women experience in their use of maternity care services—but they do so in the context of general criticism by *all* women about standards of maternity care in Britain. The needs of some minority mothers-to-be, however, are more urgent. Stillbirth and infant mortality rates are higher (about 40%) for babies whose mothers are born in the New Commonwealth compared with UK-born mothers (1990 figures), with especially poor outcomes for babies born to Pakistani women. These are the women who would most benefit by increased and improved access to care; yet, they are the ones least likely to use them because of ‘institutional and individual racism’ as well as linguistic and cultural barriers.

A number of organisations have described the poor treatment of many minority ethnic women using maternity services and some initiatives have been put into place. Two described here are the Asian Mother and Baby Campaign (started in 1984) and the Hackney Multi-ethnic Women’s Health Project (started in 1980). The features of the former include service awareness education and the use of Link-workers to liaise between minority pregnant women and health professionals. The

publicity drive appeared to have little effect but the use of Link-workers was considered successful. The Hackney project also used an advocacy approach that led to positive obstetric outcomes; caesarean section rates declined by about 2% under this scheme and differences were seen in rates of induction and length of antenatal stay.

**Arai, Y. and Farrow, S. (1995). Access, expectations and communication: Japanese mothers' interaction with GPs in a pilot study in north London. *Public Health* 109 (5), 353-361.**

The London Borough of Barnet has one of the largest Japanese populations in the UK. In this study, the patterns and nature of access to general practitioners (GPs) among Japanese mothers in Barnet are described. Respondents (with children under the age of five) were selected from four wards within the borough that have high concentrations of Japanese (n=18). Data were collected by semi-structured interviews (in Japanese) and translated and transcribed.

The results of the study indicated that the mothers could be classified into three groups: individuals who only saw Japanese doctors; individuals who consulted their GP; and individuals who saw both. Of 18 visits to the doctor, 13 were for respiratory infection or flu, three for diarrhoea and one for a developmental problem. Women who only consulted their own GP and those who consulted both Japanese doctors and their own GP said that gaining quick access to a doctor was a more difficult task than communicating in English (though all the women regarded communication as a major barrier). The mothers commented on cultural misunderstandings between themselves and their GPs (Japanese doctors, for example, would never advise a mother to bathe her fevered baby in cool water, though British GPs often do advise this course of action. Japanese mothers also expected to be given a prescription every time they consulted their GP). The authors point out that the sample size is small and not necessarily representative of the Japanese community in Britain.

**Association of Community Health Councils for England and Wales (1991). *Working towards health for all. Report of a seminar held by the Association of Community Health Councils for England and Wales at the Royal Institute of British Architects on May 22, 1990.***

This report summarises the presentations given at a seminar in 1990 by the Association of Community Care Councils for England and Wales. The focus of the seminar was on promoting equal and fair access to health and social care for minority groups. The key points made are that

health service providers need adequate statistical information about the minority communities in their areas and need to monitor the provision of services to minorities.

**Balarajan, R., Soni Raleigh, V. and Yuen, P (1991). Hospital care among ethnic minorities in Britain. *Health Trends* 23 (3), 90-93.**

The authors use General Household Survey (GHS) aggregated data (from 1983 to 1987) on in-patient admission and out-patient attendance among minority ethnic populations aged less than 65 years. The results indicate that in-patient admission had a U-shaped pattern by age among men in all groups (so that admissions were highest in the 0-15 age group and the 45-64 age group). For women, the results showed the opposite pattern (in-patient admissions were highest for women of childbearing age) and Pakistani women had the highest rates of all female groups. Age and socio-economic status adjusted in-patient rates were slightly higher (compared with White males) in West Indian male children and adolescents (odds ratio=1.04), West Indian men aged 16-44 (odds ratio=1.13) and Indian and Pakistani older men (odds ratios=1.02 and 1.31). However, these differences were not significant. Adjusted figures for women indicated that Pakistani girls, women of childbearing age and older women all had higher rates of in-patient admission compared with Whites (odds ratios=1.09, 2.12 and 1.43).

Out-patient attendance rates varied by ethnic group membership and age, with older people having higher rates (and this being particularly pronounced for minority populations). The age and socio-economic status adjusted figures did not change this relationship between age and increasing risk of out-patient attendance among non-White groups; for men the odds ratios in the 45-64 age group compared with Whites were: Indians=1.75, Pakistani=1.44 and West Indian=1.32. For women, similarly elevated odds ratios were found among older, minority ethnic women. In-patient admission rates did not vary greatly by ethnic group (except in the case of Pakistani women aged 16-44) but out-patient attendance rates varied more, with lower rates of attendance among minority children but higher rates among middle-aged minority ethnic groups.

**Balarajan, R., Yuen, P. and Soni Raleigh, V. (1989). Ethnic differences in general practitioner consultations. *BMJ* 299, 958-960.**

Data from the General Household Survey (GHS) were used to examine the patterns of general practitioner (GP) consultation between ethnic groups in the period 1983-1985. Respondents were

asked about their use of GP services in the previous 14 days and people over the age of 65 were excluded from analysis (n=63 966).

The results indicate that the highest consultation rates for men were found among Pakistanis (at all ages). For females, the highest rates were for Pakistani females (especially in the age group 45-64) and White females under the age of 15. These rates were then adjusted for age and socio-economic status for people under the age of 15. Compared with the White population, Pakistani boys had an odds ratio for GP consultation of 1.44, West Indians=1.00 and Indian boys=0.91. All young, non-White females had lower odds ratios than young, White females. The (socio-economic status and age) adjusted figures for men and women aged 16-64 continued to show high odds ratios for the Pakistani group compared with the White population (for Pakistani men, the odds ratio=2.82, for Indian men=1.53 and for West Indian men=1.65). Odds ratios for GP consultation were elevated for all non-White women aged 16-64 compared with the White reference group (Indian women=1.23, Pakistani women=1.85 and West Indian women=1.17). The authors acknowledge that the high consultation rates seen in some groups might be a reflection of their greater morbidity, which is not measured here.

**Bayne Smith, M. (1999). Primary care: choices and opportunities for racial/ethnic minority populations in the USA and UK - a comparative analysis. *Ethnicity and Health* 4 (3), 165-188.**

The author emphasises the importance of the primary care health system in delivering effective health services. Here, she considers the differences and similarities between the UK and the US in the development and implementation of primary care, especially as this relates to minority communities (only the British experience is important here). The limitations of comparisons between the health care systems of these two countries are outlined: the primary one being the demographic, social, economic and other differences between the UK and the US. Bayne Smith uses functionalist theory and conflict theory to organise her discussion. The former emphasises the interdependence of social structures (change happens slowly, from within a society and in response to a change in need). Conflict theory is built on the premise that there is an unequal distribution of resources and powerful groups want to maintain the status quo at the expense of other, less powerful groups.

The history of the development of primary care in the US is described at length. The British experience of primary care is traced from the beginning of the 20<sup>th</sup> century (and the National Health Insurance Laws of 1911) to the National Health Service (NHS) reforms of the last two decades of the 20<sup>th</sup> century. The position of minority ethnic populations in the UK should be understood in the context of colonialism, since many migrants come from former British colonies. The NHS was not established to meet their needs, and was designed to serve a mostly homogenous population. Bayne Smith maintains that medicine has failed in helping people to change their behaviour and that health systems in the future must bring about behavioural change. Questions need to be asked about why some services do not reach minority groups, how minority groups interpret the information given to them, and the ways in which medicine changes behaviour. If minority ethnic communities are to benefit, they need to be involved at every stage. They must help with the planning of research and they must help with the collection of data (since they are more likely than outsiders to collect reliable data).

Six recommendations are made: that both the US and the UK collaborate on the development of a White Paper on health; both nations must establish guidelines ensuring that it takes into account the perspectives of other medical systems (such as bio-psychosocial systems); greater training of health professionals and health promotion is needed; health professionals from minority communities should be recruited; and doctors should undergo training in cultural awareness.

**Benzeval, M. and Judge, K. (1996). Access to health care in England: continuing inequalities in the distribution of GPs. *Journal of Public Health Medicine* 18 (1), 33-40.**

The focus of this study is not on minority populations but on the fair (or otherwise) distribution of general practitioners (GPs) based on local population need, though (Asian) ethnicity is used in the analysis. The analysis consists of three stages: GP utilisation was ascertained using individual and community-level data; the odds ratios from the utilisation data were combined with small area information to weight the estimates of the population to take account of relative needs; and these data were used to assess the number of GPs needed in the area. Data were taken from the Office of Population Censuses and Surveys (OPCS) Omnibus surveys and the Department of Health (DOH) service availability data.

The results indicate that a variety of factors predict GP consultation (within the last two weeks). Limiting long-term illness (odds ratio=2.43), being a woman aged under 29 (odds ratio=1.86) and being unable to work owing to illness (odds ratio=1.81) were all significantly associated with GP consultation. Asians were more likely to consult their GPs than other ethnic groups (odds ratio=1.51), other things being equal. The authors combined these results with a 'need indicator' to produce an estimation of the 'fair' distribution of GPs for selected health authority areas. These data suggest that, despite improvements, GPs are still unevenly distributed across England, and some areas (such as Rotheram) do not have enough GPs for the needs of their local population. The authors discuss the limitations of the study, including the problems associated with defining utilisation and the exclusion of key population sub-groups, such as children and people in care and nursing homes.

**Blakemore, K. (2000). Health and social care needs in minority communities: an over-problematized issue? *Health and Social Care in the Community* 8 (1), 22-20.**

Blakemore identifies three types of 'resources' in south Asian and Black Caribbean communities that can affect the health and social care needs of minority communities. These are: the size of ageing cohorts; family change and residence patterns; and economic assets such as housing and type of employment. The age structure of Asian and Black populations, for example, is slightly younger than the White population (about 20% of the White population is over age 65, while only 6% of the African Caribbean population is elderly). Moreover, the large numbers of Caribbean people in their late middle age may mean that help is available to those suffering chronic illness (though the poor health of many of late middle age Black Caribbeans, their tendency to live alone and the 'compressed' nature of this group, may mean that a large number of them will enter old age together and become, as a group, potentially very needy).

Blakemore cautions against the notion that some communities are advantaged by low dependency ratios; much depends on the level of illness in the population and the potential levels of support offered to those in need. He also considers the strength and resilience of minority families. Many voluntary organisations working with Black and Asian elders, for example, report a decline in family support for the elderly. Also important to elderly minority individuals is the move away from multi-generational patterns of residence, though this is less evident among some Asian groups (such as Pakistanis and Bangladeshis). The move away from multi-generational residence does not

necessarily signal a decline in support for the elderly. Economic well-being also affects the kind of care offered to pensioners. The assets of better-off families can help offset the disadvantages of a decline in family support. Wealthier communities are better able to provide for those in need (as the example of the Jewish community has demonstrated). Some groups, such as Pakistanis and Bangladeshi, are especially economically disadvantaged. In addition, the condition of houses occupied by Pakistanis and Bangladeshis is often poor. These factors may make the health and social care needs of elders in these communities more difficult to meet.

Blakemore concludes that the perception that minority communities are all uniquely disadvantaged obscures the fact that there is significant variation in resources between communities. Some groups are better placed to deal with poor access to service and disadvantage than others, and there are signs of increasing inequalities in community care among Asian and Black communities.

**Butt, J. and Mirza, K. (1996). *Social care and Black communities. A review of recent research studies.* London: HMSO.**

A review of the research literature on the social care needs of British ethnic minorities, with some consideration given to the most important aspects of the demography, health and socio-economic situation of ethnic minorities. The research items cited come from three different sources: academic or published work; local authority studies that are available to the public; and research provided by voluntary and community groups. There are chapters on families and children, elders, mental health, disability and carers. In conclusion, the authors draw on the research to emphasise key themes that could guide agencies providing social care for ethnic minorities, these are: identifying needs, making fair assessments of need, making better use of information, improving monitoring of intervention outcomes and initiating inspection of services.

**Campbell, J.L, Ramsay, J. and Green, J. (2001). Age, gender, socioeconomic and ethnic differences in patients' assessments of primary care. *Quality in Health Care* 10 (2), 90-95.**

The authors describe the findings of this study of patients' evaluations of primary care services. The General Practice Assessment Survey (GPAS, a multi-item scale that addresses key areas of primary care activity, such as communication, interpersonal care and continuity of care) was administered to 7692 patients attending GP practices in inner London. Most (63%) respondents were White, a quarter was Black and 9% were south Asian. Ethnicity was a significant predictor of responses to

primary care services for eight of the 13 scales of the GPAS (even after controlling for the effects of socio-economic status, age etc.). White respondents were more likely to report favourable responses than non-White respondents. Indian, Pakistani and Bangladeshi respondents reported low scores, especially in relation to reception staff, accessibility of care and doctor-patient trust. The authors suggest that the low scores among south Asian respondents might be attributable to lack of access to female doctors, language barriers or the (probably) White ethnicity of staff in primary care reception areas.

**Chan, C. (2000). The quality of life of women of Chinese origin. *Health and Social Care in the Community* 8 (3), 212-222.**

This paper is not primarily on use of services so will only be described briefly here. Chan reports the findings of a qualitative study of quality of life among Chinese women in Manchester. The respondents' names were taken from health authority immunisation records (n=30) and data were analysed using content analysis techniques. The results suggest that Chinese women seek advice from friends and families rather than from health service sources and staff. Language barriers exist that impede use of health services, though interpreters were used by some of the women. The women reported anxiety about their private health concerns becoming known to members of the (small) Chinese community in Manchester.

**Chen, M.S. Jr (1999). Informal care and the empowerment of minority communities: comparisons between the USA and the UK. *Ethnicity and Health* 4 (3), 139-151.**

Chen provides a discussion of the role of informal care among minority communities in the US and the UK. He defines informal care as 'the practice of alleviating distressful physiological and psychological dysfunctions through...(e.g. traditional healers, family members, self, etc.) using measures that do not require a physician's prescription or intervention...' (p.140). It is opposed to formal care, which requires the intervention of trained medical personnel. Chen also considers that alternative medicine (such as herbal medicine, prayer and acupuncture) comes under the umbrella term 'informal care'. Informal care may be used more by minority populations because they are more likely to encounter barriers to health care services than majority populations and because informal care may have traditional significance for them. Empowering minority ethnic communities

using informal care may be the most culturally sensitive method of improving the health of minority groups.

Chen also traces the development of services for minority British populations from the 1980s on. The first campaigns were aimed at improving the health of Asians (the 'Stop Rickets' campaign) and, later, the health of Asian mothers and babies. By 1991, a question on ethnicity appeared in the census and in 1994, the Ethnic Health Unit was established within the National Health Service (NHS). Central to Chen's discussion is the concept of 'cultural competence' (the purpose of which is to achieve improved health outcomes) in relation to informal health care. Minority ethnic health professionals (who have a culturally competent approach) are best placed to improve the health of minority groups. This may be a pressing issue in the future, as minority communities become increasingly demographically more diverse.

The strengths and weaknesses of informal care are outlined. Strengths include its convenience and simplicity; weaknesses include its lack of statistically proven efficacy. Drawing all of the above issues together, Chen makes a number of recommendations. These range from advocating initiatives to improved definitions of informal care, to calls for the use of methodologically rigorous surveys to assess the health impact of informal care, to the recommendation that testimony be collected from minority communities about their successful use of informal care.

**Chui-man, C. and Wai-kam, Y. (1999). *Report on social and health needs of Chinese women in Sheffield*. Sheffield: Lai Yin Association.**

Data were collected using a structured questionnaire from members of a Chinese women's community association in Sheffield in the period 1997-1998 (n=85). Over half of the respondents indicated that they would not consult their doctor if they or their family members suffered from minor illness. A third said that they would buy non-prescription drugs from a chemist and 15% had used traditional Chinese medicine. Over a quarter did not believe that Western doctors understood Chinese health concepts. Nearly 70% had had a cervical smear test. Over three quarters reported language barriers as a problem for their use of social services and 41% did not know that social services existed.

**Coventry Health Information Forum (1991). *Health information needs of Black and ethnic minority groups in Coventry. A report on a survey of community-based groups.* Coventry, UK: Coventry Health Information Forum.**

The Forum describe the results of a local survey of health information needs of Coventry's Black and minority community (who constitute about 9% of the population in the city). Individuals from community groups provided the data for the survey (gathered via structured questionnaire in a group interview setting). In all, 27 community groups participated. The questionnaire elicited information on the composition of the community group, whether the group had received health information or not and use of services. Of the 27 groups in the survey, 17 were 'mainly female', four were largely male and six had mixed membership. The groups represented a variety of age groups, ethnic communities (including Mauritian and Vietnamese) languages and faiths.

The results suggest that the impact of health information on respondents was low. On some health issues (smoking, exercise), respondents had been well informed but only half of the groups had received information about the immunisation of children. Other topics, such as mental health issues and care in the community, were much less well known about by respondents. Respondents expressed an interest in, for example, information about cervical smear testing, cancer and diabetes. The sample were also asked about information they had received about alternative medicine; this was not considered such an important issue though respondents were comparatively well informed about it.

The Forum point out that 80% of respondents had received information about smoking, yet only 18% of respondents felt it was an important health issue for them (most Asians in the city are of Sikh origin and tobacco use is prohibited among them). Over 70% of the sample said that they would prefer health information to be conveyed via video, though many thought that leaflets would be helpful. Respondents were also asked where they thought improvements could be made. More information about going into hospital, accident prevention for young children and diet were cited as important issues.

**David, P.A. (1995). Service provision to Black people: a study of occupational therapy staff in physical disability teams within social services. *British Journal of Occupational Therapy* 58 (3), 98-102.**

A questionnaire was given to occupational therapists and their assistants in five locations in the city of Birmingham (n=32). Occupational therapists were asked about their perception of service take-up by Black people. Half believed that no services were being taken up and a quarter was not able to answer. The author makes a series of recommendations to improve service take-up among the Black population. These include: ethnic record keeping and monitoring, better provision of information and improved training.

**Donovan, J. (1986). *We don't buy sickness, it just comes. Health, illness and health care in the lives of Black people in London. Aldershot: Gower.***

Donovan examines the health and use of health care among 30 people of Afro-Caribbean and Asian descent (24 of whom were women) in London using in-depth, life-story interviews. Health and health care issues are considered in the context of immigration to Britain and race relations and the relative lack of research on the health of British ethnic minorities. Detailed demographic, medical, social and other information is provided on the respondents, who were recruited via personal contacts and a 'snowballing' technique. Questions were asked about: perceptions of health and illness; the causes and severity of ill health; and other factors that might affect health, such as diet and experience of racism.

All the Afro-Caribbean respondents were registered with a general practitioner (GP), though many expressed unhappiness with long waiting times, and perfunctory examinations. The men in the sample were particularly distrustful of doctors. The use of remedies by Afro-Caribbean respondents was commonplace. Three Afro-Caribbean female respondents had to wait a long time for serious medical conditions to be diagnosed; one eventually sought private treatment and four had seen a private doctor. As with the Afro-Caribbean respondents, all the Asian respondents (who were all overseas-born) were registered with a GP; most were registered with an Asian GP who spoke their own language. Six Asian respondents had sought hospital treatment, and two were very critical of it. One Asian female reported using a private doctor and one reported seeing a homeopath.

Donovan maintains that there are striking similarities in the respondents' perceptions of health and illness, and of the effects of depression, food, the environment, racism and religion on health. She also highlights the fatalism that is present in most of the interview accounts. Use of health services varied; Afro-Caribbeans tended to see their GPs less than the Asian respondents, made greater use of home remedies and were more sceptical of the National Health Service (NHS). Asian respondents were confident that the NHS could help them. Afro-Caribbeans, despite being poorer than the Asians, were more likely to use private treatment, which may be related to the practice of paying for health care in the Caribbean.

In conclusion, the themes of 'control, context and choice' are important to the health of Black people in the UK. 'Control' in the context of racism and immigration legislation, the conditions of work, place of residence and the attitudes of doctors; 'context' in relation to the way that the respondents reacts to or perceives illness; and 'choice' because the respondents lives are not controlled by overwhelming forces, there are aspects of their cultural heritage that they can draw on to deal with illness.

**Ebden, P., Carey, O.J., Bhatt, A. and Harrison, B. (1988). The bilingual consultation. *The Lancet* 1 (8581), 347.**

In the Asian community in Leicester, 27% of people speak little or no English. Here, the use of relatives as interpreters in an out-patient consultation setting is examined. Four Gujarati-speaking patients who had previously been attending an out-patients department were interviewed and recorded with a family member present who acted as interpreter. The analysis of the transcripts of 143 questions and answers yielded three areas of interest: the structure of the questions the doctor asked; translation of terminology; and aspects of Gujarati culture that hinder communication.

The results suggest there is substantial mistranslation in such situations. Simple questions had a best mistranslation rate of 16% and a worst of 39%. Questions that are more complex had a best mistranslation rate of 25% and a worst of 82%. Of the 143 questions and answers, more than half contained mistranslated or misunderstood words. Other important issues are those relating to cultural notions about what is appropriate to discuss within the household or outside it and embarrassment at having to translate questions about personal bodily functions (such as bowel movements).

**Fenton, C.S. (1985). *Race, health and welfare. Afro-Caribbean and south Asian people in central Bristol: health and social services*. Bristol: University of Bristol, Department of Sociology.**

The author presents the findings of research carried out in 1983-4 in Bristol. The focus is specifically on access to services by Afro-Caribbean and south Asian populations in the area, most of whom were adults and foreign-born (n=200). The respondents were sampled by targeting every seventh address in 15 enumeration districts in Bristol that have high concentrations of ethnic minority populations. Interviews with 50 White people were carried out for comparative purposes. Respondents provided details about various areas of their lives: the effects of racism, family and friends, and their use of language.

The analysis of data on access to health services indicates that Afro-Caribbeans and Asians were more likely than Whites to report consulting a general practitioner (GP) within the last month (57%, 47% and 40% respectively). The high rate among Afro-Caribbeans may be attributable to their older age, and it may be evidence of a poorer health profile. Whites, however, were more likely to report visiting hospital in the last month and year (20%) compared with ethnic minorities (15%). Problems with being understood by (and understanding) GPs was more likely to be mentioned by Asian females (about half of them mentioned this as a problem). Two fifths of Asians said that linguistic difficulties were a problem in their consultation with the GP or hospital staff, though some language problems were compounded by cultural misunderstandings.

The interviews with doctors suggests that they tended to see the problems they encountered with their minority patients as problems related to the inner city rather than as 'race relevant.' The responses to questions about access to social services (which were mostly about 'home helps', meals services, day centres and accommodation) suggests that it is neither true that the extended ethnic minority family can take care of its elderly nor that family structures are so fragmented that the care of the elderly necessitates help from outside the family. Knowledge of social care services for the elderly was high among Afro-Caribbeans but much lower among Asians, though use of services was low in both groups. Considerable numbers of both groups said that they would be more likely to use social care services if provision was modified to suit their tastes and needs.

In conclusion, a number of recommendations are made: that benefits advice and day centre provision be improved, that the needs of Asian women be better addressed and the accommodation

needs of ethnic elders needs to be recognised. Health services can also be improved by focusing on the language barriers that hinder effective care, addressing the specific needs of Asian women and improving hospital care access. No information on the socio-economic backgrounds of the respondents is presented, although the possible effects of poverty on health and access to health and social services are discussed.

**Forrest, D. and Sims, P. (1982). Health advisory services and the immigrant. *Health Trends 14* (1), 10-13.**

The London Borough of Tower Hamlets has a large Bengali community; many members of this community are poor and suffer from conditions such as tuberculosis and rickets. To address their needs, a health advisory service was set up in 1978 as a link organisation between migrants and the health service. The authors present a description of the service and an evaluation of its work. Data were taken from the records of the 370 individuals attending the service.

Most individuals using the service were male (83%) and were aged 20-49. Half had been in the country more than ten years. Most users of the service were registered with a general practitioner (GP) (45% had registered with a Bengali GP). Analysis of the reasons for using the health advisory service indicated that most came with physical symptoms (59%) and 28% attended for health advice. Over a third of people attending the service were referred back to a GP and 7% were referred to hospital. The results from a follow-up questionnaire completed by a random sample of 39 patients showed a high degree of geographic mobility; only 14 of these 39 patients could be interviewed. All of these patients could remember why they initially attended the service and the advice they were given. Most (12) thought the advice they received was good. The authors discuss the problems of providing a health care service to Bengalis in Tower Hamlets. They cite communication problems and a different cultural background and understanding of health and illness among Bengalis as limiting the development of services.

**Free, C., White, P., Shipman, C. and Dale, J. (1999). Access to and use of out-of-hours services by members of Vietnamese community groups in South London: a focus group study. *Family Practice 16* (4), 369-374.**

Data were collected from 51 individuals participating in focus groups in the London Boroughs of Southwark and Lewisham. All respondents were Vietnamese. There were six focus groups

comprised of a variety of individuals (the elderly, older women, younger women etc.). Group discussions were audiotaped, transcribed and coded.

The results suggest that most respondents did not know about general practitioner's (GP's) out-of-hours services, though most respondents were aware of emergency services (the 999 service) and were impressed by the speed of response. In all the groups, language problems were cited as a deterrent to use of services and a barrier to the communication of their health problems to health professionals. Children often acted as interpreters and respondents with poor English often used gestures to communicate with health professionals. The authors emphasise the commonality of themes across the focus groups, and mention the limitations of the study (focus groups do not permit in-depth exploration of individual perceptions).

**Garrish, K. (2001). The nature and effect of communication difficulties arising from interactions between district nurses and south Asian patients and their carers. *Journal of Advanced Nursing* 33 (5), 566-574.**

The author describes the findings from an ethnographic case study that explored communication difficulties between nurses and south Asian patients and their carers. Data collection involved: conducting in-depth interviews with eight managers; a review of caseload allocations; and a documentary analysis of local policy directives. This was followed by a participant observation study of nursing practice in six district nursing teams (four with high minority ethnic caseloads and two with largely White caseloads). Interview transcripts and field notes were analysed using dimensional analysis.

A major theme was use of spoken English. Over half of south Asian patients had no or poor understanding of spoken English; this was especially the case with women and older people. Garrish notes that, the fact that over half of elderly patients spoke no English, has an important bearing on the provision of care to a group who traditionally form a large proportion of the district nurses' caseload. The limited use of professional interpreters, and the dependency on family members for translation purposes, highlights how minority patients and carers who are not proficient in English can be disadvantaged. Out of 75 visits made by nurses to south Asian patients who understood little or no English, a family member interpreted in 60% of cases. Although relatives were often used to interpret, several nurses expressed dissatisfaction with this, expressing

worries about the possibility of inaccurate interpretation where relatives might not be fluent in English or did not have an understanding of medical concepts.

The author concludes that the findings from the study raise a number of issues about the quality of care provided to patients and carers who are not proficient in use of English. She maintains, however, not speaking English should not be a barrier to appropriate and effective nursing care.

**Gervais, M-C and Jovchelovitch, S. (1998). *The health beliefs of the Chinese community in England: a qualitative research study*. London: Health Education Authority.**

This book is largely about the health beliefs of the Chinese in Britain and not primarily about service access and use, so will only be described here briefly. Data were collected from experts on the Chinese community, from individual interviews and from focus group discussions. The authors link the health beliefs of the Chinese in England to the choice and evaluation of health services. They note that three sets of factors influence the use of health services by the Chinese: the structure and content of their health beliefs *per se*; the quality of encounters with health service personnel; and the availability of services. Although the Chinese people in the sample consulted three types of medical practitioner (Western medicine, traditional Chinese doctors and herbalists) they did not believe that there was a conflict between Western notions of medicine and Chinese traditional ones. Folk or classical Chinese remedies are used for minor and non-urgent conditions, or to treat the 'root or the cause of the problem'. Western medicine is used to treat severe conditions or the symptoms of illness. The choice of health service is also based on factors such as hours of opening, location of services and the availability of interpreters.

**Gillam, S. J., Jarman, B., White, P. and Law, R. (1989). *Ethnic differences in consultation rates in urban general practice*. *BMJ* 299, 953-957.**

Gillam and colleagues maintain that a 'historical perspective' is important when considering the use of health services by minority ethnic populations: 'The needs and expectations of minority ethnic groups are likely to change substantially over a generation'. They then describe the present study, where consultation rates and outcomes among minority populations who were registered with a medical practice in Brent, London in 1980 are analysed (n=10 877). Consultation rates were age-standardised and a standardised consultation ratio was constructed. To assess the effect of morbidity

on consultation rates, the number of times that a patient consulted with a specific condition was recorded and a 'patients' consultation ratio' was calculated.

A variety of differences in consultation by ethnic group status were found. For all minority ethnic women, standardised patients' consultation ratios were lower than the native British group. Among men, Asians had a slightly higher patients' consultation ratio than the British group. Consultation ratios and patients' consultations ratios were reduced for West Indian and Irish patients, and high rates of diabetes mellitus explained the high patients' consultation ratios for West Indian women and Asian males compared with White British individuals. Standardised patients' consultation ratios were reduced for all ethnic groups consulting for mental health reasons (except for Asian men who have the same ratios as White men). Standardised patients' consultation ratios for hypertension were significantly higher among West Indians. Asians had higher ratios (standardised consultation and standardised patients' consultation) for conditions of the respiratory system compared with all other groups. Native British individuals were more likely to be given a follow-up appointment after leaving the surgery and standardised home visiting rates were lower among West Indians and the Irish. The authors acknowledge the methodological limitations of the study, including small numbers (in places) and lack of standardisation for socio-economic status.

**Hawthorne, K. (1994). Accessibility and use of health care services in the British Asian community. *Family Practice 11* (4), 453-459.**

Hawthorne reviews the research literature on access to, and use of, health care services among Asians in the UK. He observes that, in the recent past, Asians in the UK were the targets of specific health education programmes, and were considered to have 'special needs' (i.e. rickets, tuberculosis and thalassaemia). The needs of this group revolve largely around issues related to communication, access to services, and information on specific conditions. Asians are not homogenous, and each group within the Asian community has its own health concerns and needs.

**Hopkins, A. and Bahl, V. (1993). *Access to health care for people from Black and ethnic minorities*. London: Royal College of Physicians of London.**

A collection of articles (from a workshop on the subject as well as commissioned) on access to health care services among British ethnic minorities. Many of the chapters are very general in scope, and will not be discussed in detail here. The book covers a number of areas, all concerned

with access in one form or another. Health policy and the purchasing of services for ethnic minorities are addressed, as is improving access to general practitioners (GPs), and better care for young people, children and ethnic elders. Five chapters deal specifically with the major illnesses that affect minority populations (diabetes, hypertension, coronary artery disease, haemoglobinopathies and mental health) and one chapter deals with health promotion and education. The importance of cultural awareness, improved and sensitive communication and consultation with the relevant groups, is emphasised throughout the articles.

**Lam, E. (1980). Health visiting Vietnamese refugees in Britain. *Health Visitor* 53 (7), 254-255.**

A brief and general discussion of one health visitor's experience of attending to the health care needs of Vietnamese refugees in Manchester. The author describes meeting families, establishing a relationship with them, aspects of their health, child care, family planning and mental health.

**Lawrenson, R., Leydon, G., Freeman, G., Fuller, J., Ballard, J. and Ineichen, B. (1998). Are we providing for ethnic diversity in accident and emergency (A and E) departments? *Ethnicity and Health* 3 (1/2), 117-123.**

Lawrenson and colleagues present the findings of a study of the collection and use of ethnicity data at Accident and Emergency departments (A&E) (with a primary care initiative in place) at five north London sites and one west London site. The study also assesses if the hospitals have policies on the training of staff in matters of importance to minority groups and if interpreters are available at the sites. Data were collected using semi-structured questionnaires, and staff in a variety of positions in A&E departments were questioned (n=22).

The results from the six sites show that all six have a policy of collecting data on the ethnicity of service users. In five of these, ethnicity is recorded by a member of staff and, at one, details are provided by the patient. Ethnicity data were used to measure attendance and improve services. Not all patients had their ethnicity recorded; in some cases, it was not considered appropriate. At most of the sites, ethnicity had not been a consideration when staff were hired and there were no formalised training for new staff at the sites. Most interviewees indicated that interpreting services were available or staff were present who could act as interpreters. The authors point out that data on ethnicity is not systematically collected (this may be attributable to the perception that it is a 'delicate issue'). Staff were not well informed about the uses of the data and there were problems

with the recruitment of staff and the provision of language services. They conclude that providing 'culturally competent' services did not appear to be a priority at the sites and there is a need for improvement of services given the ethnic diversity of the population in the north Thames area. This is a small, largely exploratory study, the findings of which may not be applicable elsewhere.

**London Group on Race Aspects of Community Care (1992?). *Black communities: who cares? Report of two workshops held in May and July 1991.***

The Group is comprised of key managerial and advisory staff from most London Boroughs' Social Services Departments (and is co-sponsored by the Department of Health Social Services Inspectorate and other groups). The report presents details of the findings of two workshops held in 1991, which examined issues about community care that are important to Black communities. It is very general and will not be discussed in detail here. After the introduction, which emphasizes the inappropriateness of many community services for Black people, the report is then divided up into findings and recommendations from the two workshops. A number of concluding remarks are made; among which is that Black care workers need to be supported in their roles so that they can work more effectively with the Black community, and care staff need more training in issues relating to race equality.

**Madhok, R., Bhopal, R.S., Ramaiah, R.S. (1992). Quality of hospital service: a study comparing 'Asian' and 'non-Asian' patients in Middlesbrough. *Journal of Public Health Medicine, 14(3), 271-279.***

The authors compare Asian and non-Asian patients' experience of, and satisfaction with, non-clinical aspects of hospital care in Middlesbrough (UK). Recently discharged patients (52 Asians and 52 non-Asians) were matched for sex, age, type of admission and hospital. The main differences between the groups related to communication and language problems, Asian women patients' attitudes to examination by male doctors, and provision of and satisfaction with hospital food (90% of Asians, but only 27% of non-Asians, required a special diet). Following the provision of Asian food, Asians reported greater satisfaction with hospital food.

**Madhok, R., Hameed, A. and Bhopal, R. (1998). Satisfaction with health services among the Pakistani population in Middlesbrough, England. *Journal of Public Health Medicine* 20 (3), 295-301.**

The authors explore the satisfaction of the Pakistani population in Middlesbrough (UK) with a range of health services. Data from a survey of Pakistani people, who had been interviewed in the home, were analysed. Generally, satisfaction among those who had used National Health Services (NHS) services was high. Most (94%) were satisfied with their general practitioner (GP), 93% with the GP's receptionist and 97% with hospital doctors. Low levels of dissatisfaction were found in relation to accident and emergency (A&E) services, care provided by hospital nurses and with information on specific conditions and treatment. Of the hospital patients (n=34), 19 were informed about the availability of Asian meals, and most (65%) were satisfied with the meals. Few respondents had been informed about the availability of interpreting services. The authors conclude that the Pakistani patients in their study reported high levels of satisfaction with health services.

**Malcolm, P.N., Chan, T.Y.K., Li, P-L, Richards, J. and Hately, W. (1995). Management of dyspepsia among Asians by general practitioners in East London. *BMJ* 310, 910-911.**

The authors explore referrals for dyspepsia among ethnic groups in the London Borough of Tower Hamlets. Data were taken from barium meal and swallow examinations referrals in the period 1991-1992 at hospitals in the borough (n=834). Data were also taken from referrals for endoscopies (n=417). The results show that there was a significantly higher referral rate for individuals of Asian origin for barium studies (7.5/1000 compared with 4.4,  $p < 0.001$ ). The referral rate for endoscopy was also higher for south Asians than other groups (3.1/1000 compared with 2.4,  $p = 0.02$ ). The actual level of illness in Asians did not explain their greater rate of referral to services. The authors note that they do not consider the effect of socio-economic deprivation on referrals and that somatisation (expression of psychological distress) among Asians may be important.

**McAvoy, B.R. and Donaldson, L.J. (1990). *Health care for Asians*. Oxford: Oxford Medical Publications.**

This is (largely) a handbook for general practitioners (GPs) though it contains chapters that deal with various aspects of the health care of British Asians. Background information is presented on the origins and lifestyles of Asians in the UK (including religious beliefs and observances, the

significance of names) and the importance of cultural factors in the health and well-being of immigrant communities. The most relevant chapter is by McNaught (though chapters by McAvoy and Sayeed on communication, and McAvoy on the health of Asian women and MacVicar on obstetric health, contain some details of service provision and use). McNaught (organisation and delivery of care) points out that health authorities have policies drafted specifically to address the issue of access to services by minority ethnic populations, but these are not always fully implemented. This failure is quite visible, however, compared to the situation that prevails at general practice level, which is by definition a very private situation that is generally not open to scrutiny.

Reviewing the evidence that exists on the use of general practice services by Asians, McNaught reminds us that the literature is surprisingly sparse considering that most minority individuals appear to be registered with (and using) GP services. The literature that is available tends to do one of three things: it looks at the extent to which Asians register with and use their GPs; it explores the difficulties that GPs have in providing a service to Asians; and, lastly, it examines the patient's perspective and addresses the extent to which GP services are sensitive to the needs of the Asian community. Studies that have examined aspects of registration and use of GPs indicate that Asians are likely to be registered and to make full use of GP services. The more frequent visits to their GP, and the greater likelihood of a home visit, may be attributable to the higher number of children in Asian households. Research into GPs' perceptions of Asian patients indicates that some GPs believe that Asian patients are more likely to present with what the GP considers to be a trivial problem (though they are less likely to present with a psychosocial problem) and they take up more time than other patients.

McNaught suggests that other studies have indicated that, where there are problems with Asians' use of GP services, these problems are related to deficiencies in the primary care system. The problems of referral for secondary care are compounded by language difficulties and there are differences between Asians according to their class background; GPs and nurses note fewer problems with 'westernised' or middle class Asians. The final category of research, which addresses Asian patients' perceptions of services, often characterises health services as insensitive to the needs of Asians and often racist in its approach to them. McNaught maintains that this situation no doubt exists, but it exists alongside a situation of high usage of services by Asians and considerable

satisfaction with services by this population. McNaught identifies a number of issues that can be extracted from this (contradictory) literature; these issues can be broadly defined as those relating to human resources management (the need to improve communication, address language barriers, train staff) and those relating to practice organisation and facilities (appropriate facilities).

**McFarland, E., Dalton, M. and Walsh, D. (1989). Ethnic minority needs and service delivery: the barriers to access in a Glasgow inner-city area. *New Community* 15 (3), 405-415.**

**And**

**McFarland, E., Dalton, M. and Walsh, D. (1987). *Personal welfare services and ethnic minorities*. Scottish Ethnic Minorities Research Unit Research Paper no. 4. Glasgow: Research Unit, Glasgow Caledonian University.**

The authors give detailed consideration to the nature of the research literature that deals with social service provision to British minority communities, which they maintain was of a fragmentary nature for a long period. The aim of this study is to explore the views of (and utilisation of) social service care by Scottish minority ethnic populations. Data were collected in the East Pollokshields area (which has a fairly large Asian population) by open-ended interviews (n=60) with individuals selected from the electoral register.

The results of the study suggest that most minority respondents were not aware of the range of social welfare services that are available to them. For those families that did require help from the social services team, one problem was that of restricted availability (in the geographic sense and also a cultural/linguistic sense). The authors found that, while most of the White comparative group (n=10) felt they did not need the help of social services, all of them knew where they could turn to for help. Most (61%) Asian women thought that their community did not make full use of welfare services, which the respondents attributed mostly to lack of awareness, language problems and the unhelpful attitude of White service providers. Most of the White group (80%) thought that Asians did make full use of such services (some expressed resentment about this).

The authors also considered the needs of mothers and small children. Many women in the sample made use of informal childcare arrangements, though it was mentioned by respondents that more playgroups would be a benefit to the community. Analysis of data on use of healthcare facilities

indicates that Asians were more likely to consult their GP than other groups, and most Asian women (82%) indicated that they would prefer to see a female doctor. The data on the health of the Asian elderly population suggests that all were being cared for at home, though there was the possibility of unmet need. The White sample was much better informed about concessionary travel, 'meals on wheels' and 'home help' services. Of those four Asian elders who did not previously know about these services, three indicated that they would be useful. Five Chinese families were interviewed for the study. The younger Chinese respondents were more aware of social welfare services. No Chinese elders were aware of concessionary travel or 'home helps', and cited language problems as the reason for this. All the Chinese respondents thought that the Chinese were 'getting a poor deal' from the welfare services and thought that Asians were more likely to use them.

In conclusion, the authors maintain that service awareness and take-up was low in the sample, and there were two main problems: inadequate provision and poor communication. These findings, while useful, are specific to this geographic location and probably cannot be generalised to other populations elsewhere. The socio-economic context within which this research was undertaken is mentioned, though little consideration is given to the effects of deprivation on access to care.

**McNaught, A. (1988). *Race and health policy*. London: Croon Helm.**

McNaught describes the National Health Service (NHS) response to the needs of migrants, tracing it from the 1965 White paper on Commonwealth Immigration (which depicted migrants as imposing a burden on the health services and recognised their healthcare needs as difference in degree, but not kind, of Whites). The White Paper did advocate 'special attention' by authorities to the needs of migrants, but did not practically follow this up. A number of researchers expressed concern about some aspects of migrant health (venereal disease, tuberculosis) but McNaught says that, from the late 1960s and throughout the 1970s, there was little research concerned specifically with the health and healthcare needs of minority groups. There have been improvements in our knowledge of the health of ethnic minorities since that time (McNaught discusses the implications of Marmot's work on immigrant mortality and the Black Report of 1980) though data limitations are still a problem.

There have been a number of initiatives in the NHS (at national and local level) to promote positive health, and address care needs among British minority ethnic groups, though many of the earlier

policy initiatives are more *generally* concerned with reducing inequality and unequal access and make little mention of minorities. McNaught makes a connection between the 'laissez-faire' attitude to post-war migrants in the early days of the NHS and the lack of policy thereafter. He then provides an example of policy development (drawing on material collected through interviews with 26 members of staff) in West Lambeth Health Authority which illustrates the key themes of his historical analysis. McNaught observes that race was not mentioned as an issue for the health authority until 1979/80 when it started to appear in policy and planning documents (and even then not in a substantive way). He also notes discriminatory attitudes towards ethnic minorities among the staff (both Black and White) in the health authority, although many workers acknowledged problems with issues relating to access for some individuals. McNaught makes a series of proposals to promote better consideration of the needs of ethnic minorities by health policymakers.

**McNaught, A. (1985). *Race and health care in the United Kingdom*. London: Health Education Council.**

Many of the issues discussed here are covered in McNaught's later work (1988, above) except that here, the name of the health authority (West Lambeth) is not given. The later work also has a more detailed discussion of the development of policy. McNaught provides a discussion of the main issues that affect access to health care for ethnic minorities and outlines a number of approaches that might be used to help minority populations access care. The inadequacy of the National Health Service (NHS) in meeting the needs of minority groups is traced back to the period after WWII when sentiment to migrants was generally hostile and migrant groups were believed to bring 'disease into the country'.

In the period 1950-1970, a number of initiatives were started to deal with the health needs of migrants and their children (provision of information, tuberculosis testing, medical examinations of children) though McNaught notes the racial stereotyping that often accompanied such initiatives. (In one example, West Indians are described as having a 'happy-go-luck' attitude to life). In the 1970s and 1980s, despite the widespread employment of minority ethnic individuals in the health service, McNaught detects scant evidence that provision improved for minority populations. The experience of a local health authority in the development of policy to deal with the needs of minority groups in the community is described and recommendations are made.

**McKinley, R.K. and Roberts, C. (2001). Patient satisfaction with out-of-hours primary medical care. *Quality in Health Care* 10 (1), 23-28.**

Only brief details of this paper will be given here since, although ethnicity is used in the analysis, the focus of this study is not on use of service by minority groups, but on describing the relationship between patient satisfaction with out-of-hours deputising and practice doctors, and associated factors (type of care given, health outcomes). Data were provided by respondents who had participated in a study of out-of-hours care in four urban locations in England and Wales and who were asked about their level of satisfaction with the service. Respondents were categorised as either 'White' or 'Nonwhite'. Over 2000 people were recruited to the study, though only 1402 completed at least part of the questionnaire. The results indicate that patients were less satisfied with treatment provided by a deputising doctor (preferring, instead, a practice doctor). Non-white respondents were less likely to be satisfied with communication and management issues, the attitude of the doctor and the initial contact person, compared with White respondents.

**Memon, M., Abbas, F., Singh, I. and Gupta, R. (2001). Ethnic minority: restricted access. *Health Services Journal* 111 (5758), 22-24.**

A very general, and brief, discussion of access to health services by British minority communities. The author describes how the government is committed to reducing inequity of service use among minority ethnic communities; this is especially important given the greater burden of ill health among such groups. A survey of health authorities showed that many were aware of the need to address the health concerns of minority groups in their areas, and some had projects in place to help minority ethnic communities. Primary care groups who were asked about their awareness of the health needs of minority groups generally showed a lower level of awareness than the health authorities and had fewer schemes in place to deal with the health needs of minority groups.

**Nguyen-Van-Tam, J., Simpson, J., Madeley, R. and Davies, L. (1995). Health care experiences of Vietnamese families in Nottingham. *Health Trends* 27 (4), 106-110.**

The authors report the main findings of a study of the health behaviour and use of health care by the Vietnamese community in the Midlands (UK). Respondents' names were taken from the Nottingham Vietnamese Centre register and a structured interview schedule was used to collect

data. Questions were asked in a variety of areas: demography, lifestyle, illness behaviour and use of general practitioners (GPs).

One hundred and thirty five individuals in 71 households were interviewed. The health service consultation patterns of the respondents indicated that, during bouts of illness, a third of respondents often consulted a GP while about 5% never consulted a GP. Two thirds claimed that they sometimes consulted a chemist during illness and 80% reported no consultation with a traditional Chinese health practitioner (though use of Chinese herbal medicines was fairly high; nearly a quarter used traditional creams and ointments during illness). Most (98.5%) respondents were registered with a GP. The sample's experience of general practice varied but, generally, between 19% and 32% of the sample found different aspects of the GP consultation very difficult (e.g. travelling to the surgery was rated as very difficult by 19% of the sample, and a third of the respondents reported great difficulties explaining to the doctor what was wrong with them). Just under half of the sample said that they had been put off going to the GP because of language problems. Of 54 women asked about their experience of the cervical and breast screening programme, 37% could not explain what was meant by a cervical smear. The authors point out that this is a small survey, though the response rate was high (at 92%).

**Rashid, A. and Jagger, C. (1992). Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester. *British Journal of General Practice* 42 (358), 197-201.**

In Leicester, 22% of the population is of Asian origin and it is important that health care services are appropriate for this large and growing population. The authors report the findings of a study of the use of, and attitudes to, various health care services (primary health care services, hospital services, home visiting, out-of-hours care) by age-matched Asian and non-Asian patients in Leicester. Respondents' details were taken from the family health services register and ethnicity was determined by name. A closed questionnaire was used and respondents were interviewed in their homes (n=896).

The results suggest that communication problems are not confined to non-White communities; though Asians had more problems communicating their symptoms in English, they were better at communicating in medical terms than non-Asians. In addition, lack of access to a doctor of a

particular sex was a problem for about 10% of Asian patients compared with nearly 12% of non-Asians. More Asian patients reported problems gaining access to their general practitioners (GPs) than non-Asians, citing waiting times as particularly important. However, receptionists were considered a barrier to GP access for nearly 19% of Asians compared with 29% of non-Whites.

The data on use of hospital services indicates that nearly half of Asians would prefer direct access to hospital consultants compared with a quarter of non-Asian patients. Asians were less likely to want telephone advice than non-Asians and both groups regarded home visits as essential. Around a fifth of both groups had received a home visit in the previous three months. There were differences between the groups in preferred home visiting times; most non-Asians expressed a preference for morning visits. Asians were significantly more likely than non-Asians to believe that doctors surgeries should stay open 24 hours a day. The authors maintain that the responses given by Asian respondents suggests that they have a different approach to use of the health care service. They use services but their need is for more personal care, greater continuity and better access. The authors do not discuss the health profile of the Asian respondents or their level of need.

**Rathwell, T. and Phillips, D. (1986). *Health, race and ethnicity*. London: Croon Helm.**

This book is a compilation of papers presented at a conference in Leeds in 1983. Part two of the book is devoted to issues of health care for ethnic minorities. Donovan (Black people's health: a different approach) describes the preliminary results of a study of the health and health care experiences of a group of people living in London in the early 80s (n=30), most of whom were women. Basic details are provided about the characteristics of the group and their recruitment to the study. The main findings suggest that the Asian women in the group were more likely to access general practitioners (GPs) than Afro-Caribbeans, while Afro-Caribbean women were more likely to use home remedies before they consult their doctors. Most of the Asian women (12) chose doctors that spoke the same language as themselves. Afro-Caribbean men were very sceptical of the National Health Service (NHS) and GPs, and they and others expressed a dislike of most medication (especially in pill form). Some of the Afro-Caribbean women had seen a private doctor.

Johnson (Inner city residents, ethnic minorities and primary health care in the west Midlands) discusses the results of a study of the use of primary care health services by minority ethnic groups in the west Midlands area (n=2147; 915 White, 867 Asian and 365 Afro-Caribbean). Almost all

(99%) were registered with a GP and 76% of Asians were registered with an Asian GP or with a practice which had an Asian GP. Consultation rates (in the previous year) were the highest for Asians (24% of whom had had six or more consultations in a year compared with 21% of Afro Caribbeans).

Johnson also examined the effect of distance from GP on access; the results suggest that this varied from place to place and by ethnic group. In Wolverhampton, for example, only 13% of Asian respondents said that their GP's surgery was in the same ward; this figure was 61% for Asian respondents in Birmingham and 90% in Coventry. The unequal distribution of Asian GPs may affect registration patterns and, consequently, access to services. Johnson also provides data on the use of services by income and socio-economic status. 'High social class' or 'high income' Afro-Caribbeans made substantially less use of their GPs than Whites and Asians. Some consideration is given to the use of preventive medicine (immunisation and use of alternative medicines), though the take-up of immunisations was high among Asians and Afro-Caribbeans and attendance at child health clinics was only slightly less than for the White respondents (and not significant). Asians in the sample were less accepting of traditional medicines, while Afro-Caribbeans expressed greater belief in the efficacy of traditional remedies (51% thought that they may be better than conventional medicine, only 24% Asians agreed).

**Richardson, J. and Leisten, R. (1994). *Access to health. Investigating the ethnicity question: a minority ethnic perspective*. Buckinghamshire: Buckinghamshire Health Authority and the Faculty of Humanities and Social Sciences, Nene College.**

The authors report the findings of a study into access to health care services among minority ethnic populations in Buckinghamshire in the period 1993-1994. The study employed a number of methods: a pilot study; a survey (n=77) using a structured questionnaire; interviews with respondents who had recently used a general practitioner (GP) (n=40); interviews with respondents who had recently used hospital services (n=40); and interviews with service providers (n=5). Respondents from minority ethnic populations were recruited from English language classes in the area and were mostly (66%) female and of Indian or Pakistani origin (73%).

The results of the survey with respondents (77 in total) indicate that most individuals (84%) had not heard of the Patient's Charter (which guarantees, in theory at least, equal access to health care

services) and most (92%) were registered with a GP. Most respondents took someone with them when they went to the GP or hospital, and expressed a need for greater language-based help. For most respondents (52%), relatives provided information about health services. Interviews with 40 respondents who had recently seen a GP suggests that language problems are an issue, with 40% reporting that someone else made an appointment with the GP for them. Women who took male members of their family to the doctors to interpret for them reported feeling embarrassed if the medical problem was a personal one (i.e. 'women's problems') or if the doctor wanted to examine them. Generally favourable comments were made about receptionists in GPs' surgeries and facilities in the waiting room. Most respondents (65%) who indicated that they needed an interpreter were not offered one. Most respondents (80%) who had recently used hospital services provided favourable responses, though some (35%) did not have access to interpreting services.

Interviews with service providers demonstrated that many were not sure that ethnic monitoring would enhance services and most did not distinguish in the provision of services between minority populations and the general populations. Many believed that some groups made more demands of services than others (West Indians made more use of mental health services, Pakistanis used services for children with learning disabilities). Most service providers were aware of language and communication problems and most were supportive of measures to improve consultation with ethnic minorities. In conclusion, language-based issues and the need to implement culturally appropriate services emerge as important to removing barriers to health care among minority populations. No data is provided on the socio-economic or educational backgrounds of respondents. The recruitment of respondents from language classes has implications for the generalisability of the findings; the views of individuals not attending such classes obviously cannot be ascertained here.

**Salisbury, C. (1997). Postal survey of patients' satisfaction with a general practice out-of-hours cooperative. *BMJ* 314, 1594.**

The results of a survey of patients' satisfaction (in Kensington, Chelsea and Westminster) with out-of-hours care are reported. These results are compared with results of a commercial deputising service in the same health authority area and a neighbouring authority (Brent and Harrow). A questionnaire designed to measure satisfaction with services was sent to patients who had received either the care provided by the cooperative or care by the deputising service, and responses were

coded and analysed. The use of service by minority groups was not a principal focus of the study, though ethnicity was used in the analysis. The response rate was 67% (1555/2312) and there were few differences, in terms of patient satisfaction, between the two models of service delivery. A significantly higher proportion of patients who used the deputising service (44%) came from non-white minority ethnic groups (no details are given about which ethnic groups these patients belong to) than did those who consulted the cooperative (25%) (odds ratio=2.29, adjusted for age and sex), and minority patients were less satisfied with general practice out-of-hours services than Whites ( $p<0.001$ ).

**Scaife, B., Gill, P.S., Heywood, P.L. and Neal, R.D. (2000). Socio-economic characteristics of adult frequent attenders in general practice: secondary analysis of data. *Family Practice* 17 (4), 298-304.**

A variety of factors affect consultation patterns and rates, including age, sex and morbidity. The aim of this study is to establish the socio-economic indicators of frequent general practitioner (GP) consultation using Fourth National Survey of Morbidity in General Practice (MSGP4) data. Frequent attendance for GP consultation was defined as: 1) 12 or more consultations over a year and 2) more than six consultations a year for minor illnesses. The effect of a variety of factors on consultations were explored, one of which was ethnicity (for White, Afro-Caribbean and south Asian groups).

The data on respondents attending 12 or more times a year suggests that frequent attendance is associated with class (people from classes IIIM, IV and V were frequent attenders) and ethnicity (as well as other factors). Afro-Caribbean respondents had an odds ratio of 1.20 and south Asians a ratio of 1.38 compared with Whites (=1). The odds ratio for the 'Other' group, who were mostly Chinese, was 0.93. Similar results were found for the other measure of frequent attendance (consulting the GP on more than six occasions for minor illness), though the odds ratio for the 'Other' group was slightly above one using this measure. Ethnicity is not the focus of this study, so the authors do not use it further in the analysis.

**Smaje, C. and Le Grand, J. (1997). Ethnicity, equity and the use of health services in the British NHS. *Social Science and Medicine* 45(3), 485-496.**

**and**

**Smaje, C. and Le Grand, J. (1997). *Ethnicity, equity and the use of health services in the British National Health Service*. LSE Health Discussion Paper No. 5. London: LSE Health.**

The authors discuss if there is equity of treatment in the National Health Service (NHS) for ethnic groups, and present an analysis of the General Household Survey. They also discuss the importance of relating use of services to need. The data used were aggregated to provide a good sample size and a random 10% of data on White respondents were used for comparative purposes.

Smaje and Le Grand use two methods to analyse the data: use/needs ratios and multivariate analysis. The results using the first method (where use of services is considered in relation to need) were generated by assessing the extent of long-term illness and calculating the use of health services, and appear to indicate that many minority ethnic groups use more services than they need (with Bangladeshis using 57% more services than they need and Pakistanis using about 33% more than they need). Disaggregated results (which distinguish between sick and not-sick, socio-economic groups and utilisation of different services) suggest that there is an excess of general practitioner (GP) consultations among sick Indians and Pakistanis, though other differences are quite small. Most minority ethnic groups underused out-patient services. Analysis of results by socio-economic status indicate that there was little variation across the groups.

The second method used is a multivariate analytic one; need, age, socio-economic status and gender are considered together. The results for the under 44 age group indicate that higher GP consultation rates among Pakistanis appear to be explained by disproportionate use of services by sick Pakistanis, with females reporting nearly 30% lower use of services compared with Whites. Caribbean males were less likely to use services than Caribbean females. High rates of GP consultation were found among the over 44 age group Pakistanis, Indians and Caribbeans. Results for out-patient utilisation suggest that illness is again the strongest predictor of use and all minority ethnic groups use out-patient services much less than Whites after controlling for need and socio-economic status in the under 44 age group. A different pattern emerged in the older age groups, with excess use for Caribbeans and Africans.

The final results, those relating to use of in-patient services, show that illness predicts the greatest use of services, as does age and being female in the younger age group; there is also little variation in use of services by ethnic group membership. After controlling for need, Indians were 20% less likely than Whites to use services, while Pakistanis were about 20% more likely. Indian females were about 40% more likely to use in-patient services than their White counterparts. The authors conclude that, of all the groups, the Chinese appear to be the least likely to use all health care services, while the situation for all other ethnic minorities may be described as 'equal treatment for equal need'. They draw attention to the lesser use of out- and in-patient services by most minorities after controlling for confounding variables. Inequity may, therefore, be present not at the GP level but at the referral level. The situation for Pakistani women is also considered (they had low rates of GP utilisation) and the high use of GP consultations by Indians and Pakistanis with illness. There are a number of assumptions that this analysis is based on: that self-report measures of health are indicative of need; that socio-economic measures used are stable across all minority ethnic groups; and also that the 'units' of use of services are comparable across minority ethnic groups. The latter point is important since no consideration is given here into the nature of the interaction between medical personnel and patients.

**Sproston, K.A., Pitson, L.B. and Walker, E. (2001). The use of primary care services by the Chinese population living in England: examining inequalities. *Ethnicity and Health* 6 (3-4), 189-196.**

Sproston and colleagues explore the use of primary care services (general practice (GP) consultations) by the Chinese population in England. The authors consider GP consultations in relation to factors such as country of birth, language spoken and use of traditional medicine. Respondents were identified by a search of electoral registers in randomly selected English wards (n=1022) and data were collected by interviewer-administered questionnaire. The results of the survey were compared with the results of similar surveys of the use of GP services in White and minority ethnic communities (such as the Health Survey for England and the Fourth National Survey of Ethnic Minorities).

The results indicate that the self-reported health of the Chinese respondents was similar to that in the general population. Lower levels of GP consultation were observed among the respondents. Nearly a fifth of the sample had visited a GP or health centre in the month before the interview (this

compares with 28% in the general population) and 64% of Chinese respondents had consulted a GP in the previous year (compared with 76% of the general population). Only 36% of Chinese people with self-reported poor/very poor health had seen a GP in the month before the interview (compared with 70% of similar Whites and 84% of Pakistanis or Bangladeshis).

Multivariate analysis of the factors associated with GP consultation (using independent variables such as age, sex, language spoken, level of illness) indicates that (after controlling for all the other factors) age, sex, general health and whether the respondent speaks English or not were significant (odds ratio for visiting a GP in the last month for women=1.91, compared with men. Odds ratio for age group 50-74=2.39 compared with the age group 16-29. Odds ratio for people having fair/bad/very bad health compared with those who reported very good/good health=2.11. Odds ratio for visiting a GP for those who do speak English compared with those who do not=2.80). A similar trend was found when the analysis used GP consultation in the previous year as the outcome variable (though age was not significant and having a long-standing illness became significant). In the discussion, the authors point out that this is the first nationally representative survey of the Chinese population's use of health services. They conclude that levels of GP consultation in this population are low and that lack of English is a barrier to use of services. The study relies on self-report measures of health status.

**Sproston, K., Pitson, L., Whitfield, G. and Walker, E. (1999). *Health and lifestyles of the Chinese population in England*. London: Health Education Authority.**

The methodology of this study of the health of the Chinese community in Britain, and results of the analysis of the data on the use of primary care are described above (Sproston et al.,2001). Additional data is presented here on the use of hospital and dental services, and the use of traditional medicine. Just over one in ten of the respondents had made an out-patient visit in the three months before the interview (this is lower than the figure for the general population, which is around 15-16%). In-patient day treatment had been used by around 9% of the sample, which was slightly higher than the figure for the general population (at 6-7%). Around 5% of the sample had stayed in hospital overnight within the last year. After controlling for the effects of: sex, age, social class, country of birth, use of English, self-reported health and self-reported long-standing illness, the odds ratio of having attended out-patients within the last three months were significant only for those reporting fair or poor general health or long-standing illness. These results were replicated for

the use of in-patient services and having stayed in hospital overnight (this was also associated with being female. Odds ratio=2.71 compared with males, after controlling for the variables mentioned above).

Around 70% of the sample was registered with a dentist, and around half of those registered had visited the dentist in the year before interview. This figure is lower than that for the general population. After controlling for the effects of sex, age, social class, use of English and country of birth, having been to the dentist within the last year was associated with being female (odds ratio=2.14 compared with males,  $p<0.01$ ), being in social classes I and II (odds ratio=1.66 compared with social classes IV and V,  $p<0.05$ ) and being able to speak English (odds ratio=2.13 compared with those who cannot speak English,  $p<0.01$ ). A fifth of the female respondents had used cervical screening services and 9% had used breast screening services.

The authors describe in detail the use of the traditional Chinese medicine (TCM) among the respondents: 6% of the sample had spoken to a traditional Chinese doctor in the four weeks before interview. People born overseas were more likely to have consulted a traditional Chinese doctor (7% compared with 1% for those born in the UK). Respondents in social classes III, IV and V were more likely than those in social classes I and II to have consulted a traditional doctor. 5% of individuals who had consulted a general practitioner (GP) in the previous four weeks had also visited a traditional Chinese doctor (2% had visited the latter but had not consulted their GP). After controlling for the effects of sex, age, social class, use of English, country of birth and self-reported general health and long-standing illness, just self-reported general health was a significant factor associated with a visit to a traditional Chinese doctor (odds ratio=2.38 for those reporting fair/bad/very bad general health compared with those reporting very good/good health).

The authors maintain that previous research has demonstrated that TCM is seen as an *additional* form of medicine to Western medicine by Chinese people in the UK, and the two forms of medicine are not mutually exclusive. There are some situations where TCM is more likely to be useful and this varies by age (e.g. the percentage of people aged 50-74 who would initially use TCM for diarrhoea was 26%, but only 10% of those aged 16-29 would use TCM first). Over half of the sample believed that there are some health problems which can be dealt with better by a traditional Chinese doctor than by a Western one, though nearly 60% of the sample thought that TCM was too expensive to use regularly.

**Swarup, N. (1992). *Equal voice. Black communities' views on housing, health and social services*. Report No. 22. Portsmouth: Social Services Research and Information Unit and Portsmouth Polytechnic and Hampshire Social Services.**

Swarup reports the findings of a 20 month-long research study of aspects of service provision (housing, social services, health care) among minority ethnic communities in south east Hampshire. A household survey was carried out (n=308) using a structured questionnaire (qualitative data were also collected). Interviews were also conducted with service providers.

The results suggest that knowledge and use of social services varies among the groups. Nearly 70% of the Bangladeshi community had not heard of the social services department, for example, compared with 30% of Chinese people. Use of social services was low among all groups. Reasons for non-use of social services included responses such as: 'no need to use the service' to 'see it as a White organisation.' Some respondents said that they would be unwilling to use the service because it would be shameful to take private problems outside the home. Most respondents (99%) were registered with a doctor and most had used health services in the year of the interview. Respondents were more likely (40%) to find out about health services from friends or relatives than by any other way. Most respondents (67%) expressed satisfaction with their general practitioner (GP) and over half (58%) were satisfied with hospital services. Many respondents had to rely on the interpreting skills of a friend or relative in a health service setting (89% of Bangladeshis) and 11% of people interviewed said that they thought that they had been discriminated against when using health services.

Interviews with health service providers demonstrate that many are unaware of the needs of the minority ethnic population in this region. Swarup highlights a number of key issues in her conclusion: the importance of communication and consultation, racism in health, social care and other services, cultural and religious sensitivity and the under-representation of minority ethnic staff in health and other services.

**Thorogood, N. (1989). *Afro-Caribbean women's experience of the health service*. *New Community* 15 (3), 319-334.**

Thorogood presents the findings of a qualitative study of Afro-Caribbean women's use of health services (n=32). All the women lived in Hackney, were aged 16-30 and 40-60 and were recruited to

the study either from the waiting room at a health centre or by word of mouth. All of the women were registered with a General Practitioner (GP).

Continuity of care emerged as a key theme from the interviews; 29 women mentioned it and 23 reported that they prefer to see the same doctor at each visit. Most respondents had strong ideas about what constitutes a 'good' doctor. For the older women especially, this would be a 'old-fashioned family doctor' similar to doctors in the West Indies. Fourteen respondents had, at some point, changed their doctor because they were dissatisfied. The author notes some generational similarities; young, UK-born women tended to have the same perspective about some aspects of medical care as the older women.

Thorogood observes that a relatively high proportion of the British Afro-Caribbean community were employed in the health service; eight women had been (or were at the time of the interview) employed in the health service. Among those women who had experienced hospital care (other than for the delivery of a baby) most felt that standards in the National Health Service (NHS) were deteriorating. Most (65%) of the respondents believed that the NHS did not discriminate against Black people, women or the poor, though many respondents said that better treatment could be obtained by paying for it.

**Walker, R. and Ahmad, W. (1994). Windows of opportunity in rotting frames? Care providers' perspectives on community care and Black communities. *Journal of Critical Social Policy* 40 (2), 46-69.**

Walker and Ahmad draw on material from a survey of 22 care providers who provided information on the implications of new community care policy in Bradford (see the paper by the same authors in the 'ethnic elders' category below, for a discussion of the methods). Here, the focus is more general and not on any specific section of the Black population. The respondents made a number of general remarks about the new policy; many expressed optimism about it but were also worried about lack of resources, excessive strain on voluntary groups and voiced the belief that government social policy is antagonistic to the community care ideal. Many respondents also expressed anxiety about increasing bureaucracy. The new policy encourages greater communication with the public but many care providers believed that this would 'swamp' services with 'unfillable demand.'

Comments made specifically in relation to the needs of the Black and Asian communities included the belief that many Black groups are marginalised in social services provision and that consultation with Black groups was often tokenistic (one respondent cited a 15 minute consultation with 70 people). The poor consultation with minority voluntary groups is not helped by their lack of resources and lack of experience. Walker and Ahmad argue that special provision to minority groups cannot be reduced to simplistic arguments: discrimination in service provision and the fact that some care needs cannot be met unless there is special provision are two factors that bolster the argument for special provision for some groups. Black and Asian people frequently get the message that services are not for them, when their dietary needs are not taken seriously, for example, or when they cannot communicate their needs because they do not speak English. The needs of carers from minority communities are especially overlooked; they are taken for granted and it is often assumed that Black and Asian people needing care live in extended families who can provide it for them. The authors conclude that it is erroneous to assume that there is a level playing field in the competition for resources; Black communities have to negotiate more barriers yet have fewer resources than many other communities. If Black voluntary sector groups are to survive, they may have to forge alliances with White groups, which may mean some loss of autonomy.

**Watt, I.S., Howell, D. and Lo, L. (1993). The health care experience and health behaviour of the Chinese: a survey based in Hull. *Journal of Public Health Medicine* 15 (2), 129-136.**

The authors describe how they randomly selected respondents from 30 Chinese 'takeaway' shops in Hull and administered a questionnaire to the Chinese individuals working in them. The respondents were asked questions on their knowledge, use and experience of primary health care, health promotion and aspects of their health behaviour (n=80). White workers in 30 fish and chip shops were given the same questionnaire (n=69). The mean age of the Chinese respondents was 38.3 years compared with 37.7 years for Whites, and the former were more likely to own their own home (85% compared with 66%).

The results suggest that the Chinese in Hull are not making full use of health care services and language problems hinder greater use of services. For example, 71% of the Chinese respondents reported that they had experienced difficulty being understood by a general practitioner (GP) compared with 33% of the White respondents. Despite these difficulties, Chinese respondents were more likely than Whites to report that their most likely course of action in the case of illness would

be to consult a GP (84% compared with 65%), though Chinese respondents reported less use of GP home visits than Whites (44% compared with 70%). Chinese respondents also reported less awareness of a range of preventative health care services (such as cervical cancer screening, immunisation etc.) and were less likely to have used preventative health care services than Whites. The authors maintain that Chinese cultural and health beliefs may affect use of services in this group. The Chinese in Britain are also geographically scattered, which may make them less visible than other minority groups.

**Williams, S., Watt, I. and Lai Fong, C. (1994). *Report of a conference on Chinese health care in Britain: the way forward*. Leeds: Leeds Health Promotion Service.**

The editors present a report on the proceedings of a conference on the health care needs of the Chinese in Britain. Many of the papers are general in nature, so will be only briefly described here. After introductory chapters, there are papers on the size and demographic characteristics of the Chinese population in Great Britain (Haskey), the health problems of the Chinese in Liverpool (Chan) and dental and oral health issues for Chinese and Vietnamese children aged 3-5 years (Williams). In the latter paper, the author briefly describes the results of a survey of use of dental services by Chinese and Vietnamese individuals in the north of England (n=230). Use of dental services was low in the sample (76% of Vietnamese and 43% of Chinese mothers did not use dental services when pregnant, despite the services being free to pregnant women). The fathers of the children in the study had lower dental service attendance rates (58% of Vietnamese and 12% of Chinese had never visited a dentist).

The dental health needs of Vietnamese children are also examined by Todd, who notes that young Vietnamese children have more dental decay than White children. She considers the social and cultural context in which Vietnamese individuals in the UK live, and which might affect their use of dental services. One reason for the low use of dental services is that many Vietnamese do not see the need to go to the dentist unless they are in pain. Vietnamese individuals are also culturally averse to blood tests and this can affect their use of dental and other health services: 'The loss of blood would give danger to the heart. Our people are skinny and they worry that they haven't enough blood. If you take some of the blood it will take me years to make it up again'. Additional papers cover: health promotion among the Chinese in Britain (Watt and Fong Chiu); the health

needs of the Chinese in Lewisham (Ling Ng); and workshop reports on women's health and the use of traditional medicine and primary health care.

**Xiao-hui, L. and McIlwaine, G. (1995). The health status and health needs of Chinese population in Glasgow. *Scottish Medical Journal* 40 (3), 77-80.**

There is little research on the health status and health care needs of the Chinese population in the UK. The authors developed a bilingual questionnaire to ascertain the demographic characteristics, health problems, use of services etc. in the Glasgow-based Chinese community. Four methods of data collection were used: hand-delivery of questionnaires, posting of questionnaires, face-to-face interviews and telephone interviews (n=493, overall response rate=61.6%). The results suggest that about half of the respondents preferred a mix of traditional Chinese and Western medicine. Older people tended to prefer traditional Chinese medicine (p=0.0000). Nearly a fifth had used private health care, and 92% were registered with a general practitioner (GP) (though use of GP services was low compared with the Scottish population). Chinese women had lower rates of take-up of cervical and breast screening programmes. The reasons reported for low use of such services included embarrassment and language problems. The authors note that the Chinese people in this sample had low rates of exercise and high rates of long-term illness, yet low use of services.

## **2.2) Asthma**

**Ayres, J.G. (1986). Acute asthma in Asian patients: hospital admissions and duration of stay in a district with a high immigrant population. *British Journal of Diseases of the Chest* 80 (3), 242-248.**

Ayres discusses acute asthma hospital admission rates in Birmingham (UK) in the period 1972-1982. Analysis of these data show that 20% of admissions are in Asian patients who comprise only 9.7% of the local population. Annual admissions for acute asthma have risen faster for Asians (+57% for non-Asians and +67% for Asians). For 1981, admission rates for acute asthma/ 100 000 (assuming equal asthma prevalence rates)=198 for Asians and 79 for non-Asians (a relative risk of 2.5). The reasons for the higher admission rates for Asians are multifactorial, but poor asthma education and poor compliance with medication may be important factors.

**Gilthorpe, M.S., Lay-Yee, R., Wilson, R.C., Walters, S., Griffiths, R.K. and Bedi, R. (1998). Variations in hospitalisation rates for asthma among Black and minority ethnic communities. *Respiratory Medicine* 92 (4), 642-648.**

Gilthorpe and colleagues explore variations in secondary health care utilisation by Black and minority ethnic individuals with asthma living in the West Midlands (where 8.5% of the population is of minority ethnic origin). Asthma-related hospital admissions data (collected in the period 1995-1996) were analysed (n=15 921). The findings indicate that age-standardised admission rates were higher in all minority groups compared with Whites. These rates were especially high for Black children (aged 5-14 years) and Indian and Bangladeshi elderly men and women. Emergency admissions to hospital for asthma were strongly associated with patients' socio-economic background. The authors note that these findings support previous studies that have also shown high hospital utilisation rates for asthma among people from minority ethnic communities, and that ethnic background is more important in asthma admissions than socio-economic deprivation. More research needs to be undertaken on the appropriateness of asthma care for minority ethnic individuals.

**Griffiths, C., Kaur, G., Gantley, M., Feder, G., Hillier, S., Goddard, J. and Packe, G. (2001). Influences on hospital admission for asthma in south Asian and White adults: qualitative interview study. *BMJ* 323, 962-966.**

Griffiths and colleagues describe the results of a study that explores the reasons for increased risk of hospital admission for south Asian individuals suffering from asthma. Data were taken from interviews conducted with patients (Asian and White) with asthma either admitted or not admitted to Newham General Hospital (in the London Borough of Newham, an area of London with approximately 30% south Asian population) (n=58). Interviews were also conducted with general practitioners (GPs) and hospital staff (n=25).

The authors identified 60 influences on hospital admission, which are collapsed into three categories: personal influences, health professional influences and access to primary care. In the first category, patients mentioned the effect of stress and adverse social events on asthma. The authors note that many south Asian patients were passive in their control of asthma, while White patients were more 'proactive' in their control of the illness. South Asian patients were also more

confused about the role that drugs played in the control of the condition. Both White and south Asian respondents reported use of complementary and alternative medicines, though Asians were more likely to make dietary changes (consistent with Asian belief systems that emphasise the role that different types of food plays in the control of illness). White patients were more likely to use self-help techniques (books, videos etc.). Patients who had not been admitted with asthma expressed the view that they could control their condition (often with family support).

The interviews conducted with GPs suggest that many thought that self-management plans were impractical and most patients would not be able to understand them. Emergency doctors (who were responsible for admissions) emphasised that their main priority was an entirely clinical one: 'Well, I don't go much into people's background when they come in...My two biggest (criteria) are pulse and respiratory rate.'

The third theme that emerged from the research was that relating to access to primary care. The interview data indicates that those patients who had good access to primary care described good relationships with their doctors. Those who reported a history of difficult access to primary care services tended to be registered with practices that had high admission rates for asthma and most patients were south Asian. Patients who referred themselves to hospital had more sudden onset asthma episodes (median duration of attack before hospital admission was 2.5 days for this group. This compared with 7 and 14 days respectively for patients with easy and difficult access to primary care).

In conclusion, the authors note that White and south Asian patients differ in their control of asthma. White patients were more confident in their management of the condition and had good access to GPs with well-developed strategies for the management of asthma (such as policies that minimised the need for hospital admission and a supportive approach). The lesser ability of south Asian patients to manage their asthma is probably linked to cultural characteristics of this group or the problems of controlling illness in difficult social conditions (Asian respondents occasionally reported that they were better able to control their asthma in India or Pakistan than in the UK). The authors also emphasise the poor understanding of the role of drugs among the south Asian respondents and the relative lack of importance of factors previously considered to important (such as language problems, the ability of single-handed and well-resourced practices to cope with asthma management and the absence of an 'ethnicity filter' at the accident and emergency department). No

differences in socio-economic status between Whites and south Asians were observed. The authors note the small sample size of the study.

**Moudgil, H. and Honeybourne, D. (1998). Differences in asthma management between White European and Indian subcontinent ethnic groups living in socioeconomically deprived areas in the Birmingham (UK) conurbation. *Thorax* 53 (6), 490-494.**

This article is primarily on management on asthma, though access to and use of services is also explored. Higher hospital admission rates have been observed for south Asians suffering from asthma compared with White patients; this may be attributable to poor access to health care or health education among south Asians which affects the management of the condition. General practitioner (GP) registers in areas of Birmingham with high numbers of minority populations and high/medium levels of deprivation were used to identify patients with asthma (of south Asian and White ethnicity, n=689). Respondents were asked to provide details of aspects of their lifestyle and demographic information, but the focus of the study was on collecting information on the management of asthma and their knowledge about the illness. Measures of airflow obstruction were taken using standard meters (spirometer and a peak flow meter) and current levels of drug prescription were ascertained.

Whites and south Asians reported similar levels of education about asthma, though south Asian men and women were significantly less likely to report that symptoms of the illness had been explained to them. South Asian women were less likely to understand the role of medication in the management of asthma compared with their White female counterparts ( $p < 0.001$ ). There were other significant differences between south Asians and Whites in relation to the ownership of peak flow meters, with the former being less likely to own them compared with Whites. The data on use of emergency secondary care services and continuing follow-up care services indicates that there were few significant differences between the two groups, though both south Asian men and women were more likely to use hospital follow-up care than Whites. South Asian women were significantly more likely to have had a previous asthma admission. The authors discuss the limitations of the study, these include: lack of allowance for differences in smoking between the two ethnic groups and the better response rate by the south Asian group.

**Myers, P. and Ormerod, L.P. (1992). Increased asthma admission rates in Asian patients: Blackburn 1987. *Respiratory Medicine* 86 (4), 297-300.**

The authors examine increases in asthma admissions, focusing on asthma admissions among Asians. Using health authority and ward admission data, admission rates/1000 were calculated. Admissions were increased in Asians aged 1-4 years and 15-29, but these increases were not significant. Admissions were significantly increased in Asian patients aged 5-14 ( $p > 0.001$ ) and 30-44 years ( $p < 0.001$ ). These increased rates were not attributable to increased re-admissions among Asians. These results suggest that increases in the Asian admission rate may be due to increased asthma prevalence among Asians.

### **2.3) Cardiovascular health**

**Cappuccio, F.P., Cook, D. G., Atkinson, R. W. and Strazzullo, P. (1997). Prevalence, detection and management of cardiovascular risk factors in different ethnic groups in south London. *Heart* 78 (6), 555-563.**

The authors describe the results of a study designed to assess the prevalence, detection and management of cardiovascular risk factors among Whites, individuals of African descent and south Asians in south London. The respondents were sampled from general practice registers in the Wandsworth health authority area and were selected on the basis of their name and by personal recommendation ( $n=1578$ ). Physical (height, weight) and blood pressure measurements were taken. A blood test was taken and an oral glucose test was administered. A questionnaire was completed by the study participants.

There were approximately 500 individuals in each ethnic group and similar numbers of men and women. The prevalence of hypertension was higher in individuals of African descent and south Asian origin compared with Whites (37%, 28% and 18% respectively). Obesity (body mass index  $>27$ ) was more common among individuals of African descent compared with Whites and south Asians, though Whites and African descent individuals were equally likely to be severely obese (body mass index  $>30$ ) (15% each, 8% for south Asians). The age-adjusted rates for hypertension were still the highest for individuals of African descent and severe obesity was also highest in this group. This group was divided up into those of African descent and Caribbeans. Hypertension was similarly high for both groups, but slightly higher for women (age-adjusted prevalence rates for

hypertension: Caribbean males=31%, West African males=40%, Caribbean females=40%, West African males=40%). Diabetes was three to four times more common among the African descent and south Asian groups compared with Whites, though raised cholesterol and smoking were less common in the former two groups.

About half of individuals with hypertension were adequately treated though 18% of hypertensives had not been detected before the survey and 17% of the previously detected hypertensives were not receiving drug treatment at the time of the survey. After adjustment for age, sex and general practice, the proportion of undetected hypertensives was significantly lower among people of African descent compared with the other groups ( $p=0.034$ ). The risk of hypertension being undetected was highest among south Asians (after controls for age, sex and general practice, odds ratio=2.34, compared with African descent individuals). African descent individuals with hypertension were more likely to be diagnosed but less likely to have their condition adequately managed (though this was of borderline statistical significance). The authors point out potential sources of bias: differential selection of general practices and differential selection of respondents.

**Chaturvedi, N., Rai, H. and Ben-Shlomo, Y. (1997). Lay diagnosis and health-care-seeking behaviour for chest pain in south Asians and Europeans. *The Lancet* 350 (9091), 1578-1583.**

South Asians are vulnerable to ischaemic heart disease yet experience delays in obtaining appropriate management for heart disease. Here, the focus is on exploring differences between south Asians and Europeans in their interpretation of, and health care-seeking behaviour for, chest pain. The names of randomly selected respondents (stratified by age and ethnicity) were taken from general practice lists in two areas of west London with large south Asian populations. Questionnaires containing a fictional account of a south Asian man experiencing chest pain were sent to all potential respondents, and respondents were asked a series of questions about how this man should deal with the pain etc. Once these had been returned, respondents were sent a second questionnaire asking more detailed questions about the respondent's perception of illness. The main outcome measure was response to the case scenario. The overall response rate was 60% ( $n=903$ , of whom 553 were European, 125 Hindu and 235 Sikh).

There was no difference between the ethnic groups in personal history of heart disease, though Sikhs reported having fewer family members or friends with the illness. Both south Asian groups

consulted their general practitioner (GP) more than Europeans. In response to the case history, 68% of Europeans, 58% of Hindus and 67% of Sikhs believed that the pain experienced by the fictional individual was in the area of the heart (no significant differences). Europeans said that they would be less worried about the pain than the other two groups (this was also not significant). Significant differences were observed in relation to how individuals would respond to the pain. South Asians were more likely than Europeans to say that they would seek advice for others, use alternative therapies, seek help from a pharmacist, for example. After adjustment (variables controlled for included age, social class, family history of disease), Sikhs were three times more likely than Europeans to say that they would immediately seek help for chest pain and Hindus were two and half times more likely than Europeans to say that they would seek help.

The authors point out that the delay experienced by south Asians in receiving appropriate treatment for heart disease appears not to be influenced by a lack of readiness in this population to seek help. Methodological issues that might have affected the findings include: possible non-response bias and the basing of the study on reported probable behaviour and not actual behaviour. Health-service related factors may affect the treatment that south Asians receive.

**Feder, G., Crook, A.M., Magee, P., Banerjee, S., Timmis, A.D. and Hemmingway, H. (2002). Ethnic differences in invasive management of coronary disease: prospective cohort study of patients undergoing angiography. *BMJ* 324, 511-516.**

The authors describe the results of a study in which they compare rates of coronary angioplasty and coronary artery bypass grafting and clinical outcomes in Asian and White patients who were undergoing angiography in the period 1996-1997. All the patients lived in one of five health authority areas. The total sample was 3476 (502 Asians and 2974 Whites). Eligible patients were identified by examination of ward admission data and case notes. Data were collected on, for example, clinical presentation, smoking, exercise electrocardiography, hospital admissions and socio-economic status. The researchers also used 'ratings of appropriateness for coronary angioplasty and coronary artery bypass grafting'. These were decided before the collection of data by a panel of experts.

The results indicate that there were differences between Whites and south Asians, with the latter more likely to be younger, male and non-obese than the former. There were no significant

differences between the two groups in clinical presentation, previous investigations and interventions, though south Asians had a greater number of general practice consultations in the year before angiography than Whites but did not spend longer on the waiting list for treatment. The overall rate for revascularization was lower among south Asians compared with Whites and the age-adjusted rate was lower. There were no differences between the two groups in the proportions that were deemed appropriate to receive revascularization. Among those patients considered appropriate to receive angioplasty, south Asians were less likely than Whites to receive it (age-adjusted hazard ratio=0.69,  $p=0.058$ ). Among those patients deemed appropriate to receive coronary artery bypass grafting, south Asians were also less likely to receive it compared with Whites (age-adjusted hazard ratio=0.74,  $p=0.007$ ). South Asian patients for whom angioplasty or coronary artery bypass grafting was intended had a lower rate for these procedures than Whites.

There were no significant ethnic group differences in mortality for those suffering from coronary artery disease. Neither physician bias or socio-economic differences explained the differences between Whites and south Asians. The authors suggest that the lower rates of revascularization among south Asians may be because of communication problems or differential treatment preferences. The fact that differences arose once patients had been put on the waiting list suggests that there may be a lack of willingness among south Asians to negotiate the system.

**Goldsmith, I., Lip, G.Y., Tsang, G. and Patel, R.L. (1999). Comparison of primary coronary artery bypass surgery in a British Indo-Asian and White Caucasian population. *European Heart Journal* 20 (15), 1094-1100.**

Goldsmith and colleagues compare clinical characteristics (at admission and after coronary revascularization by bypass surgery) of Indo-Asian and White patients in the UK. One hundred and ninety four pairs of patients were matched for age, sex and date of admission. Clinical characteristics at admission for coronary artery bypass grafting surgery, hospital morbidity, hospital mortality and length of stay in the intensive therapy unit or hospital following coronary artery bypass grafting were ascertained. A higher proportion of Indo-Asian patients had coronary revascularization on a non-elective basis (43% compared with 32%,  $p=0.018$ ), had a higher prevalence of diabetes (39% compared with 12%,  $p=0.0001$ ) and a lower rate of previous myocardial infarction (47% compared with 62%,  $p=0.012$ ).

In relation to revascularization, there was no significant difference in the number of vessels revascularized but there was a lower use of the arterial conduit in the Indo-Asian patients (72% compared with 81%,  $p=0.028$ ). There were no significant differences in major post-operative complications, and there were no differences in the length of intensive therapy unit stay and hospital stay following surgery between the two ethnic groups. There was higher in-hospital mortality (7% compared with 3%) in Indo-Asians compared with Whites but this disappeared when patients in the two groups undergoing non-elective surgery only were compared (9% compared with 7%,  $p=0.7$ ).

**Lear, J.T., Lawrence, I.G., Burden, A.C. and Pohl, J.E. (1994). A comparison of stress test referral rates and outcome between Asians and Europeans. *Journal of the Royal Society of Medicine* 87(11),661-662.**

The authors describe a study of the referral rates for exercise stress testing following acute myocardial infarction among south Asians and Europeans. They also examined the stress test outcome. Data were taken from hospital activity analysis, ward admission book and stress test referral forms and reports. There were 962 acute myocardial infarctions (90% of them European). Fewer Asian patients were referred for stress testing (32% compared with 45% for Europeans,  $p<0.001$ ). Asian patients were more likely to have a positive test than Europeans (43% compared with 31%,  $p<0.02$ ) and fewer Asian patients completed the test (14% compared with 31%). Communication difficulties between Asians and health personnel may account for the lower referral rates among Asians.

**Lear, J.T., Lawrence, I.G., Pohl, J.E and Burden, A.C. (1994). Myocardial infarction and thrombolysis: a comparison of the Indian and European populations on a coronary care unit. *Journal of the Royal College of Physicians of London* 28 (2), 143-147.**

Lear and colleagues reviewed the admission notes of 211 Indian and 192 European patients admitted over a period of 12 months to a coronary care unit. More Indian patients had myocardial infarctions than Europeans (34% compared with 27%,  $p < 0.05$ ) and Indians were more likely to have diabetes mellitus (47% compared with 14%,  $p < 0.001$ ), though they were less likely to smoke. Fewer Indian patients were treated with thrombolysis (49% compared with 80%,  $p < 0.001$ ); late presentation was the principal reason for this (62% compared with 40%). Indian patients admitted into a coronary care unit are more likely to have had a myocardial infarction and yet less likely to receive care than Europeans.

**Shaukat, N., de Bono, D.P. and Cruicksank, J.K. (1993). Clinical features, risk factors, and referral delay in British patients of Indian and European origin with angina matched for age and extent of coronary atheroma. *BMJ* 307, 717-718.**

Individuals from the Indian subcontinent suffer disproportionately from coronary artery disease. Analysis of patients' data (n=180) collected at a regional cardiothoracic centre over a period of two years showed that smoking status, diabetic status and time from the onset of symptoms to referral were the only significant factors explaining variance between the Europeans and the south Asians in their disease profile. For patients of Indian subcontinent origin, the mean referral interval (in months) was 17.4 compared with 6.9 for Europeans. The effect of referral bias among primary care health professionals should be explored further.

#### **2.4) Children**

**Baker, M. R., Bandaranayake, R. and Schweiger, M.S. (1984). Differences in rate of uptake of immunisation among ethnic groups. *BMJ* 288, 1075-1078.**

Ethnicity is associated with differences in rates of morbidity and mortality in Bradford. Over 37% of the 1980 birth cohort are of minority ethnic status so there is a need to examine use of health services by minority communities in the city. The authors examine rates of immunisation for diphtheria, measles and other childhood conditions. Immunisation data were obtained from the regional health authority and the analysis was limited to the 1980 birth cohort. The ethnic groups examined included children of mixed race origin (Asian and Black). The results suggest that there were significant differences between ethnic groups in uptake of immunisation. By the age of 27 months, just over 81% of the half-Black children had received a diphtheria 1 immunisation compared with 91% of British children, 95% of Pakistani children and 99% of Indian children. Pakistani children tended to be immunised later than other groups. No data is provided on the social class background of the children or of place of residence (both of which could affect uptake of immunisation independently of ethnicity).

**Bedford, H.E., Masters, J.I. and Kurtz, Z. (1992). Immunisation status in inner London primary schools. *Archives of Disease in Childhood* 67 (10), 1288-1291.**

Bedford and colleagues describe the present study, the objectives of which were to investigate the feasibility of reviewing children's immunisation status at school entry, to explore attitudes to immunisation provision within school settings and to examine the adequacy of immunisation data recording systems in schools. The focus is not, therefore, on ethnicity *per se*. The study was set in 33 primary schools in an inner London health authority and data on ethnicity of the children (in addition to other health and demographic data) were collected by nurses at the schools. Data were collected on 1409 children, of whom 27% were of Asian origin and 12% were Black. Most (93%) of the children were registered with a general practitioner (GP) and nearly 40% came from homes where English was not the first language.

Asian children were less likely to be immunised than other groups (50 of the 54 children who had no immunisation were Asian). Parents of children who were not immunised cited recent migration as the reason for their children not being immunised, though seven parents (immigrants) also said that they were not aware of the need for immunisation.

**Chung C. M., Vostanis, P., Cumella, S., Doran, J., Winchester, C. and Wun, W.L. (1999). Children with special needs: use of health services, behaviour and ethnicity. *Children and Youth Services Review* 21 (5), 413-426.**

The authors present the results of a study of the use of health services by disabled children from minority ethnic backgrounds. The sample (n=106) was drawn from the Birmingham Register of Children with a Statement of Special Educational Needs and were European, Asian and Afro-Caribbean children aged five to 15 years old (mean age=11) and mostly male (69%). The two measures were aberrant behaviour (irritability, lethargy etc.) and use of health services.

The results indicate that there were no significant differences between the three ethnic groups in terms of aberrant behaviour. About 20% of the sample had sustained a significant accident during the previous year, though Whites were more likely than Afro-Caribbeans and Asians to have had medical tests. Analysis of data on general practitioner (GP) consultations indicated that Afro-Caribbeans were more likely to be seen for chest problems and Asians were more likely to see a GP for cold-related problems. About 50% of individuals in each group had seen a nurse in the previous

year, and more Europeans (43%) than Asians (33%) and Afro-Caribbeans (37%) had seen a hospital doctor in the previous year. Afro-Caribbean children were significantly more likely to see an ear-nose-throat specialist than the other groups.

Use of dental services and opticians was also explored. European mothers were more likely than minority mothers to express satisfaction with GPs, while mothers of Afro-Caribbean children were more likely to express satisfaction with dentists and opticians. Pearson correlation coefficient analysis suggests that, for European children, lethargy was associated with GP consultation ( $r=0.38$ ,  $p<0.03$ ), while lethargy was negatively correlated with GP contact for Asian children ( $r=-.48$ ,  $p<0.003$ ). The generally similar use of services by all ethnic groups may have been attributable to the relatively high numbers of Asian and Black staff in health care settings. The study is limited by, primarily, small numbers (there were 42 Asian children and just 19 of Afro-Caribbean origin).

**Cooper, H., Smaje, C. and Arber, S. (1998). Use of health services by children and young people according to ethnicity and social class: secondary analysis of a national survey. *BMJ* 317, 1047-1051.**

Data were obtained from the British General Household Survey and aggregated for the years 1991 to 1994. Data were available on 20 473 children and young people, of whom about 10% were from minority ethnic communities. Health service use was measured by general practitioner (GP) consultation in the last two weeks, attendance at casualty or out-patient department in the last three months and in-patient stay within the last year. Morbidity was measured as was age, ethnicity and socio-economic background.

Results of the analysis of service use by socio-economic background indicate that there were no significant variations by class, though use of in-patient services was greater among the children of unskilled workers. Analysis of the use of health services shows that the children from south Asian backgrounds were more likely to consult a GP compared with all other groups but use of out-patient services was lower among south Asian children and young people. All minority ethnic children were less likely to use in-patient services, especially so in the case of Black children (2.6% of Black children stayed as an hospital in-patient compared with 6.5% of White children and young people).

Logistic modelling of the data to isolate the independent effect of each variable suggests that health status is strongly correlated with use of services. Ethnicity is strongly associated with GP

consultation, use of out-patient and use of in-patient services. Indian children were significantly more likely to consult a GP than other groups (odds ratio=1.59 compared with Whites). Pakistani/Bangladeshi children and young people were also more likely to consult with a GP compared with White children and young people (odds ratio=1.09) though this was not significant. Black Caribbean children and young people were significantly less likely to use in-patient services compared with the White reference group (odds ratio=0.38) and Indian and Pakistani/Bangladeshi children were significantly less likely to use out-patient services compared with Whites. The authors conclude that use of health services is largely equitable in terms of socio-economic status. The high use of primary care services and low use of secondary care services by minority children and young people is consistent with previous research (though, here, Indian children were also likely to have high GP consultation rates). The limitations of the study are not discussed; they include the use of subjective measures of health status and (in some places), the use of a 'south Asian' category to boost sample size (but which overlooks the differences between the three Asian groups in the study).

**Daryanani, R., Hindley, P., Evans, C., Fahy, P. and Turk, J. (2001). Ethnicity and use of a child and adolescent mental health service. *Child Psychology and Psychiatry Review* 6 (3), 127-132.**

The authors examine the characteristics (including ethnicity) of children referred to Child and Adolescent Mental Health Services (CAMHS) (n=769). Data were taken from the database of CAMHS in the London Borough of Wandsworth and neighbouring boroughs in the period 1996-1997. Mode of referral was noted in the database. The categories included: general practitioners (GPs), specialist doctors, neurologists, speech therapist, psychiatrists and parents. The clinical team allocated a problem type based on the letter of referral. Over 60% of the sample was White, about 18% were Black and nearly 13% were Mixed Race.

The results indicate that referrals came from a number of sources. Nearly a third came from GPs, about a fifth from specialist doctors and about 10% were self-referrals. There was an over-referral of White children by their GPs, Black and Asian children by specialist doctors, Black children by education services and Mixed Race children by social services. Analysis of the type of problem children and adolescents presented with (which were categorised into 19 types of problem ranging from 'multiple problems' to 'psychosomatic and medical illness') and their ethnicity produced no

significant results. There were no significant differences by ethnic group for attendance and there were no differences between the sexes. The authors conclude that there is evidence of 'a significant bias operating in referral route according to the ethnic background of the child'. The authors note the limitations of the study, which include: the broad categorisation of ethnicity (Black Africans are considered with Black Caribbeans, for example) and the limitations of defining children's problems (which is dependent on medical personnel's perception of the problem and is highly subjective).

**Johnson, M. (1985). Provision of services for the under 5s. In *Ethnic minorities, between two cultures. A study of issues affecting ethnic minority families. National Association for Maternal and Child Welfare 72<sup>nd</sup> Annual Conference Report, 26<sup>th</sup> June, London. London: National Association for Maternal and Child Welfare.***

Johnson outlines the difficulties faced by minority ethnic women and their children in securing adequate access to maternal and child health services. He recommends improved monitoring of the use of services by minorities, better training for workers and recruitment of more minority ethnic health care workers.

**Sharma, A., Lynch, M.A. and Irvine, M. L. (1994). The availability of advice regarding infant feeding to immigrants of Vietnamese origin: a survey of families and health visitors. *Child: Care, Health and Development* 20 (5), 349-354.**

The authors explore infant feeding practices in the Vietnamese community in London, and consider how services can be adapted to suit the needs of Vietnamese mothers and babies. The names of babies born in a Health Authority area in south London were taken from birth notification lists, and 45 families were selected at random for inclusion in the study (40 completed a questionnaire). A questionnaire was also posted to health visitors in the area (n=73). Of the 40 babies, 12 had been breastfed initially and 11 of these had been breastfed for longer than three months. All of the breastfeeding mothers had breastfed previous babies. Reasons cited for not breastfeeding among those women who bottle-fed their babies include convenience and the belief that formula milk is better for the baby. All mothers were visited by a health visitor, though only 33 recalled this and seven of the mothers had contacted their doctor about problems with infant feeding.

Of the 73 health visitors who returned the questionnaire, 33 said that they given advice to Vietnamese mothers about infant feeding. Language barriers were mentioned by 93% of the health

visitors as significantly affecting communication with Vietnamese mothers. The authors point out that, in Vietnam, nearly all mothers breastfeed their babies and that, since arrival in Britain, there has been a change to bottle-feeding. There is a need to improve infant feeding advice to Vietnamese refugees.

**Watson, E. (1984). Health of infants and use of health services by mothers of different ethnic groups in east London. *Community Medicine* 6 (2), 127-135.**

The author explores the use of health services by mothers in the London Borough of Tower Hamlets. Details of respondents were taken from the 'Notifications of Births' held by the health authority (n=101) and letters sent out to all mothers selected. Data were collected by semi-structured questionnaire at three points in time (eight weeks, eight months and 14 months after birth).

Bengali mothers were younger than the indigenous mothers (Bengali mean age=23, indigenous=26) and less likely to be employed. English-speaking immigrant mothers had a mean age of 25 and higher educational levels than the Bengali mothers. Both Bengali and English-speaking immigrants were more likely than indigenous mothers to live with relatives (18%, 21% and 4% respectively). Bengali mothers consulted their doctors later in their pregnancy than the other two groups (>25 weeks gestation: Bengali=11%, English-speaking immigrants=4%, indigenous=0). Only 8% of the Bengali mothers went to antenatal classes. Only 4% of the indigenous women had caesareans compared with 14% of Bengali mothers and 17% of the English-speaking immigrants. Bengali women were more likely to complain of health problems eight weeks after birth than the other two groups (symptoms in their children that they complained about included sticky eye, coughs and constipation). Bengali mothers were less likely to have visited the hospital eight weeks after birth than the other two groups (11% of Bengalis had visited accident and emergency with their baby, compared with 13% of the English-speaking immigrants and 25% of the indigenous women), though Bengali women indicated that they would seek medical attention for their children more readily than the other groups. The authors conclude that the health services are used by Bengali mothers but that these women are '...hampered by their lack of knowledge of what is considered good child health practice in this country' (p.134).

**Webb, E. (2000). Health care for ethnic minorities. *Current Paediatrics* 10 (3) , 184-190.**

The author discusses provision of health care to British minority populations generally, and children specifically. The issues covered are: racism in service delivery; the specific health needs of minority populations; the needs of disabled minority ethnic children; and the use of services by refugees and asylum seekers. Case studies are provided throughout the paper. Examples of institutionalised racism in health services include the lack of provision for interpreting services and the stereotyping of non-White patients. Conditions that disproportionately affect minority communities include the haemoglobinopathies, such as sickle cell and thalassaemia. There are deficiencies in the screening techniques and communication of results to affected individuals. The needs of minority ethnic children affected by learning and other disabilities are not sufficiently addressed.

There is some evidence that minority children may be disproportionately affected by disability (which may be the result of consanguineous marriage or social deprivation). Hearing impairment may also be common in such communities; intervention for the hearing impaired must be culturally sensitive. Refugees and asylum seekers are often children, and they may have witnessed traumatic incidents (such as the death of a parent) and experienced famine or war. Many will require basic health care, such as immunisation and vision and hearing tests. They will also need appropriate therapy.

**2.5) Dental service use****Kwan, S.Y. and Holmes, A. M. (1999). An exploration of oral health beliefs and attitudes of Chinese in West Yorkshire. *Health Education Research* 14 (4), 453-460.**

This study is largely about oral health beliefs, and not service use, in a Chinese population in the UK, so will only be described briefly here. Qualitative data were collected in focus group settings from a sample of Chinese in West Yorkshire. Regular dental check-ups were not considered important among adults and the elderly; some respondents claimed that they had not been to the dentist since they moved to the UK, 30 years previously. Teenagers were happier to visit the dentist. Costs, communication problems and the use of alternative remedies discouraged use of dental services.

**Kwan, S.Y. and Williams, S. A. (1999). Dental beliefs, knowledge and behaviour of Chinese people in the United Kingdom. *Community Dental Health* 16 (1), 33-39.**

This study is largely about oral health beliefs, and not service use, in a Chinese population in the UK, so will only be described briefly here. Chinese respondents, recruited through community contacts, were interviewed using a semi-structured questionnaire (n=156) in north east England. About a third of the sample were UK-born and half reported problems speaking English. Most respondents believed that it was natural for people to lose all their teeth in old age and use of the dentist was more common in the younger respondents (though 61% of the whole sample claimed that they went to the dentist as part of their dental care routine). Use of traditional medicine was not common in the sample; only 13% reported using traditional methods to keep their teeth healthy. Older respondents had a more fatalistic attitude to their oral health, which may affect their use of services.

**Mikami, Y., Croucher, R. and Hector, M. (1999). Knowledge and reported behaviour concerning the prevention of caries in children: a questionnaire survey of Japanese parents resident in London, UK. *International Dental Journal* 49 (2), 115-121.**

Mikami et al. present the findings of a study of knowledge and behaviour among Japanese parents resident in London in relation to the prevention of caries in their children. The parents completed a questionnaire distributed through the school authorities to 17 primary schools. Data were collected on children's dental service use and knowledge and behaviours in relation to the prevention of dental caries in their children (n=111). Respondents with children born in the UK were more likely to take their children to the dentist regularly and more likely to be able to identify the cause and prevention of dental caries. A majority of respondents reported that their children brushed their teeth twice daily, though toothpaste was not used by a quarter of the children. The parents of Japanese-born children were disadvantaged in relation to knowledge about the causes and prevention of dental caries and the use of UK primary dental care services.

**Pearson, N., Croucher, R., Marcenes, W. and M. 'O'Farrell (1999). Dental service use and the implications for oral cancer screening in a sample of Bangladeshi adult medical care users living in Tower Hamlets. *British Dental Journal* 186 (10), 517-521.**

Pearson and colleagues present the results of a study of dental service use, and the use of tobacco and paan, by Bangladeshis in Tower Hamlets, London. Adult (>40 years) respondents were

recruited from one of four medical practices in the area. Data were collected by interview. Of the 158 respondents, a quarter had never visited a dentist; these respondents were more likely to be female. Most (73%) of the sample had experienced language difficulties when using health services. About a third of the sample were tobacco smokers and paan was chewed by 78%. The authors note that this minority population attend general practices for treatment but appear to access dental services much less.

**Robinson, P.G., Bhavnani, V., Khan, F.A., Newton, T., Pitt, J., Thorogood, N., Gelbier, S. and Gibbons, D. (2000). Dental caries and treatment experience of adults from minority ethnic communities living in the South Thames Region, UK. *Community Dental Health* 17 (1), 41-47.**

This paper is largely about dental caries so will only be described briefly here. Respondents' contact details were collected using community contacts and 'snowballing' techniques in the South Thames Region and data were collected using a 25-item questionnaire. Data were available on 1113 people, of whom 928 agreed to a clinical examination. The largest minority groups were Black Caribbean (141), Indian (190) and Chinese/Vietnamese (143). Length of residence in the UK predicted treatment experience in the sample as a whole.

**Williams, S.A., Godson, J.H. and Ahmed, I.A. (1995). Dentists' perceptions of difficulties encountered in providing dental care for British Asians. *Community Dental Health* 12 (1), 30-34.**

Williams and colleagues explore dentists' concerns about provision of care for Asians in the UK. A postal questionnaire was sent to dental practitioners and community dental officers working in seven family health service areas. Of 1546 questionnaires sent out, 639 (41%) were returned. The findings indicate that language and communication problems were most frequently identified as affecting take-up and use of services. Dental practitioners reported that some patients were unable to understand the nature of the treatments offered (67%), and 64% of practitioners reported difficulties obtaining medical histories. Other areas of concern mentioned were: attendance as casual patients and difficulties with preventive, periodontal and orthodontic care. A small proportion of dentists thought that issues around consent for treatment were important. The authors note that the survey had a low response rate, but that the survey findings point to some significant areas of concern.

## ***2.6) Diabetes and hypertension***

**Cruickshank, J.K., Mbyana, J.C., Wilks, R., Balkau, B., Forrester, T., Anderson, S.G., Mennen, L., Riste, L. and McFarlane-Anderson, N. (2001). Hypertension in four African-origin populations: current 'rule of halves', quality of blood pressure control and attributable risk of cardiovascular disease. *Journal of Hypertension*, 19 (1), 41-46.**

The authors describe the findings of a study that assesses the public health burden from high blood pressure and its detection and management in African-origin populations (n=3674). Data were collected in four locations: Jamaica, Britain, rural Cameroon and urban Cameroon. Data were also available from a European sample in Manchester. The results show a clear gradient in age-adjusted high blood pressure prevalence rates from 5% in rural Cameroon to 29% in Britain. Treatment rates varied by location: 34% of individuals in urban Cameroon received treatment compared with 69% of individuals in Jamaica and Britain. Up to 22% of premature, all cause and 45% of stroke mortality could be reduced by detection and appropriate treatment.

**Goyder, E. C. and Botha, J.L. (2000). Inequalities in access to diabetes care: evidence from a historical cohort study. *Quality in Health Care* 9 (2), 85-89.**

The authors present the results of a study of the factors associated with use of diabetes care services in the city of Leicester. The focus is not on the ethnicity of patients but primarily on socio-economic factors that affect use of services (though ethnicity is used in the analysis). The primary explanatory variables were: age, sex and ethnicity. Clinical variables were also used and the socio-economic characteristics of respondents were measured using postcode, car access, housing ownership and occupation. Of 620 individuals identified from a pre-existing cohort of diabetes patients in the city, 20% had at least one recorded diabetes review in a general practice setting and 54% had attended a hospital diabetes clinic. Hospital diabetes clinic attendance was associated with White, rather than Indian, ethnicity. The adjusted odds ratio for hospital clinic attendance (controlling for age, treatment type, duration of diabetes and co-morbidity) continued to show that attendance was associated with White ethnicity (odds ratio for non-White ethnicity=0.99, though this was not significant). General practice diabetes review attendance was also associated with White ethnicity. The adjusted odds ratio for attendance at a general practice review=0.24 for individuals with non-White ethnicity (p<0.0001).

**Scott, P. (1998). Lay beliefs and the management of diseases amongst West Indians with diabetes. *Health and Social Care in the Community* 6 (6), 407-419.**

The author provides a discussion of an exploratory study of the management of chronic diabetes in West Indians. Scott notes the high rates of diabetes in the Black population and that the research on diabetes in Blacks is concerned mostly with clinical features of the condition and not with the health beliefs and practices of this group (which may affect service use). Data were collected by semi-structured, in-depth interview with 12 West Indians and 12 Whites, all with non-insulin dependent diabetes mellitus (NIDDM) who were located at four sites (in London and Cambridge). Key informants (doctors, nurses etc.) were also interviewed (n=13). Data were analysed using a computer package designed for the analysis of qualitative data (NU\*DIST).

More West Indians than Whites knew little or nothing about the disease and many were confused about which parts of their anatomy were affected by the disease (one said that he thought the problem lay with the liver, for example). Scott attributes misunderstanding of the disease to poor communication between health professionals and many West Indian patients; this was also mentioned by one of the GPs interviewed who expressed a belief that, despite speaking the same language as his patients, cultural differences hindered communication. Many West Indian respondents mentioned the importance of religion in their attempts to deal with their illness. They also used 'natural' remedies, such as Bush teas, evening primrose oil and laxatives, and adhered to certain diets or body care regimes.

The data on use of health care services by West Indians with NIDDM highlight a contradictory finding. Most respondents (both Black and White) expressed overall satisfaction with their treatment but many West Indians said that they did not trust doctors (a finding which also contradicts previous research). Some respondents said that doctors had not taken their needs seriously, and one mentioned that she had been given the wrong drugs by a hospital doctor, which so worried her that she did not take her medication for seven years (until her health deteriorated so much that she then again sought medical attention). One male respondent expressed a mistrust of the health services and commented that he believed that the health service is selling his blood and an elderly female respondent said that she avoided her hospital appointments out of fear of being treated by an 'arrogant' hospital consultant. In conclusion, Scott cites communication problems (many West Indians were not comfortable using standard English and speak Patois) and 'defensive'

strategies (such as not taking medication) as factors (along with others), which ultimately adversely affect the health of West Indian diabetics. She recommends better training of health professionals and more culturally appropriate service provision.

**Stewart, A. and Rao, J.N. (2000). Do Asians with diabetes in Sandwell receive inferior primary care? A retrospective cohort study. *Journal of the Royal Society for the Promotion of Health* 120 (4), 248-254.**

The authors describe the results of a study of the care received by diabetic Asian patients in Sandwell (UK). Data were collected from records of diabetic patients (n=774) in 14 Sandwell practices. The results indicate that no significant differences were observed between Asians and non-Asians for checks on feet, eyes, body mass index (BMI), smoking or blood pressure. However, significantly fewer Asians received an HbA1c check (the HbA1c tests blood sugar control), and the mean HbA1c value was higher in Asians. More Asians received a urine test than non-Asians, and Asians had lower BMI values. After stratification by practice, no significant differences between Asians and non-Asians were observed for any single check. Wide, inter-practice variation was observed in the proportion of patients who had individual checks, though there were no systematic differences in the standard of care given to Asians and non-Asians.

### **2.7) Disability**

**Ahmad, W.I.U. (2000). *Ethnicity, disability and chronic illness*. Buckingham: Open University Press.**

A variety of perspectives on the relationships between ethnicity and chronic illness are explored here (such as the everyday experience of living with chronic illness and perceptions of disability). Many of the chapters contain some discussion of service provision and use. Those that do so substantially include Atkin and Ahmad ('Living with sickle cell disorder: how young people negotiate their care and treatment'). In this chapter, the response by young people with sickle cell disorder (SCD) to treatment and precautions is considered. Data were taken from in-depth interviews with 26 young people (of mostly African Caribbean origin) suffering from the disease.

The results highlight the importance, in the daily life, of medication and treatment regimes for these young people (despite the treatment for SCD not being as disruptive as that for thalassaemia). Many

respondents expressed doubts about the efficacy of some of their medication and saw the dangers of non-compliance as too distant to worry about. Many young people heeded precautions but did not follow their treatment regimes. There was a difference in compliance by age, with those under the age of 12 being more compliant. Respondents sought to secure 'normality' by being non-compliant and felt that having to follow a medical regime restricted them. In most cases, their parents were not aware of their transgressions (which made some respondents feel guilty). The authors also elicited information about how respondents coped with a SCD crisis (the onset of severe pain). Most were well supported by parents and some were able to be cared for at home (with painkillers) though most needed to be hospitalised. There was some ambivalence about when to go to hospital, partly because of the disruption this would cause (many had to go to casualty first so were not given pain relief). Hospital doctors were considered often ill informed about sickle cell disease and arrogant. Nurses could be supportive but often failed to appreciate the severity of a painful SCD crisis.

In Ahmad and colleague's chapter on the use of services by minority deaf people ('I send my child to school and he comes back an Englishman: minority deaf people, identity politics and services') a number of issues are explored, including the use of services. The authors examined 104 initiatives for minority ethnic deaf people in a variety of locations and interviewed users of services and workers (n=85). The authors observe that many minority parents of deaf children worried that their children would have no understanding of their own culture and religion (which is a frequent occurrence given the poor communication between deaf children and their parents and the wider minority community they live in. Schools did little to ameliorate this). The authors also describe the emergence of social groups that exist to represent the need of minority deaf people. A number of shortfalls in service provision were noted, including a lack of counselling services and a lack of interpreting services.

Other chapters that deal wholly or substantively with issues around access to and use of services (health, social and other) include Chamba and Ahmad ('Language, communication and information: the needs of parents caring for a severely disabled child') and Atkin and colleagues ('Service support to families caring for a child with sickle cell disorder or beta thalassaemia major: parents' perspectives). In the former chapter, data are taken from a study of 587 parents of disabled children of Asian and Black Caribbean/African origin.

The authors conclude that service providers need to take greater account of the language and communication needs of minority parents with disabled children. In Atkins et al.'s chapter, parents of children with SCD and thalassaemia were asked for their views on service provision. Many of the parents' reports echo the findings reported above (Atkin and Ahmad). In the final chapter of the book, Bhakta and colleagues examine the use of primary health services by south Asian carers ('South Asian carers' experiences of primary health care teams'). Many carers expressed dissatisfaction with their consultations with their general practitioners (GPs) (these were rushed and inadequate and the needs of the carer were not frequently not considered). Many carers also lacked information about what to do in an emergency.

**Atkin, K., Badger, F., Cameron, E. and Evers, H. (1988). *The community care project: why don't GPs refer their Asian disabled patients to district nurses?* Community Care Project working paper no. 23. Birmingham: Department of Social Medicine, University of Birmingham.**

Atkin and colleagues provide a brief discussion of the research that addresses the reasons for low rates of general practitioner (GP) referral of Asian disabled patients to community nurses. They describe how, in a random sample of disabled patients from district nursing caseloads, over 70% had been referred by their GP yet just two of these were Asian (and neither had been referred by their GP). Could the reason for this be low GP consultation rates by Asians? The authors refute this by pointing out that, in a sample of 162 respondents, Asians had higher consultation rates. Nor does the data indicate that Asians are being offered access to the service but are refusing it. Over half did not know about the district nursing service though many said they would use it if they needed to. The authors conclude that it is likely that GPs are not referring their disabled Asian patients, believing, perhaps, that other family members will care for their patients ('Asians tend to look after their own'). GPs may not also understand the work that district nurses do and hold assumptions about the 'typical district nurse patient'.

**Baxter, C., Poonia, K., Ward, L. and Nadirshaw, Z. (1990). *Double discrimination. Issues and services for people with learning difficulties from Black and ethnic minority communities.* London: King's Fund Centre and Commission for Racial Equality.**

This document is a resources handbook for anyone interested in helping people with learning difficulties, but it also provides a comprehensive review of the issues, with chapters on issues and provision of appropriate services for ethnic minority children, adults and elders with learning difficulties

### **2.8) *Ethnic elders***

**Askham, J. (1996/7). *Ageing in black and ethnic minorities: a challenge to service provision.* *British Journal of Hospital Medicine* 56 (11), 602-604.**

Askham presents a general discussion of the implications of the ageing of minority groups on health service provision. The author argues that service providers should not be colour-blind and providers need to be aware of the differences in need between ethnic groups, as well as those between men and women, age groups, etc.

**Atkin, K., Cameron, E., Badger, F. and Evers, H. (1989). *The community care project: Asian elders' knowledge and future use of community and health services.* Community Care Project Working Paper no.22. Birmingham: Department of Social Medicine, University of Birmingham.**

**And**

**Atkin, K., Cameron, E., Badger, F. and Evers, H. (1989). *Asian elders' knowledge and future use of community social and health services.* *New Community* 15 (3), 439-445**

Asian, Afro-Caribbean and White elderly respondents were identified from general practice registers (n=162) and both quantitative and qualitative approaches were used in this exploration of use of health and social services by ethnic elders. The results indicate that Asian elders, in particular, were less likely to be in touch with (or have knowledge of) community services (district nurse, bath nurse, chiropody, 'meals on wheels' etc.) than Whites. Many Asians said that they would use such services, though they expressed the view that such services should be culturally

appropriate. Service providers were often unaware of the needs of ethnic elders and frequently relied on stereotyped notions about minority communities. Services are 'ethnocentric' (oriented to the White community) and effective use of services is hampered by language difficulties. In conclusion, the authors suggest that potential service users need to be better informed.

**Bhalla, A. and Blakemore, K. (1981). *Elders of the minority ethnic groups*. Birmingham: All Faiths for One Race.**

Bhalla and Blakemore present the findings of an early (and, they claim, the first) major study of the use of health and social services by Black and Asian elders (n=400). The study is summarised below (Blakemore, 1982). In conclusion, the authors emphasise the language barriers to use of services, especially for Asians. They also discuss cultural isolation and loneliness (a quarter of the Asian elders had no family in the UK). The authors interviewed service providers as part of the survey and conclude that many were unaware of the special needs of minority elders, especially in relation to the provision of food and different patterns of leisure. They make a series of recommendations. These range from improved monitoring of provision of services to minority elders, to better training for health and other personnel and the recruitment of staff from minority communities.

**Blakemore, K. (1982). Health and illness among the elderly of minority ethnic groups living in Birmingham: some new findings. *Health Trends* 14 (3), 69-72.**

Blakemore summarises the main findings of a survey of elderly people in four Birmingham wards. The respondents were Black (179), Asian (169) and European (52) and trained interviewers collected data. Respondents were asked about general practitioner (GP) consultation, their contact with hospital, use of aftercare services and health and social problems. Europeans were less likely than the other two groups to have consulted a GP in the previous year. The higher consultation rates among minority groups may be a reflection of cultural attitudes to health or of higher morbidity among minority ethnic individuals.

The data on visits to hospital in the previous year indicate that similarly significant high rates of hospital use were present in minority groups. Nearly a quarter of Afro-Caribbeans had had contact with a hospital in the previous twelve months, compared with 18% of Asians and 17% of Europeans. Afro-Caribbean women were more likely to have had contact with a hospital than their

male counterparts. Afro-Caribbeans were also more likely than Asians and Europeans to have had two or more contacts with hospital services, though Asians were the least likely of the three groups to have had two or more contacts with hospital services. Blakemore maintains that these higher rates among Afro-Caribbeans are attributable to diabetes and hypertension among women.

Respondents were asked about their experience of post-hospitalisation care in the previous 12 months. Afro-Caribbean respondents were more likely to have looked after themselves compared with Europeans and Asians (among the latter, none had to look after themselves). Common health problems in the sample ranged from poor sight to dental problems. Half of the Afro-Caribbean respondents reported having problems walking and 21% of Asians reported having dental problems (though only 18% had received treatment). The researcher used the degree to which individuals go out of the house as a measure of physical health and well-being. In all three groups, men were more likely to go out than women (this was very marked among Asians). No Asians in the sample used social services help, such as 'home helps' or 'meals-on-wheels'. Two thirds of Asian elders had not heard of such services. The Europeans in the sample (who were slightly older than the other two groups) were more likely to report health-related problems. The author concludes that the study uncovered evidence that there is an unmet need among minority elders, even though they have a slightly younger age profile compared with the European group. The findings of the study should be treated with caution given the small numbers (in places) and lack of detail about the socio-economic situation of the respondents.

**Boneham, M.A., Williams, K.E., Copeland, J. R. M., McKibbin, P., Wilson, K., Scott, A. and Saunders, P.A. (1997). Elderly people from ethnic minorities in Liverpool: mental illness, unmet need and barriers to service use. *Health and Social Care* 5 (3), 173-180.**

Barriers to care (welfare and psychiatric) among minority elders in Liverpool are examined by the authors. 'Barriers' here may be those relating to lack of knowledge of services, lack of access (transport, cost etc.) or lack of 'intent' (acceptability). The respondents were located via general practice lists in the city and by 'snowballing' techniques (respondents were asked if they could recommend anyone for inclusion in the study) (n=71). Some interviews were conducted with a friend, relative or acquaintance of the respondent. Most respondents (63%) were widowed, divorced or separated and most came from the most deprived wards in Liverpool. A third of the respondents

lived in sheltered housing. All of the sample had been diagnosed as suffering from depression or dementia in an earlier phase of the study.

The authors provide a series of vignettes to illustrate the circumstances of the respondents, and their use of services. They describe, for example, a Nigerian man living in an old terraced property who had not seen his doctor for three years and uses homeopathic remedies. An alcoholic Somali man in sheltered housing had not seen his doctor for five years and did not keep his appointments with his doctor or social worker. A elderly Chinese man who suffered from depression and had had two strokes. He kept missing his treatment. Boneham and colleagues categorised the sample by level of need. A quarter of the sample was classed as 'independent loners' and another quarter as 'dependent family' (that is, they were largely confined to their homes and dependent on their families). A fifth were 'dependent loners' (who were at high risk, since they may live alone but needed greater access to services than they currently received). Only 8% were 'dependent institutionalised' and 18% were 'independent family' (they lived with family members but were largely independent).

Although the respondents clearly had pressing mental and physical health needs, only a fifth used 'home helps' and 16% used luncheon clubs. Over 40% of minority elders cited inappropriateness as a barrier to use of 'home helps'. Some (11%) respondents did not know that the service existed. A third of the sample believed that the food provided by meals-on-wheels was inappropriate and nearly half said that food provided at luncheon clubs was inappropriate or they valued their independence too much to use such a service. Half of the sample (39) had foot problems but only 16 of these had received care from a chiropodist. In addition, only 28% of the sample had seen a dentist in the last year and over 80% said that they did not attend regularly. A third of the sample had seen a general practitioner (GP) in the last two weeks. Although all the sample had mental health needs, only a third had seen a GP about their mental health. Most respondents reported that they had not experienced racism in the health or care services and about a third did not offer any criticism of services.

In conclusion, the authors maintain that there is evidence of considerable unmet need amongst the elders in the sample and that '...strategies of delivery (of care services) must be suited to local conditions' (p.179). Delivering services with users' neighbourhoods would help users overcome their lack of knowledge of, or mistrust in, services.

**Bowling, B. (1991). *Ethnic minority elderly people: helping the community to care. *New Community* 17 (4), 645-652.***

Bowling describes four initiatives started under the auspices of the Department of Health and Social Security's 1986 'Helping the Community to Care' programme. The details of the projects are available below (Bowling, 1990). Here, Bowling outlines the projects and concludes that, given the lack of funds from government to support such initiatives, it is hard to believe that there is a policy commitment to helping ethnic elders. Many elderly non-indigenous individuals cannot return to the countries they came from; Britain is now their home and many will grow old in isolation and fear.

**Bowling, B. (1990). *Elderly people from ethnic minorities: a report on four projects. London: Age Concern Institute of Gerontology and King's College.***

Bowling summarises the main issues confronting elders from minority ethnic groups (an ageing population, their relative poverty, the low take-up of services by this population) and assesses the merits of four Department of Health-funded projects that are designed to address the provision of services to elders from minority ethnic populations (service development and provision for elderly east Europeans in Berkshire; service development for Asian elders in Lancashire; day care for Afro-Caribbean elders in Northampton; and an Age Concern Project concerned with the needs of Asian elders in Southall). Bowling describes the aims and progress of each project using open and semi-structured interviews with people involved with and using the projects.

Each project is described in detail. In the Berkshire case, for example, the demography and history of the east European population is discussed (the 1981 census indicates that there were 3765 people born in eastern Europe resident in Berkshire, though unofficial opinion estimates that there may be as many as 10 000 people from eastern Europe in Berkshire). The problems of (war-induced) trauma in this group is highlighted (which may affect the provision and take-up of mental health services) and the fact that there are twice as many men in this population as women means that there are many single, older people who face an unsupported and lonely old age. Bowling maintains that the Berkshire project was invaluable to social service personnel who had to deal with the needs of elderly eastern Europeans (the project employed a Polish-speaking worker) and the wider community.

The Lancashire project (for Asian elders) provided support to community groups and ran a series of seminars on aspects of service provision and take-up by Asian elders. Leaflets on various aspects of health care were made available to the elders by the project. Bowling notes that the project failed to bring the plight of Asian elders to attention of the statutory services. The provision of day care facilities to Northampton's Afro-Caribbean elders occurred against a backdrop of almost nonexistent services to this population (who numbered nearly 3000 in 1981) and included the provision of hot Caribbean meals, domiciliary support etc. The Southall project took a long time to come to fruition, and focused on the needs of sheltered accommodation for frail and elderly Asians.

Bowling provides an overview of the projects and draws some common themes. He highlights the issue of isolation for ethnic elders; the poor, pre-existing service provision (which, even where good, he describes as 'basic'); the belief by service providing agencies that elders from minority ethnic groups 'look after their own' and therefore do not need assistance. Bowling remarks that minority groups are able to 'look after their own' only with the assistance of voluntary and statutory organisations. He also notes that relying on chronological age as a marker for old age is problematic; some groups become 'elderly' before others. Bowling concludes that the projects described above suffered from 'loose project job descriptions,' the lack of volunteers and short-term funding.

**Ebrahim, S. (1996). Caring for older people: ethnic elders. *BMJ* 313, 610-613.**

Ebrahim provides a general discussion of the care of ethnic elders. He covers areas such as the history of migration, the concept of ethnicity and the idea of 'triple jeopardy' (age, discrimination and lack of access to health and other services among minority communities adversely affect health and well-being). Ebrahim also discusses the use of services by minority elders; their general practice consultation rates are high compared with other groups but this may be because they consider themselves sicker than the general population. He suggests practical ways that hospitals can improve their services to minority communities (such as by providing culturally appropriate meals, providing tapes and books in community languages). The myth that minority ethnic families 'look after their own' must be dispelled.

**Ebrahim, S. (1992). Health and ageing within ethnic minorities. In Morgan, K. (ed.), *Gerontology: responding to an ageing society*. London: Jessica Kingsley Publishers in association with The British Society of Gerontology.**

Ebrahim provides a very general discussion of the demographic changes in the minority ethnic population and the implications of this for health and social care services. Most of the chapter is given over to a discussion of the demography and health of British minority ethnic groups, though he does provide some limited consideration of the use of health and social care services. Drawing on the existing literature, he notes that ethnic elders are high users of general practice and hospital services but low users of community nursing and social services. The fact that ethnic elders are high users of health services does not mean, however, that quality of care or outcomes of care are the same as for the majority population. He notes the prevalence of the belief that ethnic elders will be 'looked after by their own' which, in reality, means that the family is too often left without help or support. Ebrahim also refers to the usefulness of Norman's (1985) notion of 'triple jeopardy'; though he adds that, for elderly Asian women, their sex also constitutes another dimension of jeopardy. Recommendations are made for changes at primary and community care level.

**Fenton, S. (1987). *Ageing minorities: Black people as they grow old in Britain*. London: Commission for Racial Equality.**

Fenton provides a (mostly background) discussion of some of the main issues relevant to social service provision to Black elders (which here includes individuals of Caribbean and Asian origin) in the UK. The demography, history of migration and health and social service needs of these populations are described.

**Foong, A., Walsh, B., Goh, D. and Mann, S. (2000). Meeting the primary mental health needs of elderly Chinese people in the UK: a case for specialist provision? *Mental Health Care and Learning Disabilities* 4 (4), 130-133.**

The authors discuss the main findings of a study (undertaken as part of an evaluation of a day centre) of the health care experiences of elderly Chinese in Glasgow. Data were collected using a structured questionnaire (n=66). Most (56.5%) of the respondents were married, came from Hong Kong and time spent in the UK ranged from four to 37 years (mean=22). Of 58 health and social care agencies listed on the questionnaire, the most commonly attended were the general practitioner

(GP) and day hospitals. Many respondents reported being dissatisfied with their GP. Interviews with those who had experienced mental health services indicate that communication problems and cultural issues (such as the provision of food) are important concerns for Chinese elders. Services need to be made more responsive to the needs of Chinese elders

**Moledina, S. (1990). *Great expectations. A review of services for Asian elders in Brent. Brent: Age Concern.***

The author presents the results of an exploratory study of the Asian community in Brent and their service needs. Moledina describes, in some details, how racism affects Asians (personally, and in institutions). Institutional racism affects the provision and take-up of services by Asians; services may not be appropriate for their needs or their use of services may be hampered by language difficulties. The Asian population in Brent is described (Asian elders comprise 7% of the elderly population in Brent) and the report is interspersed with quotations from Asian elders and service providers, demonstrating the inappropriateness of many services and the lack of awareness on the part of providers. Community groups and Asian elders in a variety of locations in Brent were interviewed.

Specific issues raised include: difficulties understanding the results of hospital diagnostic tests; the poor quality of 'ethnic meals' in hospitals; the reluctance of general practitioners (GPs) to undertake home visits; lack of knowledge about community health services; low take-up of 'home help' services; and low awareness of occupational therapy services. Moledina makes a number of recommendations, many of which are related to implementation of equal opportunities and promotion of service awareness among minority communities.

**Norman, A. (1985). *Triple jeopardy: growing old in a second homeland. Policy Studies in Ageing no. 3. London: Centre for Policy on Ageing.***

Norman explains the use of the term 'triple jeopardy' to describe the situation of ageing members of minority ethnic communities in the UK by saying that minority elders are at risk because they are old, because of the physical conditions (and hostility) with which they have to live *and* because services are not appropriate or accessible to them. She examines the provision and use of a variety of services for minority elders (housing, health, social service care) and draws on existing literature and a survey of day centres and clubs for the elderly in a variety of locations. She provides an

extensive discussion of the issue of service provision and use and makes targeted recommendations (for example, to doctors, to health authorities and then to central government).

Most of the recommendations about improving health service provision and use are the expected ones: minority ethnic groups should make full use of existing services and campaign for more awareness of their needs; doctors should ensure that they and their staff are in a position to offer optimum service to minority patients; health authorities must be fully committed to ensuring that minority ethnic populations in their areas are kept informed of developments and that services meet their needs; and central government should set clear targets and provide funds for improvements to service provision. Similar recommendations are made in relation to day centre and other provision. Norman points out in the conclusion that many individuals from minorities complain that they are treated with curiosity by sociologists and the like, who succeed in gathering information but are less effective at implementing reform in service provision. There is, she says, a gap between theory and practice which must be closed if ethnic elders are not to suffer.

**Patel, N. (1991). *A 'race' against time. Social services provision to Black elders. Runnymede Race and Policy Series No. 1. London: Runnymede Trust.***

Patel discusses the background (demography, socio-economic situation and history of migration) among British Black populations, focusing on the plight of Black elders who are a substantial and growing proportion of Britain's elderly population (numbering some 97 000 in 1986). The degree to which Black elders are aware of social services, and use them, is assessed by reference to six key studies of the 1980s, which varied in sample size (from 1234 to 27) and geographic location (Birmingham, Nottingham, Manchester, London, Coventry and Leicester). Some of these studies highlighted the poor awareness of services by Asians, in particular, which may be attributable to language problems. These studies also considered the importance of modifying services so that minorities feel more able to use them. Patel notes the harmful effect of the myth that minority families 'look after their own' pointing to signs of family fragmentation (high numbers of elderly Afro-Caribbeans living alone, in particular). Extensive consideration is given to the effects of racism on service provision.

**Perry, S. I., Hsu, R.T., Brooks, W. and Cherry, D. (1999). Perceptions of community services among Asian and White stroke survivors and their carers: an exploratory study. *Ethnicity and Health* 4 (1-2), 101-105.**

The authors present the findings of a study of the experiences of community services among 28 Asian and White stroke survivors in Leicester. Data were collected using semi-structured interview techniques. The results indicate that feelings of isolation and depression are more common in the Asian group, though experience of stroke is similar in both groups. Both groups expressed a desire for more information and concerns about not knowing whom they were dealing with in health care settings.

**Redelinghuys, J. and Shah, A. (1997). The characteristics of ethnic elders from the Indian subcontinent using a geriatric psychiatry service in west London. *Aging and Mental Health* 1 (3), 243-247.**

The aging of the minority ethnic population may lead to an increase in psychiatric morbidity and greater use of geriatric psychiatry services. The authors describe the findings of a cross-sectional, comparative study of the demographic, social and clinical characteristics of Indian Subcontinent Origin (ISO) elders with mental illness using a geriatric psychiatry service in London. Of the patients in the study, 17% were of ISO origin compared with 7% in the general population. Ethnic elders using the service were younger, had more children, had more people their household and were more likely to have schizophrenia than the indigenous population. There were no differences in use of health and social services between ethnic and other elders.

**Ritch, A.E.S, Ehtisham, M., Guthrie, S., Talbot, J.M., Luck, M. and Tinsley, R.N. (1996). Ethnic influence on health and dependency of elderly inner city residents. *Journal of the Royal College of Physicians of London* 30 (3), 215-220.**

The authors describe the findings of a study of the characteristics, prevalence of disease, health needs and use of health services by ethnic elders in an inner city area. A prevalence study was conducted using a questionnaire administered to people (aged >65 years) who were registered with general practices in west Birmingham: 669 individuals (297 men, 372 women) completed the questionnaire. Respondents were divided into four ethnic groups: UK, Asia, West Indies, and 'Other' and data were collected on language use, household composition, prevalence of disease and

health problems and knowledge of community health services. The level of dependency was similar in all groups. Contact with community health services was low among Asians who also were less aware of the availability of these services than the other groups. Ethnic elders are less well served by, and have little knowledge of the existence of, community health services. For older Asians, difficulty in communicating with English-speaking health personnel is a barrier to effective health care.

**Tameside Black Elderly Working Group (1989). *The provision of services to Black elderly people in Tameside. Proceedings of a Conference held on the 17<sup>th</sup> September 1988 at the Town Hall Ashton-Under-Lyne, Tameside. Ashton-under-Lyne: Tameside Metropolitan Borough Council on behalf of Tameside Black Elderly Working Group.***

The authors present the report of a conference concerned with the care needs of elderly Asians in Tameside. The results of a survey are presented (n=186). The conception that Asian families 'look after their own' is considered and the linguistic barriers faced by elderly Asians is described (60% of whom had no knowledge of spoken English at all, and 42% had received no formal education. Women had much lower standards of literacy than men). The level of service awareness among the respondents was low; more than half were unaware of the Local Authority's Social Service's provision and 80% said that they would like services to take into account their cultural and dietary needs. A number of initiatives and issues are described: the example of provision of suitable housing to elderly Asians in Leicester, housing and other initiatives in Bradford and the need to implement appropriate policy in social services departments. Based on the workshop proceedings, a number of recommendations are made.

**Walker, R. and Ahmad, W.I.U. (1994). *Asian and Black elders community care: a survey of care providers. New Community 20 (4), 635-646.***

Walker and Ahmad discuss the findings of a survey of the health and care needs of minority ethnic elderly populations in Bradford, as reported by community care providers and others (n=22). Respondents interviewed included health and social service planners, care workers, patients advocates and a *hakim* (a traditional healer). Half of the respondents were from a minority group. Data were collected via an unstructured, recorded interview in the workplace.

The authors point out that, in theory, most respondents welcomed the new community care legislation (which includes a recommendation that the needs of minority communities be addressed). However, many respondents expressed worries about, for example, lack of resources, problems that existed before legislation (such as inappropriate hospital discharge) and the strain on carers and voluntary groups. Respondents also mentioned the widespread belief that many minority families look after their own elderly. The *hakim* pointed out that there is still an expectation that Asian elders will be looked after by their families but that this is increasingly hard to do; the younger generation have a different attitude.

The care of minority elders needs to be considered against the backdrop of disadvantage in access to services, often because such services are inappropriate or ‘off-putting’ (failure to cater for dietary requirements, lack of interpreting services and the under-representation of minorities in services, for example). Service providers also spoke about the needs of carers, who tend to be taken for granted and the role of voluntary organisations, who tend to be over burdened and ill-resourced. In conclusion, Walker and Ahmad maintain that many Black and Asian elders suffer from serious health conditions and this is compounded by lack of access to health and social care services.

### **2.9) Eye conditions**

**Fraser, S. Bunce, C., Wormald, R. and Brunner, E. (2001). Deprivation and late presentation of glaucoma: case-control study. *BMJ* 322, 639-643.**

**And**

**Fraser, S., Bunce, C. and Wormald, R. (1999). Retrospective analysis of risk factors for late presentation of chronic glaucoma. *British Journal of Ophthalmology* 83 (1), 24-28.**

Late presentation at services is a significant risk factor for blindness, though little is known about factors associated with late presentation. Here, ethnicity, demographic and other factors are explored using a retrospective, case-control study methodology. Data were taken from the medical records of patients presenting to services at the Moorfields Eye Hospital in London in the period 1993-1995 (n=200). Over 60% of the sample were White, 13% African Caribbean and 9% Asian. Data on ethnicity were not available for nearly 13% of the sample.

The odds for late presentation at service for African Caribbeans=2.38 compared with Asians (for Whites=0.58). The adjusted figures (controlling for age, ethnic origin, referral source etc.) for African-Caribbeans=4.55 and for Asians=1.22. African Caribbean patients were, therefore, four and a half times more likely to present with advanced loss of vision than White patients of the same sex, referral source etc. The authors maintain the greater risk of late presentation in African-Caribbeans may be attributable to their lower use of eye care services or more rapid, or earlier, progression of eye disease. The reliance on medical notes and the possible misattribution of ethnicity is noted as limiting the study.

### **2.10) HIV/AIDS**

**Gibb, D. M., MacDonagh, S.E, Gupta, R., Tookey, P.A., Peckham, C.S. and Ades, A.E. (1998). Factors affecting uptake of antenatal HIV testing in London: results of a multicentre study. *BMJ* 316, 259-261.**

The authors examine factors affecting the uptake of antenatal Human Immunodeficiency Virus (HIV) testing in Inner London maternity unit settings. The focus of the study is not on ethnicity, *per se*, though ethnicity of respondents is used in the analysis. Data were taken from six maternity units, all serving areas with high rates of HIV seroprevalence. Data on demographic, obstetric factors, and risk factors for HIV infection were collected by questionnaire in the period 1995-1996, and data on women booking for antenatal care from each unit were collected and checked with laboratory data on number of samples sent for rubella antibody testing. One maternity unit was excluded from analysis because too few forms were returned. Of the five units, 21 247 women were booked for antenatal care over the period, and 18 791 forms were returned (giving a response rate of 88%). The detection of previously undiagnosed HIV infection during pregnancy ranged from 4.9% to 60%.

Uptake of HIV testing was significantly higher among the 7% of women who disclosed a risk factor during the antenatal interview. Women who believed that their partner was at risk, or that they were at risk, had the highest uptakes and women disclosing intravenous drug use (IVDU) also had high uptake. Those who had been exposed in Africa, and those who had a partner who was Black African, had the lowest uptakes. Among those women not disclosing risk for HIV infection, there were strong ethnic differences: uptake being lowest (9%) in women of south Asian ethnic origin and

highest (33%) in women of Mediterranean or Latin American origin. The authors note that, because of their higher HIV seroprevalence, the finding that uptake among women exposed in Africa (or with partners exposed in Africa) was no higher than among most women with no disclosed risk is a cause for concern. Midwives may be reluctant to offer HIV testing to African women because of concerns about racial discrimination.

**Erwin, J., Morgan, M., Britten, N., Gray, K. and Peters, B. (2002). Pathways to HIV testing and care by Black African and White patients in London. *Sexually Transmitted Infections* 78 (1), 37-39.**

The authors report the results of a study of the factors associated with uptake of human Immunodeficiency Virus (HIV) clinic services by Black African HIV positive (HIV+) people attending St Thomas's Hospital (London) for treatment. Respondents were asked to complete a questionnaire (available in English, French, Spanish, and Portuguese), which was administered to patients in the clinic (n=392). Respondents were 64% white, 26% Black African, and 10% Black Caribbean/Other (the latter were excluded from analysis). Ninety two per cent of White patients and 40% of Black Africans were male. Black Africans were mostly (36%) from Uganda and Zimbabwe (14%). Black Africans were more likely to be unemployed than Whites (49% compared with 19%).

One quarter of Black Africans were first diagnosed HIV+ on a hospital ward, and 53% first tested positive at a genitourinary medicine clinic. Twenty eight per cent of Black Africans suspected they were HIV+ before testing compared with 45% of White patients (p<0.01). Of those Black Africans who did suspect, 62% waited 12 months or more before testing compared with 31% of White patients (p<0.01). Sixty seven per cent of Black Africans and 78% of white patients received HIV care within one month of diagnosis. The authors observe that, though Black Africans are a high-risk group for HIV infection, they do not suspect that they might be HIV+. Their use of HIV clinic care and after diagnosis is similar to their White counterparts

**Madge, S., Olaitan, A., Mocroft, A., Phillips, A. and Johnson, M. (1997). Access to medical care one year prior to diagnosis in HIV-positive women. *Family Practice* 14 (3), 255-257.**

The primary objective of this study is to explore use of (and reasons for use of) services before Human Immunodeficiency Virus (HIV) infection in women. Ethnicity is used in the analysis. Of the 100 HIV positive (HIV+) women recruited to this study from the Royal Free Hospital in

London, 50% were Black African. Most women (84%) were probably infected by heterosexual sexual contact. Over 60% of the Black women had symptomatic HIV or AIDS at presentation, and 71% of these women had seen a general practitioner (GP) before diagnosis (27% recalled a discussion about HIV). The authors maintain that the Black African women in the sample appeared to access care as frequently as White women but that language or cultural barriers may mean that GPs find it difficult to raise issues about HIV infection with them (despite them coming from a 'high-risk' group). The study is limited by reliance on patient recall.

**Malanda, S., Meadows, J. and Catalan, J. (2001). Are we meeting the psychological needs of Black African HIV-positive individuals in London? Controlled study of referrals to a psychological medicine unit. *AIDS Care* 13 (4), 413-419.**

Black Africans are the largest ethnic group among individuals who have contracted Human Immunodeficiency Virus (HIV) abroad. Here, the aims are to: 1) ascertain what proportion of Black African HIV positive (HIV+) individuals being treated at the Chelsea and Westminster Hospital received treatment from the Psychological Medicine Unit (PMU) and 2) compare Black Africans with non-Black African controls who have been referred to PMU.

Over 5000 patients were treated at the hospital in the period 1992-1999, of whom 260 were Black African. Of these, 35 patients were identified who had been referred to PMU. Black African patients were three times less likely than non-Black Africans to be referred to PMU, regardless of the gender of the patient (14% of Black African women were referred to PMU compared with 37% of non-Black African women). Of those Black Africans referred to PMU, most were women (54%). These 35 were matched with 63 controls. Black African men were less likely to be gay/bisexual than controls (38% compared with 73%), as were the Black African group as a whole. Black African patients were significantly more likely to have been given a diagnosis of AIDS by the time they had been referred to PMU than controls, and were more likely to be referred for assessment of organic brain disorder or depression. There were no significant differences between Black African patients and controls in out-patient care use. Limitations of the study include: the low representation of Black African patients in the local area and at the hospital and the reliance on database information and hospital records.

**McMunn, A.M., Mwanje, R., Paine, K. and Pozniak, A.L. (1998). Health service utilization in London's African migrant communities: implications for HIV prevention. *AIDS Care* 10 (4), 453-462.**

Ugandans are the second largest group to be affected by Human Immunodeficiency Virus (HIV) in the UK (after gay men) and it is important that health care information and treatment is culturally appropriate. Here, the authors report the results of a study of health service use by Black Africans from Uganda residing in south east London. Respondents' details were taken from community organisation lists and additional respondents were recruited via 'snowballing' techniques (respondents were asked if they could recommend other individuals for inclusion in the study). Data were collected using a 161 item, mostly 'closed' questionnaire designed to measure knowledge and use of health services. Most respondents were female and all had been born and raised in Uganda (n=118). Respondents were asked about their knowledge of health services in their area. Most (74%) named a specific general practitioner (GP) and most (71%) were aware of an African voluntary organisation.

The data on the use of health services shows that most (97%) respondents were registered with a GP and 98% of these had seen a GP in the last year. At least one attendance at a genitourinary clinic was reported by 15% of the sample (compared with 7% for the British population generally). Most women who had given birth in the UK had received antenatal care. Most (87%) of those who had used services expressed satisfaction, though communication problems were noted and 40% of the sample said that health services should work more closely with African community organisations. Respondents were also asked about their experience of health promotion material. Of the 17 topics itemised (ranging from healthy eating to HIV/AIDS) a third of respondents had received information on 14 of the 17 topics. Information on HIV/AIDS had been received by 76% of the sample. Men, older respondents and post-'A' level educated respondents were significantly more likely to have received HIV/AIDS information (though these results are confounded by the older age and higher education of men in the sample). Men were also significantly more likely than women to request additional information on HIV/AIDS (p=0.00001). Members of northern (Ugandan) ethnic groups were more likely to request additional information on HIV/AIDS than their southern Ugandan counterparts (odds ratio=2.85). Most respondents (70%) had received free condoms at some point. The authors maintain that primary care settings are appropriate locations for

health promotion initiatives and African voluntary groups should be more involved in health service delivery. The results cannot be generalised to all African populations in the UK (Uganda was one of the first African nations to deal with HIV/AIDS and English is the official language of the country, both of which affect the use of health services by London-based Ugandans).

### ***2.11) Head injury***

**Moles, D. R., Gilthorp, M. S., Wilson, R. C. and Bedi, R. (1999). Variations in admission to hospital for head injury and assault to the head. Part 2: ethnic group. *British Journal of Oral and Maxillofacial Surgery* 37 (4), 301-308.**

The authors use head injury admissions data from a west Midlands hospital in the period 1995-1997 to examine variation in injury and assault among minority ethnic populations. Data were available on the age, sex, diagnosis, length of stay and ethnicity (using 1991 census categories). Dates of admission were grouped by calendar month.

The results showed significant differences between men and women, with substantially lower rates of admission for head injury and assault for women. There was some seasonal variation in injury and assault admission rates, with higher rates in the summer months for minority groups. Black males stand out as particularly vulnerable to head assault in summer, with about two to three times the rate of admission. A similar pattern was observed for Black women, though the overall rate was lower. Examination of the day of admission showed little variation by day of week for injury for all ethnic groups and for men and women (except for south Asian women who had lower rates of injury mid-week). Data on admissions for assault to the head showed a very different pattern, with substantial daily variation. For Black males, assault-related admissions were highest on Saturday and lowest on Wednesday. For south Asian males, admissions were highest on both Saturday and Sunday and lowest on Wednesday. Among Black females, the highest rates of admission for assault to the head were on Sunday and Monday and the lowest on Wednesday. There was less variation for White women. Analysis of length of stay data indicates that White and south Asian women stayed longer than their male counterparts in hospital after injury to the head and south Asians stayed a significantly shorter time than Whites. For admission after assault to head, females stayed longer than males and south Asians stayed longer than Whites.

In conclusion, the authors discuss the importance of considering head injuries by ethnicity and discuss the research from the US, New Zealand and South Africa. British research has also shown greater head injury to non-White children though this has been less conclusive in relation to injuries among adults. The authors also note the deficiencies of the study; data on the ethnicity of patients was not complete and there was no consideration of the effect of socio-economic status on head injury or assault. There was also no measure of injury severity.

### ***2.12) Hospice and palliative care***

**Gaffin, J., Hill, D. and Penso, D. (1996). Opening doors: improving access to hospice and specialist palliative care services by members of the black and minority ethnic communities. Commentary on palliative care. *British Journal of Cancer* 74, Supplement XXIX, (S51-53).**

The authors discuss the concept of palliative care and the variety of palliative care services. Individuals from minority backgrounds may be less familiar with the idea of palliative care; they may be less likely to ask their general practitioner (GP) for access to palliative care. The development of a project designed to increase awareness and uptake of services among minority ethnic groups is described. One finding from the project was that the lack of people from minority backgrounds accessing palliative services may be less of a problem than originally believed. Most people receiving palliative care do so for cancer, and the incidence of this is lower in many minority ethnic groups. Also, the lower proportion of elderly in minority communities means that they are less likely to use palliative services. There is a general lack of awareness of services among minority groups.

The National Council for Hospice and Specialist Palliative Care Services made a number of recommendations in light of these findings. One of these is concerned with ethnic monitoring and equal opportunities, which are essential if culturally sensitive services are to be developed. Services should also be appropriate for minority groups in terms of their dietary needs, religion and language.

**Karim, K., Bailey, M. and Tunna, K. (2000). Nonwhite ethnicity and the provision of specialist palliative care services: factors affecting doctors' referral patterns. *Palliative Medicine* 14 (6), 471-478.**

Karim and colleagues explore the use of palliative care services by members of Black and minority ethnic communities. Referral patterns of hospital consultants and general practitioners (GPs) to a Birmingham hospice were analysed and semi-structured interviews were carried out with doctors (n=27) to explore their perceptions of the benefits and limitations of hospice services minority ethnic patients. Referrals received by the hospice in the period 1996-1997 were collected from the Hospice's database. The results indicate that, compared with White Europeans, there was an under-utilisation of day care and in-patient hospice services by members of minority communities, though doctors did refer their minority ethnic patients to hospice home-care services. Nearly 9% of referrals received by the hospice were for minority patients (this increased to 19% in locations with significant minority ethnic communities).

**Koffman, J. and Higginson, I.J. (2001). Accounts of carer's satisfaction with health care at the end of life: a comparison of first generation Black Caribbeans and White patients with advanced disease. *Palliative Medicine* 15 (4), 337-345.**

Koffman and Higginson describe the findings of a study of satisfaction with health care services among carers of recently deceased Black Caribbeans. Respondents' information was taken from records held by the health authority covering the London Boroughs of Lambeth, Lewisham and Southwark. About ten months after the death, a letter was sent to the person who registered the death. The person who had provided main care for the deceased was identified, and data were collected via a structured, face-to-face interview in the respondent's home. Fifty Black Caribbean respondents, and 50 White, were identified this way.

Respondents were asked to rate health care professionals (from 'excellent' to 'poor'). Black Caribbean respondents reported lower ratings for many health care professionals, including general practitioners (GPs), community and district nurses and hospital doctors and nurses. Lower satisfaction with health care staff was most marked for GPs (35% of Black Caribbeans rated GPs as 'poor' compared with 24% of Whites,  $p=0.044$ ). Specific aspects of primary care were given low ratings by Black Caribbeans: the length of time that district nurses spent with the deceased patient

and the ease with which the deceased patient could communicate with the GP. Qualitative data collected at the time of the interview with the carer suggests that some Black Caribbeans found it difficult to secure GP home visits for the deceased person, and that district nurses sometimes had a 'distant' attitude to the deceased. A smaller proportion (26%) of Black Caribbeans had received specialist palliative care than Whites (42%). Black Caribbean respondents also mentioned instances of insensitivity among hospital staff: hospital doctors were insensitive to a family praying at the bedside of a dying Black Caribbean patient, for example. The authors point out that this is the first study of its kind, but is limited by relatively low response rate and did not measure if and how the views of respondents differed from the views of the deceased. The process of bereavement may affect the type of response.

**Rees, W.D. (1986). Immigrants and the hospice. *Health Trends* 18 (4), 89-91.**

The author presents a discussion of the use of hospices by minority populations. Respondents' details were taken from lists of users of a hospice in Birmingham and restricted to individuals born outside the UK (n=74), most of whom were from the New Commonwealth and Pakistan. Most minority ethnic hospice users had been referred to the hospice by their general practitioner (GP) (62%) and some by a hospital doctor (38%); these proportions are similar to those in the general hospice population. Migrants from the New Commonwealth and Pakistan were less likely to receive hospice care than Caribbean migrants. Use of domiciliary care services and admission rates to the hospice were lower among the foreign-born.

**2.13) Mental health**

**Baylies, C., Law, I. and Mercer, G. (1993). *The nature of care in a multi-racial community: summary report of an investigation of the support for Black and ethnic minority persons after discharge from psychiatric hospitals in Bradford and Leeds. Working Paper 8. Leeds: University of Leeds, Sociology and Social Policy Research.***

The minority populations in Bradford and Leeds comprise 15.6% and 5.8% of the total population, respectively, and in both locations, minority ethnic individuals experience discrimination, poverty and unemployment. The authors describe the nature of mental health services in the two cities. In Bradford, there is a centralised 'Transcultural Unit' (TU) (a service specifically oriented towards minority users with mental health needs) whereas, in Leeds, services are more dispersed. The goal

of the study was to assess the provision of care and support offered to minority patients discharged from psychiatric services. Data were taken from interviews with users discharged from psychiatric hospital care in 1990/1 (n=101), carers (n=62), case studies (n=10) and key informants in statutory and community organisations. Afro-Caribbeans were over-represented among respondents.

The results of the study fall into seven broad categories. Firstly, interviews with service users suggest that the skills and activities they were offered on the hospital wards were unhelpful. They were perceived to be irrelevant, and some respondents cited specific instances of racism during such activities. Group discussions, however, were considered more useful. Information on aftercare services (transport, education, employment etc.) was generally lacking. Secondly, the interviews also suggest that take-up of services after discharge was low, though contact with general practitioners (GPs) after discharge was generally viewed positively. Thirdly, the authors describe various factors that respondents said affected use of services. These included problems relating to language or cultural barriers and problems of geographic access. Fourthly, the study highlights a general lack of support for carers. Fifthly, many respondents maintained that their housing quality was poor and they were vulnerable to racial harassment. The sixth major finding is that poverty was pervasive in the lives of respondents and their carers. About 70% of respondents were unemployed and over 40% of carers provided financial support to service users. Lastly, the authors point to a lack of consultation with service users, carers and community groups. Baylies and colleagues make a series of recommendations based on these findings. These range from encouraging greater use of services by minority individuals to extending existing services. Additional support for carers is also needed.

**Bebbington, P.E., Feeney, S.T., Flannigan, C.B., Glover, G.R., Lewis, S.W. and Wing, J.K. (1994). Inner London collaborative audit of admissions in two health districts. II: Ethnicity and the use of the Mental Health Act. *British Journal of Psychiatry* 165 (6), 743-749, 759.**

*Full description of methods given in:*

**Flannigan, C.B., Glover, G.R., Feeney, S.T., Wing, J.K., Bebbington, P.E. and Lewis, S.W. (1994). Inner London collaborative audit of admissions in two health districts. I: Introduction, methods and preliminary findings. *British Journal of Psychiatry* 165 (6), 734-742, 759.**

Methods described in Flannigan et al. (1994). Bebbington et al. test the hypothesis that ethnicity determines rates of compulsory admission independently of other factors in two health districts. Six key variables were used in a log-linear analysis: compulsory admission, challenging behaviour, diagnosis, ethnicity, age, and sex. The findings indicate that there were no differences between the health districts. The analysis provided two similar statistical models and, in both, admission under the Mental Health Act (MHA) was associated with challenging behaviour and diagnosis of schizophrenia. There was no significant interaction for ethnicity and compulsory admissions and, in the second model, there was only a weak association. The authors conclude that ethnicity did not appear to be of great importance in decisions to use the MHA, though there was a strong link between ethnicity and diagnosis.

**Bhui, K., Bhugra, D., Goldberg, D., Dunn, G. and Desai, M. (2001). Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychological Medicine* 31 (5), 815-825.**

Asians are reported to have lower levels of mental illness than comparison British groups, yet epidemiological and ethnographic evidence suggests that they have high rates of common mental disorders. Asians visit their general practitioners (GPs) more often than other ethnic groups, but are less likely to have psychological distress identified. To explore cultural influences on the prevalence of common mental disorders, the authors recruited Asian and English general practice attenders to a two-part survey in London over a period of a year. Respondents were screened using the Amritsar Depression Inventory (ADI) and the General Health Questionnaire. They were also asked about their age, place of birth and language. GPs completed Likert questionnaires assessing psychiatric

symptoms and physical symptoms. In the second phase, data were collected from 209 Punjabi and 180 English subjects. In the whole sample, Punjabi respondents were less likely to be unemployed than English respondents (odds ratio=0.25,  $p=0.002$ ) and more likely to be married (odds ratio=3.90,  $p=0.001$ ).

The weighted unadjusted prevalence of common mental disorders was 39.1% for English respondents and 41.2% for Punjabi individuals. GPs considered 12% of Punjabi and nearly 20% of English individuals to have a 'significant psychiatric disorder'. GPs were less likely to believe that Punjabi individuals with depressive ideas had significant psychiatric disorder. Where GPs had rated Punjabi respondents as having a 'subclinical emotional disturbance', these individuals were 3.4 times more likely to be cases than those individuals who had been rated as having an entirely physical illness only. Punjabi GPs did not perform better than non-Punjabi GPs and there were few significant differences between Punjabi and English individuals in their help-seeking behaviour. Help-seeking cases were more likely to be assessed as having a 'significant psychiatric disorder' if they were English (odds ratio=5 compared with 3.15 for Punjabi individuals). The authors point out possible sources of bias: Punjabi subjects had better social circumstances than English subjects, for example, and elderly Punjabis were under-represented in the sample.

**Bhui, K., Christie, Y. and Bhugra, D. (1995). The essential elements of culturally sensitive psychiatric services. *International Journal of Social Psychiatry* 41 (4), 242-256.**

A review of the literature on various aspects of mental health service utilisation by Black individuals. The authors describe how use of compulsory orders, police involvement and reliance on psychotropic medication is often a feature of Black people's use of services. Services need to be made more culturally appropriate.

**Bindman, J., Johnson, S., Wright, S., Szukler, G., Bebbington, P., Kuipers, E. and Thornicroft, G. (1997). Integration between primary and secondary services in the care of the severely mentally ill: patients' and general practitioners' views. *British Journal of Psychiatry* 171 (8), 169-174.**

The authors explore communication between general practitioners (GPs) and psychiatric teams about patients with severe mental illness (SMI). Patients' views were elicited in two main areas: their satisfaction with primary care; and their contacts with primary care (and the reasons for

contact). GPs' views in three areas were explored: the GP's satisfaction with communication and joint working in the care of each patient; the GP's knowledge about the psychiatric care received by each patient; and the GP's role in the care of each patient. The authors tested the hypotheses that service integration is poorer for Black patients, that they have less contact with their GPs, and that they are less satisfied with their contact with their GPs. All patients who had contact with two psychiatric teams in south London over a period of six months were identified, and those meeting the inclusion criteria were selected (n=100. Whites=49, Black Caribbeans=34, Black Africans=11, Asians=3). GPs were identified from case notes and information provided by the local Health Commission. A questionnaire was completed during a telephone or face-to-face interview.

The results suggest that there were no significant differences in relation to GPs' satisfaction with communication about Black patients or the GPs' knowledge of Black patients' care. However, GPs regarded themselves as less involved in the care of Black patients (of 39 GPs providing information on their level of involvement with Black patients, only 5 (13%) considered themselves to be 'highly involved' in their patient's care. This contrasts with 44% of GPs who considered themselves to be 'highly involved' with their White patients). This difference was not reflected in the Black patients' own perceptions of the care they received (or would prefer to receive) from their GPs. In a multivariate analysis of the factors that affect the GP's level of perceived involvement in their patient's care, gender and ethnicity were the only significant variables. The authors note the limitations of the study, among which is reliance on telephone interviews with GPs (the information provided could not be validated). Nor could patients' reports of contact with primary care be validated.

**Bracken, P. J., Greenslade, L., Griffin, B. and Smyth, M. (1998). Mental health and ethnicity: an Irish dimension. *British Journal of Psychiatry* 172 (2), 103-105.**

Irish people living in Britain are White but are different from other Whites in their experience of social disadvantage and racism. Irish people in Britain are the largest minority group in Western Europe. The Irish are over-represented as users of psychiatric services; age-standardised mental hospital admission rates/100 000 in England and Wales in 1981 were: males born in the Irish Republic=1054, males born in Northern Ireland=793 and males born in England=418. A similar gradient can be seen for females. Rates of mental hospital admission for individuals born in the Irish Republic are very high for those suffering from alcohol misuse and depression (332 Irish-born men/

100 000 were admitted to hospital and were given a diagnosis of alcohol misuse in 1981 compared with 38 English-born men. For depression, the figures are 197 and 79 respectively). High mental hospital admission rates among the Irish have been observed in North America and also in some parts of Ireland, though this does not necessarily reflect the level of mental illness in the Irish population (the incidence of schizophrenia in Dublin is not high compared with other countries). The mental ill health of the Irish may be explained by social factors, such as poverty.

**Burnett, R., Mallett, R., Bhugra, D., Hutchinson, G., Der, G. and Leff, J. (1999). The first contact of patients with schizophrenia with psychiatric services: social factors and pathways to care in a multi-ethnic population. *Psychological Medicine* 29 (2), 475-483.**

The authors describe how patients' pathways to care, type of admission and sectioning details were recorded for all first contact patients presenting at south London psychiatric services over a two year period (Whites=38, African-Caribbeans=38 and Asians=24, all diagnosed with broad schizophrenia). A retrospective analysis of data from the Camberwell Register, comparing rates of compulsory admission between Whites and African-Caribbeans for first and re-admissions (over a 20 year period) was also conducted. For the first sample, general practitioner (GP) referral was found to be the most common mode of contact, and there were no significant differences between the ethnic groups in relation to compulsory admission. The analysis of data from the Camberwell Register also showed no significant differences in rates of compulsory admission between Whites and African-Caribbeans. When all re-admissions were examined, however, African-Caribbeans were more likely to be admitted involuntarily. The authors conclude that the less desirable routes of entry into the psychiatric services among African-Caribbeans do not apply to first admission but probably develop over time and after repeated contact with services.

**Christie, Y. and Moore, L. (1991). *A question of race. The report of a conference on the future of mental health services for the Black communities held at the City University, London on 19<sup>th</sup> and 20<sup>th</sup> September 1990. London: King's Fund Centre.***

The report of a conference on the provision and use of mental health services for Black and other minority ethnic groups. An brief overview of services and reports from the workshop are provided and a number of recommendations made. These include: more consultation with service users; better education about the Community Care Act; more support for Black workers; increased

networking; a growth in collective action between groups and individuals; greater sharing of information; and effective training of personnel.

**Christie, Y. and Blunden, R. (1991). *Is race on your agenda? Improving mental health services for Black and minority groups. Briefing Paper. London: King's Fund Centre.***

A Briefing Paper from the King's Fund, which examines mental health service provision to Black people and suggests ways to improve it. The findings are based on the views and opinions of experts in the field (though few details of these are provided). Gaps and limitations in service provision and quality are identified. These include: geographical variation in provision; inappropriate community services (lack of residential services, treatment services etc.); lack of suitable housing for mentally ill minority people; overdiagnosis in some populations (African-Caribbean ones, in particular); inadequate interpreting services; and lack of consultation. Guidelines for specific grant proposals are described.

**Coid, J.W., Khatan, N., Gault, S. and Jarman, B. (2000). *Ethnic differences in admissions to secure forensic psychiatry services. British Journal of Psychiatry 177 (9), 241-247.***

Admissions to secure forensic psychiatry services among ethnic groups were explored using data from seven Regional Health Authority areas over a seven year period. Data on socio-demographic characteristics, criminal and noncriminal behaviour leading to admission, diagnosis and source of referral were used in the analysis. Area poverty was measured using the Jarman Underprivileged Area Score (UPA).

The analysis indicates that, in the period 1988-1994, there were a total of 3155 first admissions to maximum and medium secure forensic psychiatry services in England from the seven regions (Whites=2358 (74%), Blacks=656 (21%), Asians=81 (3%) and Others=57 (2%)). Admissions were higher for Black males than for White males, and lower for Asian males; a similar pattern was observed for females. There were 5.6 times as many Black males admitted as White males, and nearly three times as many Black females as White females. Logistic regression analysis suggests that, compared with White patients, Black patients were more likely to be male, single, foreign-born, living in the 20% most socio-economically deprived wards of England and Wales and less likely to have been admitted following non-criminal behaviour.

Black patients also were more likely to receive diagnoses such as schizophrenia, brief psychotic episodes, drug abuse or dependence, and less likely to receive diagnoses of depression, alcoholism and borderline personality disorder than Whites. Asians were more likely to be given a diagnosis of schizoaffective disorder and less likely to receive a diagnosis of drug dependence/misuse and antisocial personality disorder than Whites. Analysis of source of referrals and the location of the patient before admission showed no differences between the groups according to whether they were admitted from prison, other psychiatric hospitals, the community etc., though Blacks were significantly less likely to have been referred by a lawyer than Whites (adjusted odds ratio 0.69,  $p=0.008$ ).

**Cole, E., Leavey, G., King, M., Johnson-Sabine, E. and Hoar, A. (1995). Pathways to care for patients with a first episode of psychosis. A comparison of ethnic groups. *British Journal of Psychiatry* 167 (6), 770-776.**

Cole and colleagues describe the findings of a study of the pathways to care among patients with a first episode of psychosis. In the period 1991-1992, all new cases of psychotic illness were screened at a north London hospital. Subjects were interviewed at the time of first contact with services. Demographic data and details of time to presentation at services, type of first contact, rates of compulsory admission and police and primary care involvement were also collected. Data were collected in interview settings with patients and carers, and a semi-structured questionnaire was used to trace the individuals and agencies seen during contact with services. Of 106 patients identified, 93 were recruited to the study. Most (42%) of these individuals were White, 20% Black Caribbean, 15% Black African, 5% Indians and 3% Pakistanis. Most cases were unemployed and 37% were living in public housing (compared with 31% in the London Borough of Haringey).

The results suggest that there were no significant differences between the ethnic groups in their first point of contact with services. The general practitioner (GP) was the most common first point of contact for all groups. Compulsory admissions had been experienced by 31% of patients. Factors associated with compulsory admission included living in public housing, living alone and living away from family. Compulsory was more likely for Black patients (40% of Black patients had experienced compulsory admission, compared with 28% of Whites), but the excess was not as great as previous studies have found, and Black patients were no more likely than other groups to have

had police involvement. The authors conclude that ethnicity was not a significant determinant of the pathway to care in this sample of patients with first onset psychosis.

**Commander, M.J., Cochrane, R., Sashidharan, S.P., Akilu, F. and Wildsmith, E. (1999). Mental health care for Asian, Black and White patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. *Social Psychiatry and Psychiatric Epidemiology* 34 (9), 484-491.**

Commander and colleagues compare pathways to psychiatric hospital and the provision of in-patient and aftercare for Asians, Blacks and Whites with non-affective psychoses. Data were analysed from two samples of 120 patients (40 from each ethnic group), one at admission and the other at discharge. Socio-demographic data were collected, as were data on pathways to care and the in-patient episode. Needs and service provision assessment was made three months after discharge and patient satisfaction was ascertained at each stage. The findings indicate that Asian and Black patients experienced more complex pathways than Whites, and had higher levels of involvement with the police and compulsory detention than Whites. They were less likely to perceive themselves as having a psychiatric problem and reported less satisfaction with the admission process. Black patients were more likely to have experienced detention in hospital against their will, though there were few differences in satisfaction with hospital care. Perceptions of unmet need, provision of aftercare and satisfaction with services were similar across all ethnic groups.

**Commander, M.J., Odell, S., Sashidharan, S.P. and Surtees, P.G. (1999). Psychiatric morbidity in people born in Ireland. *Social Psychiatry and Psychiatric Epidemiology* 34 (11), 565-569.**

Commander and colleagues explore the mental health of the Irish-born, and their use of services, in the West Birmingham Health District. Data were collected from a survey of psychiatric services in the area and from private households (respondents' names were taken from the Family Health Services Authority database of general practice registrations). Measures included mental health status as well as socio-demographic data. Data were collected by semi-structured interview.

The results suggest that of the 2657 individuals aged 16-64 using specialist mental health and addiction services in the period 1994-1995, 7% were White Irish-born and 56% were White born

elsewhere. The total, all-age morbidity rates for Irish-born males were: 359/10 000 and for Whites, 238 (odds ratio=1.5). High rates of alcohol use disorder were observed for the Irish-born using services (Irish-born males aged 16-44 were six times more likely to have an alcohol use disorder than same aged Whites. In the age group 45-64, this was reduced to 2.6). The private household survey results also show elevated levels of alcohol use disorder among the Irish-born (four times the level of that for Whites, though this was not significant because of small numbers).

**Commander, M.J., Sashidharan, S.P., Odell, S. M. and Surtees, P.G. (1997a). Access to mental health care in an inner-city health district: I. Pathways into and within specialist psychiatric services. *British Journal of Psychiatry* 170 (4), 312-316.**

Psychiatric morbidity and pathways to care in West Birmingham Health District (WBHD) are explored by Commander and colleagues. The focus is not on ethnicity, though ethnicity features in the analysis. All patients using local psychiatric services for a six month period were identified, hospital admissions data were obtained and in-patient service use was monitored. Data were collected on socio-demographic situation and clinical and service use. A primary care survey was also undertaken and a random sample of WBHD residents registered with a general practitioner (GP) was drawn. These individuals were then interviewed about their health status, use of services and life experiences (parental loss etc.). The results indicate that Blacks are over-represented among users of specialist services, they were also more likely to be admitted to hospital and detained under the Mental Health Act (MHA).

**Commander, M.J., Sashidharan, S.P., Odell, S.M. and Surtees, P.G. (1997b). Access to mental health care in an inner-city health district: II. Association with demographic factors. *British Journal of Psychiatry* 170 (4), 317-320.**

This study's methodology is described above (Commander et al, 1997a). The results here suggest that Asians are more likely to consult their general practitioner (GP) compared with Whites and Blacks, but Whites are more likely than Asians or Blacks to have their mental health problems diagnosed. Case recognition in primary care settings is poor for Blacks, who are over-represented in specialist service settings.

**Davies, S. Thornicraft, G., Leese, M., Higginbotham, A., and Phelan, M. (1996). Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *BMJ* 312, 533-537.**

**And**

**Thornicraft, G., Davies, S. and Leese, M. (1999). Health service research and forensic psychiatry: a Black and White case. *International Review of Psychiatry* 11 (2-3), 250-257.**

The authors report the findings of a study of compulsory admission to hospital and contact with forensic services among minority ethnic individuals with psychosis in south London. Data on cases were taken from a variety of sources: social services, general practitioners (GPs), psychiatric case records etc. Data collected included: age, place of birth, socio-economic status, family history of mental illness, contacts with mental health services. Ethnicity was determined by case notes and reports by health care staff. Of 535 patients identified, 439 fulfilled the criteria for psychosis. Nearly 58% of cases were White, 26% were of Black Caribbean origin, nearly 7% of Black African origin and the rest were categorised as 'Other'. There were no significant differences between the groups in their socio-demographic characteristics, though Black individuals were younger.

Nearly 52% of the sample had been placed on a section of the Mental Health Act (MHA) at some time, and this was significantly higher for Black Caribbean and Black African patients than for Whites (70% of Black Caribbeans and 69% of Black Africans had been detained under the MHA compared with nearly 43 % of Whites). In a logistic regression, controlling for living alone, age and number of admissions, the adjusted odds ratio for Black Caribbeans for detention under the MHA=3.67 ( $p<0.001$ ), and for Black Africans=2.88 compared with Whites ( $p=0.04$ ). The analysis of data on contact with forensic mental health services suggest that Blacks were more likely than Whites to have been admitted in the past to a psychiatric intensive care facility or to prison (25% of Blacks had been admitted to a psychiatric intensive care facility compared with about 10% of Whites). The authors conclude that Black individuals have greater contact with the police and forensic services and are more likely to receive involuntary treatment than Whites. This may be because Black patients see mental health services as inaccessible or inappropriate.

**Department of Health and the Home Office (1992). *Services for people from Black and ethnic minority groups. Issues of race and culture. A discussion paper (reviews of health and social services for mentally disordered offenders and others requiring similar services)*. London: Department of Health, Home Office.**

A discussion paper that refers to many of the key studies on the mental health of Blacks and others, draws out the main themes and makes a number of recommendations. The background to the paper is the recognition (perhaps belatedly) that there is an urgent need to address the kind of services that would benefit mentally disordered offenders from minority ethnic groups. A greater proportion of Black people are: removed by the police to a place of safety (S136) under the Mental Health Act; detained in hospital under the same act; diagnosed as suffering from schizophrenia or some other psychotic illness; detained in locked wards; and are less likely than Whites to receive appropriate treatment at an early stage of illness and to receive counselling or psychotherapeutic treatments.

Primary and community mental health services consistently fail to take account of the needs of Black and minority individuals, and many individuals are suspicious of such services and consider them coercive. Many individuals lack appropriate information and are wary about approaching services, which are staffed (at the top levels, at least) almost entirely by White people. The conclusions and recommendations emphasise the need for greater consultation with minorities, the need for all the different agencies and bodies (health authorities, criminal justice system, local authorities) to work together and the improvement of data collection systems.

**Fatimilehin, I.A. and Coleman, P.G. (1999). 'You've got to have a Chinese chef to cook Chinese food!!' Issues of power and control in the provision of mental health services. *Journal of Community and Applied Social Psychology* 9 (2), 101-117.**

The authors explore issues of power and control in the use of child and adolescent psychology services using material from focus group discussions. All respondents (n=24) were of African-Caribbean origin and had a child aged five or older. Most (62%) were female, second generation and none of the respondents had used psychology/psychiatry services.

The results indicate that most respondents knew little about the services and how to access them. A number of themes were explored: power and control in use of services; the impact of migration; community self-reliance; and parenting. Many respondents said that they would prefer their

children to see a Black psychologist, and indicated that they are generally wary of such services, believing that confidentiality might be compromised. Respondents also expressed anxiety about members of their community knowing that their children had used psychological services, and that this might affect where the service should be located. Some respondents mentioned that in the Caribbean, problems would be dealt with 'in-house', though this could mean either keeping the problem within the family or within the Black community. The ability of the Black community to offer support was discussed, though some again expressed fears about confidentiality. The role of parents was also considered. The difference between the UK and the West Indies was commented upon; in the latter, relationships with parents are more formal and punishment is used more.

In conclusion, the authors note that these themes provide important information about how best to target mental health services at Black people; most individuals in the study indicated that any service would have to '...offer confidentiality, self-referral, a non-stigmatizing environment and access to Black psychologists who are able to practise from a non-Eurocentral knowledge base' (p.116). The study is limited by a sampling bias; a higher proportion of the parents had professional and managerial jobs than is found in the general Black population. Those with lower status occupations might have been suspicious of the aims of the study and chosen not to participate.

**Feinstein, A. and Holloway, F. (2002). Evaluating the use of a psychiatric intensive care unit: is ethnicity a risk factor for admission? *International Journal of Social Psychiatry* 48 (1), 38-46.**

The authors examine ethnicity as a risk factor for admission to a psychiatric intensive care unit (PICU) at the Maudsley Hospital, London. Data from 107 admissions to the PICU were collected over a five month period in 1993. Functioning was assessed using the Global Assessment of Function Scale (GAFS) and details of socio-demographic situation, admission and history of mental illness were collected.

Of the 107 patients, 42% were of Afro-Caribbean origin and 10% were Black African. Most (80%) of the patients had been compulsorily admitted to the PICU under the Mental Health Act (MHA). There were no significant differences between the ethnic groups in relation to age, marital status or living setting, though Afro-Caribbeans were significantly less likely to be employed than Whites ( $p=0.03$ ). Whites were less likely than the Black ethnic groups to have been detained under the MHA, though this was not statistically significant. Afro-Caribbean patients were significantly more

likely to be given a diagnosis of schizophrenia than Whites ( $p=0.005$ ) and were significantly more likely to have abused cannabis than both Black Africans and Whites. The authors note that the Afro-Caribbean patients had a poor level of functioning on admission and that Afro-Caribbeans and Black Africans are disproportionately admitted to the PCIU. This may be explained by the use of cannabis among Afro-Caribbeans, which can precipitate psychotic episodes. Lack of social support may also be a problem for Afro-Caribbeans.

**Greenwood, N., Key, A., Burns, T., Bristow, M. and Sedgwick, P. (1999). Satisfaction with in-patient psychiatric services. *British Journal of Psychiatry* 174 (2), 159-163.**

Ethnicity is not the focus of this study, so the study will only be described briefly here. In-patients from six psychiatric wards in two hospitals were approached over a six month period ( $n=433$ ). Data were collected using a structured questionnaire and questions were asked about various aspects of in-patient psychiatric services (three patient satisfaction measures were used). Black patients tended to be less satisfied with services than Whites, but this was not statistically significant. The authors note the possible importance of two confounding factors: Black patients tended to be younger (mean age=37.8 years compared with 43.3 for White patients,  $p=0.003$ ) and they were also more likely to be detained (55.4% compared with 27.8%,  $p< 0.001$ ), both of which are significantly associated with dissatisfaction in this study. However, when ethnicity was entered into a logistic regression model, it was not significant in explaining variation in dissatisfaction.

**Hull, S.A., Cornwall, J., Harvey, C., Eldridge, S. and Omo Bare, P. (2001). Prescribing rates for psychotropic medication amongst east London general practices: low rates where Asian populations are greatest. *Family Practice* 18 (2), 167-173.**

The authors present the results of a study of prescribing rates for antidepressants and anxiolytics, and the proportion of Asian names on general practice lists. Data were taken from 164 practice lists in the East London and the City Health Authority area (ELCHA) and drug prescribing information were obtained from the Prescription Pricing Authority.

The prescribing rates varied greatly from practice to practice; with a greater range for anxiolytics than antidepressants (for the latter, there was a 25-fold difference between the highest and the lowest prescribers). The proportion of Asian names on practice lists varied from less than 2% to 98%. Multivariate analysis using data from 138 practices indicates that 48% of the variation in

antidepressant prescribing between practices can be explained by differences between practices in the proportion of Asian names on the register, the size of the partnership, the presence of a practice manager and the location of the practice. Antidepressant prescribing was significantly higher in practices with low proportions of Asian names on the register, in large practices and where there was a practice manager. Anxiolytic prescribing was also lower where there were low proportions of Asians on the practice lists.

The authors point out that previous studies have shown high (general) prescribing rates for Asians, and the present study highlights the importance of considering the type of drugs being prescribed (Asian populations have high rates of diabetes and ischaemic heart disease, and they will have high prescribing rates for these drugs). The study is limited by reliance on cross-sectional measures, the variable quality of the data, a reliance on the use of Asian names (which misses other ethnic groups) and no data on counsellors or psychologists are used in the analysis. Mental health morbidity in Asian populations may not be well recognised (it may not be picked up by standard screening instruments).

**Kai, J. and Hedges, C. (1999). Minority ethnic community participation in needs assessment and service development in primary care: perceptions of Pakistani and Bangladeshi people about psychological distress. *Health Expectations* 2 (1),7-20.**

This research will only be described briefly here since it focuses primarily on exploring perceptions of psychological distress among Pakistanis and Bangladeshis and not with service access or use (though the study findings will be used to in order to facilitate the development of appropriate services). The authors describe how they recruited paid community project workers (CPWs) among an minority ethnic community in a deprived area (n=13) and trained them to conduct small-scale, qualitative research on mental health in their own communities. These CPWs then interviewed 104 respondents from their own communities (Pakistani and Bangladeshi) about their experiences of psychological distress.

The results indicate that most respondents mentioned deprivation, racism and crime as contributing to their distress. Respondents were asked about the type of help they had sought. Most (72%) thought that their own doctors were not the most appropriate person to consult about emotional or psychological distress. Most respondents reported that they would like to receive help from

someone the same gender as them. The authors maintain that the findings of the study have implications for the provision of services; Asian counsellors, for example, should be employed alongside existing welfare workers and awareness of services needs to be raised in the community.

**Koffman, J., Fulop, N.J., Pashley, D. and Coleman, K. (1997). Ethnicity and use of acute psychiatric beds: one-day survey in north and south Thames regions. *British Journal of Psychiatry* 171 (9), 238-241.**

The use of acute psychiatric beds by minority ethnic individuals in 31 health authority areas in the north and south Thames region is explored. Data were taken from patient forms completed by ward managers (using clinical data on patients) in all National Health Service (NHS) adult acute and low-level secure psychiatric and seven private units in the Thames regions on one day (15<sup>th</sup> June) in 1994. Data were collected on mode of admission and mental health diagnosis, as well as on ethnicity and demographic characteristics. Data were available for every NHS and private unit in the study area (number of units=3978). Most patients (75%) were White, 16% were Black and 4% Asian. Of the 78 patients in private wards, nearly a quarter was Asian. The age and gender-adjusted psychiatric in-patient admission ratios: Whites=83%, Blacks=432% and Asians=113%. Two-thirds of Blacks had been admitted compulsorily under the Mental Health Act compared with 39% of Asians and 31% of Whites (this remained significant after controlling for clinical diagnosis). Black patients were also more likely to be on low-level secure units and less likely to be registered with a GP than Whites and Asians. Black patients also had high rates of schizophrenia (71% compared with 36% for Whites and 51% for Asians). There were no significant differences between the three groups in frequency of psychiatric in-patient admissions. The authors note the limitations of using census data on ethnicity (possible under-enumeration) and their inability to consider the impact of socio-economic status on outcomes

**Leavey, G., King, M., Cole, E., Hoar, A. and Johnson-Sabine, E. (1997). First-onset psychotic illness: patients' and relatives' satisfaction with services. *British Journal of Psychiatry* 170 (1), 53-57.**

The authors examine the satisfaction of patients with a first episode of psychotic illness, and their families, soon after presentation to services, focusing especially on the satisfaction of Black patients. A service satisfaction questionnaire was designed to explore patients' satisfaction with the

psychiatric service and treatment, hospital stay and staff-patient interaction. Relatives were asked to complete two questionnaires; one, a modified version of the questionnaire given to patients, and the second, the Family Service Satisfaction Scale (FSSS) questionnaire.

Of 93 patients approached, 59 completed the questionnaire and 55 (of a possible 71) relatives completed their questionnaires. The findings indicate that most patients and relatives were generally satisfied with the treatment but were less satisfied with the 'hotel' aspects of hospital care. No significant differences were found between Black and other patients in any of the four domains of care, and there were no differences in scores between Black and other patients in their attitude towards helpfulness of medication (68% of the Black patients and 72% of other patients felt that medication had been helpful). The results for the relatives of patients were more mixed; there was a trend for relatives of Black patients to be less satisfied with some aspects of aftercare services. Patients born abroad were significantly more satisfied than those born in Britain, regardless of ethnicity. Compulsory detention under the Mental Health Act was significant in determining low satisfaction for patients, and especially their relatives. The authors conclude that Black patients and their relatives were not especially likely to be dissatisfied with services, though this study has low statistical power.

**Lelliott, P., Audini, B. and Duffett, R. (2001). Survey of patients from an inner-London health authority in medium secure psychiatric care. *The British Journal of Psychiatry* 178 (1), 62-66.**

The focus of this survey is not specifically on the experience of minority groups (here, Black patients) but on comparing the use of medium secure psychiatric care in the National Health Service (NHS) with that in independent units. Medium secure psychiatric care is described as that which caters for the needs of individuals for whom both general psychiatric services and high security services are inappropriate. Patients' details were taken from lists provided by three NHS units and 12 independent units in an inner city London health authority area. Data were collected in a number of areas: socio-demographic information, forensic history, offending behaviour, aggressive behaviour etc. Information was taken from case notes and by interviewing key workers.

In total, 183 patients' details were used in the analysis. Most patients were male and had been unemployed before admission. Over half (57%) of the group was Black. Patients in independent units were less likely to have been referred from the criminal justice system and to have been

admitted for violence compared with patients in NHS care. Comparisons between White and Black patients shows that Blacks were slightly younger and more likely to have a psychotic disorder. Blacks and Whites were similar in source of referral to medium secure care. There were few differences between Blacks and Whites in terms of previous offending. The authors conclude that there was three times as many Black patients than would be expected given their population size. The authors point out that this is a cross-sectional study (and thus provides only a 'snapshot' of the situation).

**McCreadie, R.G., Leese, M., Tilak-Singh, D., Loftus, L., Macewan, T. and Thornicraft, G. (1997). Nithsdale, Nunhead and Norwood: similarities and differences in prevalence of schizophrenia and utilisation of services in rural and urban areas. *The British Journal of Psychiatry* 170 (1), 31-36.**

Socio-demographic, service use and other data on patients receiving care at various health and other services in three locations were analysed (sample size: Nithsdale (Scotland)=161, Nunhead (London)=177, Norwood (London)=130). Just over half of the patients in the two London locations were White, and three quarters of the remainder were Black Caribbeans. There were no significant differences between the White patients in the three locations (with the exception of Whites in Nunhead in relation to ICD-10 diagnosis of schizophrenia). There were significant differences between non-White groups and Whites in schizophrenia prevalence rates (overall prevalence rates for a clinical diagnosis of schizophrenia/1000: Nithsdale=2.78, Nunhead Whites=3.46, Nunhead non-Whites=7.36, Norwood Whites=2.24, Norwood non-Whites=5.53). Nithsdale patients had experienced more lifetime admissions to psychiatric in-patient care (7.5 compared with 4-4.6 admissions for patients in the other two locations,  $p < 0.00001$ ). The London-based non-White patients had a shorter psychiatric history, more had a history of violence and more had experienced compulsory detention. Comparison of use of services during the survey year between the three groups revealed a number of significant differences. The authors conclude that the Nithsdale patients made substantially better use of services than patients in the London locations. This may be because Nithsdale has more community psychiatric nurses than the London areas, and fewer Nithsdale patients had been to prison.

**McGovern, D. and Hemmings, P. (1994). A follow-up of second generation Afro-Caribbeans and White British with a first admission diagnosis of schizophrenia: attitudes to mental illness and psychiatric services of patients and relatives. *Social Science and Medicine* 38 (1), 117-127.**

The authors test a number of hypotheses concerning the attitudes of Birmingham-based Black Caribbean and White individuals with schizophrenia and their relatives to mental health services. A variety of issues relating to psychiatric care are explored, including emergency access to staff, consultation with staff about treatment, continuity of care etc. Twenty eight White patients and 40 Afro-Caribbean patients were interviewed and 27 White and 32 of their relatives were interviewed.

The results indicate that many of the White/Afro-Caribbean differences did not reach statistical significance (in the areas of global satisfaction, aspects of health care, conceptualisations of problems) though Afro-Caribbeans were less satisfied than Whites in a number of areas. The relatives of Afro-Caribbean individuals were more likely than White relatives to attribute illness to substance use and to consider mental health services to be influenced by racism.

**McGovern, D. and Cope, R. (1991). Second generation Afro-Caribbeans and young Whites with a first admission diagnosis of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology* 26 (2), 95-99.**

Using case notes from a Birmingham hospital, McGovern and Cope analyse first admissions among Whites and second generation Black Caribbeans with a diagnosis of schizophrenia in the period 1980-1983 (n=62). The results indicate that Black Caribbeans in the study are more likely to live alone (42% compared with 10%) to have an onset of illness of less than a week, to be admitted from prison and to have higher rates of re-admission in the two years follow-up period than Whites (48% compared with 28%). There is no evidence that misdiagnosis is a significant factor. The authors recognise that the small numbers make it difficult to generate statistically significant results. The analysis is further limited by reliance on case notes.

**McGovern, D. and Cope, R. V. (1987). First psychiatric admission rates of first and second generation Afro-Caribbeans. *Social Psychiatry* 22 (3), 139-149.**

First admission rates of young Whites were compared with those of second generation Black Caribbeans using case notes from a Birmingham psychiatric clinic in the period 1980-1983. The

results indicate that British-born Afro Caribbeans and migrants aged 16-29 have elevated rates of admissions compared with same-age Whites. More Black Caribbean migrants and British-born Blacks than White individuals are classified as psychotic (White males aged 16-29=49%, Black Caribbean migrants same age=82% and British-born Black Caribbean=92%). The data for the two latter groups were pooled and they comprise the 'second generation' categories, who have higher first admission rates compared with Whites. The authors address the limitations of the study, these relate to overestimate of first admissions (though not disproportionately affecting any ethnic group), false identification of first admissions and the exclusion of individuals with no address and from outside the catchment area.

**Parkman, S., Davies, S., Leese, M., Phelan, M. and Thornicroft, G. (1997). Ethnic differences in satisfaction with mental health services among representative people with psychosis in south London: PriSM study 4. *British Journal of Psychiatry* 171 (9), 260-264.**

Parkman and colleagues describe the findings of a study designed to measure degree of satisfaction with mental health services among groups in south London (n=184). The results of the questionnaire administered to the study population indicate that the Black UK-born population expressed less satisfaction with services (p=0.04). Regression analysis suggests that number of hospital admissions was important, with evidence that satisfaction decreases with number of hospital admissions. The study is limited by small sample size (the second generation Black Caribbean group number just 27) and definition of ethnicity using case notes.

**Perkins, R.E. and Moodley, P. (1993). Perception of problems in psychiatric inpatients: denial, race and service usage. *Social Psychiatry and Psychiatric Epidemiology* 28 (4), 189-193.**

This study will only be described briefly here since it is largely about how people with psychiatric illness perceive their difficulties and not primarily about service use. Data on 60 consecutive acute admissions to wards in an inner city area in London were collected. The results indicate that more than half (56%) of the sample did not consider themselves to have psychiatric problems, 15% believed that they had no problems at all and 40% believed that their illnesses were physical or social in nature, rather than psychiatric. Afro-Caribbeans were more likely than other groups to consider that they had no problems at all and to be compulsorily admitted to services. Afro-Caribbeans were also more likely to be diagnosed as experiencing psychotic disorders.

**Pierre, S.A. (2000). Psychiatry and citizenship: the Liverpool Black mental health service users' perspective. *Journal of Psychiatric and Mental Health Nursing* 7 (3), 249-257.**

The authors explore the status of user involvement within mental health services in Liverpool, focusing especially on the use of services by minority ethnic groups. Data were collected using semi-structured and unstructured interviews (n=20) and analysed according to thematic content analytic procedures. No data is provided on the characteristics of respondents. Nine principle themes are discerned using this method. These range from the appropriateness, or otherwise, of respondents' diagnoses to the importance of consultation. Other themes included: the lack of counselling for respondents and the over-medication of Black mental health service users. The authors conclude that '...Black mental health service users are being given a raw deal'(p.253).

Extensive consideration is given to the methodology used in the study. Qualitative studies of service use can overlook wider social and environmental factors that contribute to difficulties accessing and using services. Unstructured interviewing can also mean that service use is not systematically examined. A number of recommendations for service providers are made, these include: the establishment of a database showing the ethnicity and care pathway of all minority ethnic users of mental health services; the use of unstructured and semi-structured interview data to strengthen the quality of data collected on service use; and the implementation of service changes suggested by service users.

**Pui-Ling, L., Logan, S., Yee, L. and Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health Medicine* 21 (1), 74-80.**

Pui-Ling et al. present the results of a study of the mental health needs of the Chinese community. Respondents were recruited through Chinese community centres in a variety of English communities and asked to complete a questionnaire. Of those who completed the questionnaire, 86 screened positive for a mental disorder (current and/or past) and 71 agreed to participate. Most respondents were born in Hong Kong and over half were married.

The results indicate that most of the sample was registered with a general practitioner (GP) and health-seeking behaviour and knowledge of services among the sample varied (39% said that they had consulted their GP about mental health problems, and 13% had not sought help). Of those respondents with a current mental health disorder (n=50), most had consulted their GP, and smaller

numbers (20%) had been to an accident and emergency department. One had consulted a doctor in China. Most of those who had sought help were given a diagnosis, and 90% of those who had received treatment were still taking their medication at the time of the survey.

Respondents mentioned a number of barriers to seeking help, including language difficulties and their belief that their symptoms of illness were not psychiatric in origin but solely somatic. Of those respondents who had consulted a GP, 67% did not have any problems with the consultation and 58% said the consultation was a positive experience because the GP spoke Chinese or because their condition was explained. Forty one respondents who sought professional help had consulted a psychiatrist and some respondents had consulted professionals within their own community. Over a third of the sample was not aware of the range of services available. A third mentioned problems with mental health services (lack of knowledge of services, insensitive staff, long waiting times). The authors also consider the impact and causes of mental illness in this population. Respondents mentioned stigma against the mentally ill in the Chinese community. The authors note that the population here is not representative of individuals with mental illness in the Chinese community, and tended to be at the extreme end of the mental illness spectrum. Assignment of mental illness was based on self-report by the respondent.

**Secker, J. and Harding, C. (2002). African and African Caribbean users' perceptions of inpatient services. *Journal of Psychiatric and Mental Health Nursing* 9 (2), 161-167.**

In-depth interviews were carried out with a sample of Resource Centre clients in a London borough (n=26). All respondents were African or African Caribbean, 16 were male and two thirds were aged 25-44. Interviews were taped, transcribed and then analysed using content analytic techniques. Three main themes emerged from the analysis: loss of control, experience of racism and relationships with staff. Respondents experienced loss of control in relation to their treatment and care, racism inside and outside the mental health services (which was not experienced by all respondents, but was major theme) and generally poor relationships with health care staff. The authors conclude that the results of the study are 'disturbing' and service users' perceptions need to be taken more seriously if services are to be more effective.

**Shaw, C.M., Creed, F., Tomenson, B., Riste, L. and Cruickshank, J.K. (1999). Prevalence of anxiety and depressive illness and help seeking behaviour in African Caribbeans and White Europeans: two phase general population survey. *BMJ* 318, 302-305.**

The authors describe the results of a survey of anxiety and depression in African Caribbeans and Whites. The survey used a two-phase design. The entire sample (n=612) received a screening questionnaire and those who scored three or more (plus a random sample of people with two or less) on the questionnaire comprised the second phase population. This reduced sample (n=230) was assessed for anxiety and depression, and interviewed about their help-seeking behaviour.

The results indicate that similar numbers of African Caribbeans and Whites had more than one disorder (13% and 14% respectively). Anxiety disorders were less significant among African Caribbeans, but Caribbean women were more likely to be depressed than White women (19% and 11% respectively). Health-seeking behaviours among the sickest individuals (n=58) were approximately similar for African Caribbeans and Whites, though the former were more likely to seek non-medical help (such as herbal treatment). The authors point out that the study is limited by sampling bias, attrition between the two phases and the limitations of the screening questionnaire.

**Thomas, C.S., Stone, K., Osborn, M., Thomas, P.F. and Fisher, M. (1993). Psychiatric morbidity and compulsory admission among UK-born Europeans, Afro-Caribbeans and Asians in Central Manchester. *British Journal of Psychiatry* 163 (7), 91-99.**

Thomas and colleagues report the findings of a study designed to explore admission, modes of referral, compulsory detention and diagnoses in a sample of Black Caribbeans, Asians and Europeans. Data were collected from psychiatric admissions to Central District of Manchester in the period 1984-1987 (n=1534). Ethnicity was determined by consultation with staff and examination of case notes. The results indicate that Black Caribbeans have significantly higher rates of first admission compared with same age Europeans (nine times higher for schizophrenia and five times for 'other psychoses'). Re-admissions are also significantly higher for Black Caribbeans. The authors discuss the methodological flaws with the study; these include small numbers and problems with estimating the size of minority populations.

**Wheeler, E.L. (1998). Mental illness and social stigma: experiences in a Pakistani community in the UK. *Gender and Development* 6 (1), 37-43.**

The author draws on material collected from a sample of women (two thirds of whom were Pakistani migrants) who were released from psychiatric care in West Yorkshire. The identity of the women (which is primarily that of wife and mother) was compromised by their illness and they were stigmatised within the community, marginalised within the family and derided for their mental illness. This was compounded by the effects of medication, which often made the women drowsy and unable to perform their duties as wives and mothers. From the point of view of developing appropriate services to Asian women, more attention needs to be given to the development of services in a non-hospital setting. Some of the women had used group therapy techniques, but they had to have been hospitalised first, and some were receiving counselling. Both of these services need to be expanded. The author highlights some important issues that should inform provision of services, but the study described here is largely exploratory; no demographic or other details of the respondents are provided, nor is sample size. No information is provided about how the material was collected or analysed.

**Wilson, M. and MacCarthy, B. (1994). GP consultation as a factor in the low rate of mental health service use by Asians. *Psychological Medicine* 24 (1), 113-119.**

British Asians are under-represented in psychological departments providing care for mental health problems. It has been suggested that Asians may have fewer mental health problems, or they may use services in a different way to other groups. This study is designed to explore ethnic group differences in the ways in which Asian and White patients present to, and are assessed by, their general practitioner (GP).

Consecutive attenders at five health centres in north west London were asked to complete a non-psychotic psychiatric illness questionnaire, and also asked about their ethnicity and their reason for visiting their GP. GPs were asked to complete a questionnaire after the consultation with the respondent indicating if they believed that the patient had consulted them for a mental health problem or another kind of problem. A total of 813 people were approached, 157 refused to complete questionnaires and 495 met all the study inclusion criteria. Rates of non-psychotic mental illness were approximately the same in Whites and Asians. Asian patients scoring above the cut-off

point (for non-psychotic mental illness) were significantly more likely to report that they were consulting the GP about a physical problem alone (65% compared with 46% for Whites,  $p < 0.01$ ). GPs were more likely to identify psychiatric morbidity in Whites (49%) than in Asians (19%) ( $p < 0.01$ ). The authors conclude that Asians and Whites appear to have similar levels of emotional distress, but that they communicate this differently to the GP. There may be the possibility of ‘...a interaction between the ways in which patients experience and communicate psychological distress, their ethnic origin, and their GP’s mode of responding’ (p.113).

#### **2.14) Renal care**

**Soni Raleigh, V. (1997). Diabetes and hypertension in Britain’s ethnic minorities: implications for the future of renal services. *BMJ* 314, 209-213.**

The author discusses the use of renal services by minorities in the UK. She points out that diabetes is more prevalent in Britain’s Asian and Afro-Caribbean population than in the White. The relatively young age profile of these populations has implications for the future provision of services. Soni Raleigh also highlights the fact that diabetic nephropathy and end stage renal failure are more common among Asian diabetics than White ones and diabetes-related mortality is over three times higher for Afro-Caribbean men and six times higher for women, compared with national rates. The quality of care for Black and Asian diabetics is inadequate and compliance is poor—often because of lack of knowledge about the disease.

Hypertension is also discussed, a condition which affects 25-35% of Afro-Caribbeans. The prevalence of hypertension in some communities can be associated with lack of access to care. Access to renal replacement treatment is considered. Although the numbers of individuals from minority ethnic groups using renal replacement treatment is high, many of these individuals may be missing treatment since no ethnic data is available on referrals. Health authorities in areas with substantial minority populations need to make provision for the future given the estimated rise in the number of elderly people from minority communities (this population is expected to triple between 1991 and 2011). The relevance of the American experience to the UK is considered, where 30% of people receiving renal replacement therapy are African American even though they comprise just 12% of the population. Suggestions are made about how to prevent and control diabetes and hypertension. Improvements to the monitoring of illness in the ethnic minority

populations, and measures to enhance screening, are also suggested. Much of these developments can take place within the primary care context.

**Roderick, P., Clements, S., Stone, N., Martin, D. and Diamond, I. (1999). What determines geographical variation in rates of acceptance onto renal replacement therapy in England? *Journal of Health Services Research and Policy* 4 (3), 139-146.**

The objective of this study was to determine the effects of need and supply factors on geographical variation in rates of acceptance onto renal replacement therapy (RRT) in England; the focus was not specifically on minority ethnic populations but ethnicity was used extensively in the analysis. Data were collected from all the renal units in England (53 in all) of all individuals accepted onto RRT. The ethnic categories were: White, Asian and African-Caribbean or Other. Individual level data were matched to ward level data on deprivation and multilevel modelling was used. The results of the analysis of 5715 acceptances onto RRT indicate that age was an important determinant of acceptance for therapy; men over age 64 had seven times higher acceptance rate than younger men and the proportion of people of Asian and Black origin in each ward was also significantly related to acceptance rates.

**Roderick, P.J., Jones, I., Raleigh, V.S., McGeown, M. and Mallick, N. (1994). Population need for renal replacement therapy in Thames regions: ethnic dimension. *BMJ* 309, 1111-1114.**

Hypertension and diabetes mellitus are more common among Black and Asian populations in the UK, yet some research indicates that there are higher rates of diabetic end stage renal failure in Asians. Data on patients receiving renal therapy in all four Thames Regions were obtained, and acceptance rates for therapy were calculated.

The results indicate that crude acceptance rates and prevalence were three times higher in the Black and Asian population compared with the White population (acceptance of renal replacement therapy relative risk=1, 2.9, 2.9 for Whites, Blacks and Asians; prevalence of renal replacement therapy relative risk=1, 2.6, 2.7 for Whites, Blacks and Asians). The relative risk of acceptance for ethnic minorities compared with Whites population increased with age (it was eight times higher at ages 65 and older). There was considerable variation across districts in treatment of minorities. The authors conclude that a higher prevalence and acceptance rate among Blacks and Asians is the result

of end stage renal failure. Given the younger age structure of Black and Asian populations, the research has implications for the provision of treatment.

**Roderick, P.J., Raleigh, V.S., Hallam, L. and Mallick, N.P (1996). The need and demand for renal replacement therapy in ethnic minorities in England. *Journal of Epidemiology and Community Health* 50 (30), 334-339.**

There is growing evidence that minority ethnic populations have an increased need for renal replacement therapy. Using data from the National Review of Renal Services in England (which is collected from 53 adult renal units) the authors examine the uptake of health care among minority groups and issues around geographical access. Data on Pakistanis, Bangladeshis and Indians were aggregated into the 'Asian' category and data on Black groups were likewise pooled.

Of the 5091 adult acceptances of renal replacement therapy, most were White (86.3%), Asians comprised 7.7% of accepted patients and Blacks just 4.7%. Asian and Blacks had threefold higher acceptance rates compared with the White population. Age and sex-adjusted rates for acceptance were even higher for Blacks and Asians compared with Whites. For both of these groups, the most common reason for their acceptance into treatment was diabetes (the cause-specific relative risk of treatment for diabetes=5.8 for Asians and 6.5 for Blacks, compared with 1.00 for Whites). Could these increased acceptance rates for Asians and Blacks be a reflection of geographic proximity to services? Data on 37 districts containing high proportions of minority populations were analysed to ascertain if acceptance rates differed by ethnicity. Rates of acceptance were still high for non-White groups compared with Whites (at around four times higher for Asians and Blacks). The authors discuss the implications of the findings. They note the higher incidence of non-insulin dependent diabetes in Asians in Britain (which is more than four times greater than it is for Whites) and the greater incidence of hypertensive disease among Blacks.

### **2.15) Sickle cell and thalassaemia**

**Anionwu, E. N. and Atkin, K. (2001). *The politics of sickle cell and thalassaemia*. Buckingham: Open University Press.**

This book is more generally about sickle cell disease (SCD) and thalassaemia (with chapters on its origins, geographic distribution and clinical features) but it also has an extensive discussion of

service and treatment provision. The authors provide a chapter on screening, where the *ad hoc* nature of services is discussed. The provision of information to affected families, and counselling to women who have been diagnosed as carrying an affected child, is often culturally inappropriate. This is particularly pertinent in the case of SCD and thalassaemia, where explanations provided by health professionals about the nature of these conditions are made more difficult by the need to impart information about the genetic basis of the conditions. The authors observe that lay perceptions of inheritance, risk and prevention may differ from professional perceptions. In addition, some Asian parents are assumed not to want to terminate affected foetuses; an example of a 'cultural myth' undermining good practice.

Shortfalls in service provision are identified by the authors. Provision of services to minority communities is affected by institutional racism, which is important for those affected by haemoglobinopathies since they will be mostly from minority communities. The tendency to attribute illness in minority ethnic individuals to some aspect of their culture (such as consanguineous marriage) means that the effects of poverty and discrimination on access to health care are overlooked. One problem faced by affected individuals is the tendency of health professionals to underestimate the severity of pain of SCD. Some minority groups are even considered to have a lower pain threshold or to be exaggerating their pain. Some doctors are reluctant to prescribe painkillers, fearing that their Black patients will become drug-dependent. The blood transfusions that are necessary for sufferers of thalassaemia major means that regular trips to hospital are necessary, with all the difficulties that that entails. Some hospitals cannot be flexible about when they can transfuse which means that the lives of affected families are unduly disrupted.

Poor communication and a general lack of support are common in the health service, and health service workers frequently feel that they lack the necessary knowledge to deal with such illnesses. The authors discuss the development of service provision. They point to an increase in haemoglobinopathy counselling centres as a welcome development and the useful contributions provided by voluntary agencies, such as The Sickle Cell Society.

**Atkin, K., Ahmad, W.I.U. and Anionwu, E. N. (1998). Screening and counselling for sickle cell disorders and thalassaemia: the experience of parents and health professionals. *Social Science and Medicine* 47 (11), 1639-1651.**

**And**

**Ahmad, W. and Atkin, K. (2000). Primary care and haemoglobin disorders: a study of families and professionals. *Critical Public Health* 10 (1), 41-53.**

The authors examine screening policy and practice, diagnosis, informed decision-making, and communication in relation to service provision for families affected by sickle cell disease (SCD) and thalassaemia. The data were collected via in-depth interviews with 62 parents of affected children. The respondents were found after consulting health professionals' records in northern England. Most families were of Caribbean and Pakistani origin. Fifty one key service providers were interviewed.

The interview data suggests that diagnosis was often *ad hoc* since no area in the study had a universal screening policy. Decisions about whom to screen were often made on the basis of appearance; those who did not appear to have the 'right' ethnicity were not screened. General practitioners (GPs) were criticised by parents for their poor communication in relation to testing and in their late referring of patients to hospitals for screening. The process of diagnosis highlights the widespread dismissal of parents' fears about their children. Health professionals considered many minority women 'hysterical' when they insisted that there were problems with their children. Many respondents felt patronised by the attitude of health professionals. Health professionals, managers and health commissioners accepted that care of families affected by SCD and thalassaemia was often poor and hospital staff's knowledge of the conditions was out-of-date. Prenatal diagnosis was unusual among the respondents because of a general lack of screening.

**Brozovic, M. and Davies, S. (1987). Management of sickle cell disease. *Postgraduate Medical Journal* 63 (742), 605-609.**

A review paper describing the genetic basis, diagnosis and symptomology of sickle cell disease (SCD). The authors describe the problems typically experienced by individuals suffering from SCD. These include: visceral sequestration crises, swollen joints, priapism and infections. These problems

affect the management of the disease and have implications for provision and use of services. Counselling, for example, is likely to be necessary; painful illness and failure to grow may cause psychological or social problems for young children.

**Kadkhodaei Elyaderani, M., Cinkotai, K.I., Hyde, K., Waters, H.M., Howarth, J., Goldstone, S. and Richards, J.T. (1998). Ethnicity study and non-selective screening for haemoglobinopathies in the antenatal population of central Manchester. *Clinical and Laboratory Haematology* 20 (4), 207-211.**

Data from patients attending the antenatal clinic at a hospital in Manchester who had been asked to record their ethnicity on a form were analysed (n=6718). Most (62.3%) were White, 13.2% were Asian, 7.9% were Black, 3.8% were Chinese and nearly 13% did not give details of their ethnicity. A subset of 1144 patients was screened for haemoglobinopathies over a period of a month. The incidence of haemoglobinopathies was 2.62%. Blacks had the highest incidence at 18.2%. Among those who provided no information about their ethnicity, the incidence rate was 5.6%. Given the high incidence in this group, non-selective screening should be offered in the antenatal population in Manchester.

**Maxwell, K., Streetly, A. and Bevan, D. (1999). Experiences of hospital care and treatment seeking for pain from sickle cell disease: qualitative study. *BMJ* 318, 1585-1590.**

The authors present the results of a qualitative study of the sociocultural factors that affect the management of the sickle cell disease (SCD)-related pain. Two groups were compared; individuals who manage their pain at home and individuals who seek help from hospital. Focus groups and semi-structured interview methods were used. Fifty seven respondents (all of African or Caribbean origin, all resident in Greater London) participated in the study.

Two themes were utilised for the analysis of qualitative data: experience of hospital care; and strategies for treatment of pain and treatment seeking behaviour. Respondents' experience of hospital care suggests that doctors frequently do not believe patients' description of the severity of pain, while respondents who manage their pain at home are suspected of understating the degree of pain. Many patients mentioned stigmatisation as a problem and medical personnel expressed the worry that sickle cell patients might become addicted to painkillers. Respondents also described

how medical personnel attempted to control their care regimens and neglected some aspects of their illness.

In relation to issues of pain management and treatment seeking behaviour, there were differences between those who managed pain at home and those who stayed at home. The latter group had two main characteristics: a belief that spending time in hospital was not in their best interests and a desire to be responsible for themselves. Those individuals who are more frequently admitted to hospital mentioned the benefits of developing good relationships with hospital staff, though they also mentioned the difficulty of achieving this, citing instances of acts of aggression and, in some instances, extreme passivity. The authors conclude that individual management of pain is affected by experiences of hospital care, and that care of pain at home does not imply lesser degree of pain. The authors also refer to the history of race relations in the UK, believing there to be a relationship between the treatment of sickle cell patients and the more general treatment of the health of Black people in London. SCD is seen as a 'Black disease' and is thus marginalised within the health care services.

**Modell, M., Wonke, B., Anionwu, E., Khan, M., See Tai, S., Lloyd, M. and Modell, B. (1998). A multidisciplinary approach for improving services in primary care: randomised controlled trial of screening for haemoglobin disorders. *BMJ* 317, 788-791.**

The authors present details of a two-year, randomised controlled trial (RCT) conducted in a north London area with a large minority ethnic population. The objective of the RCT was to investigate the possibility of using a nurse in a general practice setting to improve screening for haemoglobin disorders such as sickle cell and thalassaemia. The primary outcome measure was a change in the number of requests for screening in control and intervention groups. Twenty six practices out of a possible 93 agreed to participate. The intervention consisted of giving information (via posters, leaflets etc.) and educational sessions (presentations on screening, counselling etc.).

The results of the trial suggest that there were 292 more requests for screening in the intervention group and 74 fewer requests in the control group, with substantial differences *within* the intervention group (just four practices accounted for 75% of the increase in requests). The authors note a number of factors that may affect the changes in requests for screening, including level of interest on the part of the general practitioner (GP), the proportion of the population that is of

minority ethnic status and the number of partners in a practice. Overall, the conclusion is that it is feasible to introduce or improve screening services in general practice settings.

**Modell, B., Petrou, M., Layton, M., Slater, C., Ward, R.H.T., Rodeck, C., Varnavides, L., Nicolaides, K., Gibbons, S., Fitches, A. and Old, J. (1997). Audit of prenatal diagnosis for haemoglobin disorders in the United Kingdom: the first 20 years. *BMJ* 315, 779-784.**

The authors present an audit of services for prenatal diagnoses for haemoglobin disorders, and the use of these services. The focus of the paper is not specifically on the use of services by minority groups, though the ethnicity of service users is a key theme in the paper. Data were taken from the three centres for prenatal diagnosis of haemoglobin disorders (two in London and one in Oxford) and analysed. Data were available on ethnicity of parents, location, diagnosis and obstetric procedures. The 'Black African' and 'Black Caribbean' groups' data were combined.

The results indicate that, by the end of 1994, there had been 2068 prenatal diagnoses carried out on 2035 pregnancies, and 531 foetuses had been diagnosed as being homozygous for a haemoglobin disorder. The number of diagnoses for haemoglobin disorders for Black parents increased from 1991 and overtook diagnoses for other groups, such as Cypriot and Asian groups (these groups showed substantial variation in service use; 89% of Cypriots used the thalassaemia diagnosis service compared with just 10% of Bangladeshis). There were also regional variations in utilisation of prenatal diagnosis for thalassaemias and sickle cell disorders, which was not wholly attributable to the prevalence of at-risk pregnancies (in Yorkshire, 0.66/1000 pregnancies were at-risk, and utilisation was 26%. In the West Midlands, the prevalence of at-risk pregnancies was twice as high yet utilisation was just 5%).

The present service does not provide a satisfactory service to over half of the population at risk of haemoglobin disorders, and the authors maintain that the fact that there are wide regional and ethnic differences and similar variations for thalassaemias and sickle cell disorders, raises important questions about the adequacy of services. The reasons for variation in utilisation may be attributable to the fact that screening is not incorporated into routine medical care, parents are offered screening at a later stage in the pregnancy than they would like and some couples may have religious or other reservations about using the services.

### ***2.16) Substance use and abuse***

**Commander, M.J., Odell, S.O., Williams, K.J., Sashidharan, S.P and Surtees, P.G. (1999). Pathways to care for alcohol use disorders. *Journal of Public Health Medicine* 21 (1), 65-69.**

Commander et al. discuss the findings of three surveys of pathways to care for alcohol use disorders. The surveys are not specifically about the experience of minority individuals, though ethnicity is used in the analysis and the west Birmingham population (from where the sample is taken) has substantial Black and Asian communities (14% and 23% respectively). Respondents were located in three settings: addiction and psychiatric services, primary care and the community. Goldberg and Huxley's pathways to care model was used to examine how individuals access services (the model consists of five levels—from community to in-patient care—and four filters, such as admission or referral, through which individuals must pass if they are to access services) and respondents were asked about their use of alcohol using the CAGE (an alcohol screening questionnaire).

The results indicate that about half of respondents who had been identified as having a problem with alcohol use had consulted their general practitioner (GP) and only about half of individuals who did see a GP had had their condition diagnosed. Asian respondents were more likely to consult their GPs and Blacks were least likely. Asian and Black respondents were also less likely to be referred to specialist services. The authors caution against drawing conclusions from prevalence surveys. Other potentially confounding variables (such as socio-economic status or educational level) are not used in the analysis.

**Khan, F., Ditton, J. and Hammersley, R. (2000). Ethnic minority use of illegal drugs in Scotland: potential difficulties for service provision. *Addiction Research* 8 (1), 27-49.**

Most of this article is about drug use among Asian and other minority groups in Scotland (n=31) and measures taken by respondents to hide their use of drugs, though some information is provided about the implications for service development and use, and this will be briefly considered here. Data were collected by interview and discussion group and respondents were contacted via snowballing or chain-referral. Respondents identified a number of problems with services. Young, Asian women reported that they would be wary of services and feared their families and communities finding out about their drug use. One respondent suggested that an anonymous

counselling service over the 'phone might be more effective for minority clients. The tendency of many minority communities to deal with their own problems was mentioned by many respondents, and a drugs worker maintained that many Whites using the services are racist. The authors conclude that bilingual drugs workers could be used to liaise between young, minority ethnic drug users and their parents.

### **2.17) Travellers**

**Pahl, J. and Vaile, M. (1988). Health and health care among travellers. *Journal of Social Policy* 17 (2), 195-214.**

Relatively little attention has been given to the health care needs of Britain's oldest minority ethnic community, the gypsies (or travellers). Here, Pahl and Vaile discuss the implications of a study of the health and health care needs of travellers in Kent (which has a substantial traveller community). The authors provide some discussion of traveller demography, housing and culture, pointing out that traveller suspicion about health and welfare agencies affects their take-up of services. Data were collected by health visitors in 1984 using a short questionnaire. Only traveller women with children were asked to provide information, and topics covered ranged from site facilities, to the reproductive history of the mother to use of services (dentist, doctors etc.). Data were available on 263 mothers who had at least one child under age 15.

The data on use of health services indicate that 85% of the mothers were registered with a general practitioner (GP) and 7% had used private medical care at some point. Mothers who needed treatment were likely to go to their GP but one third had gone to the hospital. There had been 814 pregnancies between 263 women, but only a small proportion of the mothers (5%) had received no antenatal care and 72% had shared care (GP and hospital). Perinatal and infant mortality rates were higher among the Kent travellers compared with the national and regional figures. Women on local authority sites were more likely to have live births compared with women on private or other sites (which may reflect differences in levels of amenities, such as water). Data on the health of children under the age of five suggests that accidents were quite common among children. Examination (hearing, sight) rates for children were 80% in first year of life but fell off at later ages. Immunisation rates were low compared with the English average, which may be attributable to the belief that immunisation is dangerous.

In conclusion, the authors describe initiatives to improve access to health care facilities. The conditions on traveller sites are often poor, lacking toilets and water, and health authorities are often unaware of the health needs of travellers. Though a large proportion of the Kent travelling community was interviewed, the results here cannot necessarily be generalised to all travellers. The authors note also the problems of using health visitors to collect data; since respondents may answer questions with responses which they think will please the interviewer.

### ***2.18) Women's sexual and reproductive health***

**Baraister, P. (1999). Family planning and sexual health: understanding the needs of south Asian women in Glasgow. *Journal of Ethnic and Migration Studies* 25 (1), 133-149.**

The south Asian community in Glasgow is the second largest minority ethnic community in the city. Previous research has focused mostly on linguistic barriers to service use; the present study focuses on linguistic and other constraints on family planning services use. The data were taken from semi-structured interviews with 24 south Asian women who were users of either one of three different types of family planning service (two family planning services—one, a domiciliary service—and a 'well woman' clinic) or a baby clinic (these were women who were not necessarily using family planning services) in Glasgow in 1996.

Analysis of the ethnic background of women using the 'well woman' clinic indicates that the proportion of south Asian users was approximately the same as their proportion in the local population. The number of south Asian women using the domiciliary service was higher than expected. All of the women interviewed for the study had been married and had children (except one). Parity was also higher among the south Asian women. Most respondents were Muslims though none reported that their religion affected their use of contraception. Most respondents believed that their place of birth and time since immigration affected their use of sexual health services. UK-born respondents described women who had recently migrated from south Asia as naïve about matters of sexual health, though this view was not universally held. UK-born respondents also reported that they considered themselves sources of information for relatives who had recently migrated. The author notes that existence of generational differences in attitudes to sexual health and contraception (older respondents reported that young south Asian women, for

example, were more likely to need contraception before marriage than was the case with previous generations).

Most respondents (16) spoke good English and several expressed surprise when asked if they had ever had communication difficulties with health professionals (though eight women did report that they had experienced such difficulties). Some respondents mentioned communication difficulties not related to language use; this was often related to embarrassment at having to relate their sexual health problems to medical personnel. Some respondents were also embarrassed about the prospect of somebody from their own community seeing them using family planning services (especially if they are unmarried). The media or female relatives were the primary source of information about sexual health for most of the women in the sample. The author describes the implications of these findings for the provision of services to the south Asian community. She maintains that too much emphasis is placed on linguistic barriers to service access; not all women require interpreters. A theme that emerged from the interviews was that of 'modern' women and 'traditional' women. The latter were often women who had recently migrated from south Asia and who might be embarrassed about accessing sexual health services. Though the fact that the 'right' proportion of women (given their size in the local population) were accessing family planning services would seem to suggest that most women are not anxious about using such services.

**Bell, T. S., Branston, L. K., Newcombe, R.G. and Barton, G.R. (1999). Interventions to improve uptake of breast screening in inner city Cardiff general practices with ethnic minority lists. *Ethnicity and Health* 4 (4), 277-284.**

The authors report the results of an intervention to increase the uptake of breast screening in three general practitioner (GP) practices in Cardiff in 1997. All of the practices had high numbers of minority ethnic individuals on their practice lists and low take-up of breast screening (on average, about 35%). The intervention consisted mainly of sending out invitations and letters to screening in six languages, including the main south Asian languages and Arabic and Somali. In addition, free transport for women attending screening was offered and link workers were available to offer support.

The results suggest that these interventions had an effect on uptake of services. Of the 369 women invited for screening (of whom 59% were identified as non-English speakers), 187 attended for

screening (99 of these were the non-English speakers). The overall attendance rate was nearly 51% compared with just 35% three years previously. All Punjabi-speaking women attended the screening, 62% of Gujarati-speaking women attended and just 25% of Bengali women attended. Bell and colleagues discuss the problems of population mobility, exacerbated by the return of many women to their country of origin. Some women were also illiterate, so could not read leaflets in their mother tongue (this was especially true of Somali women). Only 30 women requested the free transport, which suggests that it was not that significant a part of the intervention. External factors (not measured here) could have affected the uptake of the screening; this can only be measured using randomised controlled trial methods.

**Cameron, J. and Rawlings Anderson, K. (1998). Circumcision, culture and health-care provision in Tower Hamlets, London. *Gender and Development* 6 (3), 48-54.**

The authors argue that because health care professionals tend to consider only the biological effects of female circumcision, and not the cultural context within which circumcision occurs, many women who have experienced circumcision believe that health care workers are being judgmental. This may influence their decision to access health services.

Using data collected on the experience of Somali women at the London Black Women's Health Project in the London Borough of Tower Hamlets, Cameron and Rawlings Anderson make a number of recommendations for service providers. They point out that very little is known about circumcised women's expectations of health services or their health needs. Women, for example, are not aware that they can be 'deinfibulated' (have the vagina re-opened prior to marriage or childbirth) at a community clinic. The authors argue that one way to challenge the attitudes of British health care workers to female circumcision is to remind them that such practices are not confined to minority communities; procedures such as episiotomy might also be considered invasive and unnecessary.

**Chapple, A., Ling, M. and May, C. (1998). General practitioners' perceptions of the illness behaviour and health needs of South Asian women with menorrhagia. *Ethnicity and Health* 3 (1/2), 81-93.**

Data were obtained from semi-structured interviews with 50 general practitioners (GPs) in north west England in the period 1995-1996. The results highlight some key differences between south

Asian women and White women. South Asian women, for example, were less likely to use tampons, which may affect their perception of the volume of menstrual blood. The doctors expressed the belief that south Asian women are not inclined to complain about menorrhagia, which may be attributable to the (male) gender of the doctor. The reluctance of south Asian women to consult male doctors and gynaecologists means that heavy blood loss can lead to anaemia. In addition, there are problems of communication with this population, which is partly about the shyness of the women and lack of knowledge about their own bodies.

**Clarke, M. and Clayton, D. G. (1983). Quality of obstetric care provided for Asian immigrants in Leicestershire. *BMJ* 286, 621-623.**

Clarke and Clayton assess the quality of care provided by general practitioners (GPs) and hospitals to Asian mothers in Leicestershire using a case control study design. The outcome measure is perinatal mortality (n=939) in the period 1976-1980.

The results for the control group suggest that the GPs of Asian mothers were less likely to be on the obstetric list and were more likely to have no higher qualifications than the GPs of non-Asian women (nearly 15% of Asian mothers were registered with GPs that were not on the obstetric list compared with just 3% of non-Asian mothers). Whether a GP is on the obstetric list or not affected at what point in pregnancy formal antenatal care was taken up. Between 14 and 20 weeks gestation, both Asian and non-Asian women with GPs who were not on the obstetric list had later enrollment into care than those with a GP on the list. The relative risks of experiencing perinatal mortality were higher for babies of Asian women (165% compared with non-Asian women) and for babies whose mothers had GPs who were not on the obstetric list.

Once socio-economic status, parity, height and legitimacy were controlled for in the analysis, being of Asian origin and having a GP not on the obstetric list were risk factors for perinatal mortality. Infants with Asian mothers had a relative risk of 142% compared with infants with non-Asian mothers, even after controlling for class, parity, height, legitimacy and GP obstetric list status. The figure for non-list GPs compared with list GPs was 181%, controlling for the same factors—except the GP status—and ethnicity. Use of antenatal care was the significant, avoidable factor between the two ethnic groups that accounted for perinatal deaths. The authors make a series of

recommendations, including the use of community midwives in practices where the doctor is not on the obstetric list and greater awareness of the benefits of antenatal care in the Asian community.

**Doyle, Y (1991). A survey of the cervical screening service in a London district, including reasons for non-attendance, ethnic responses and view of the quality of the service. *Social Science and Medicine* 32 (8), 953-957.**

After poor response to invitations for cervical screening, the Family Health Service Authority (FHSA) conducted a survey in Ealing (London) of 400 residents, many of whom were from minority ethnic communities. The sample was selected from non-responders and responders to invitations for screening, and data were collected by questionnaire. The questionnaires were posted and women who did not complete it were visited at home.

Initially, 284 (71%) questionnaires were returned. After home visits, this increased to 353 (88%) of which 214 were completed. In all, 139 (40%) of women approached did not complete the questionnaire. Significantly, more Asian and Irish women returned blank questionnaires. Most of the returned and completed questionnaires were from women who had attended screening. Asian women were more likely to use the Family Planning Clinics for screening compared with other groups. Doyle discusses the high number of wrong or old addresses provided by the FHSA and notes the high mobility among Asian women (44% of blank questionnaires were assigned to Asians and most of these were because of wrong addresses). The lack of awareness of the importance of cervical screening among Asian women was noted during the survey.

**Fong Chiu, L., Heywood, P., Jordan, J., Mckinney, P. and Dowell, T. (1999). Balancing the equation: the significance of cervical screening amongst minority ethnic women. *Critical Public Health* 9 (1), 5-22.**

The authors use a participatory action research framework (a theoretical perspective which emphasises the 'practice' of a behaviour and the role played by, for example, health professionals as well as women using screening services) to identify the barriers that hinder the promotion of screening for cervical cancer among minority women and to gauge the merit of an intervention strategy. The respondents were categorised according to their use of language rather than ethnicity (the language groups were: English/Black English, Arabic, Bengali, Chinese, Mirpuri and Vietnamese) (n=27). Health professionals (who take cervical smears) were also interviewed (these

were selected from six general practices across south Yorkshire). The data were collected in focus group settings.

The results suggest that the health professionals responsible for smear tests categorise minority women according to their degree of 'westernization'. The most westernized women were considered not to present a problem in relation to smear testing. Health professionals' perceptions of minority ethnic women were categorised into four main themes: docility (which affects their health-seeking behaviour), culture as a barrier to education, communication difficulties and dysfunctional communication. The docility shown by many women centres around sexual shyness. Aspects of (the largely south Asian) culture that affect uptake of services include: minority ethnic women's failure to prioritise their own health and the perception by many non-westernized minority women that health education and screening is a 'luxury'. Communication problems identified by the health professionals includes a belief that minority women's husbands 'do all the talking'.

Health professionals were asked how they might improve uptake of services by minority ethnic women; the use of interpreters and improved cultural awareness on the part of health professionals were suggested. The data from the focus groups conducted with minority ethnic women indicates that many had little understanding of the purpose of the cervical smear test, though many expressed an interest in finding out more about it. Most had had negative experiences of smear testing and expressed a feeling of helplessness about the procedure. Non English-speaking women communicated with smear takers through their husbands or daughters, but were generally given little information. Minority ethnic women suggested that improved explanation would help communication between health professionals and service users, and the use of interpreters or advocates was suggested for those with little or no English. Some women expressed a desire to only see female doctors.

**Harris, T.J., Cook, D.G., Wicks, P.D. and Cappuccio, F.P. (1999). Ethnic differences in use of hormone replacement therapy: community based survey. *BMJ* 319, 610-611.**

The authors maintain that little is known about the use of hormone replacement therapy (HRT) by minority ethnic women. This study, drawing on a south London population, is designed to measure the use of HRT by 865 women aged 40-59 attending one of nine general practices in the area. The results indicate that south Asian women are less likely to use HRT than White and African descent

women (25%, 70% and 51% respectively). White ethnicity, hysterectomy and smoking were all associated with use of HRT and, when these were adjusted for, the odds ratios for use of HRT=0.54 for African descent women and for south Asian women=0.37. There are differences within ethnic groups in use of HRT; Caribbean and Pakistani women are more likely to use it than African or Indian or Bangladeshi women. The authors conclude that women from ethnic minorities are less likely to use HRT than White women, net of other factors. The limitations of the study are discussed, including possible response bias.

**Hennink, M., Cooper, P. and Diamond, I. (1998). Asian women's use of family planning services. *British Journal of Family Planning* 24 (2), 43-52.**

Data on family planning behaviour and use of services were collected via in-depth interviews with women from Indian, Pakistani and Bangladeshi backgrounds in the South and West Regional Health Authority area (UK). The findings suggest that there is diversity in the knowledge and use of contraception between different groups of women (married professional women; married non-professional women; and unmarried women). Professional married women and unmarried women are generally able to meet their family planning needs by using existing services, whereas married non-professional women experience difficulties in using family planning services. This is because of communication problems and low levels of personal autonomy. Most Asian women showed a strong preference for a female general practitioner (GP) and a non-Asian GP for sexual health and contraceptive services.

**Howell, S.R., Barnett, A.G. and Underwood, M.R. (2001). The use of pre-conceptional folic acid as an indicator of uptake of a health message amongst White and Bangladeshi women in Tower Hamlets, east London. *Family Practice* 18 (3), 300-303.**

This study assesses the uptake of a health message in two ethnic (White and Bangladeshi) groups (though the findings have implications for service provision and use) and will only be described briefly here. Pregnant women were recruited to the study by health service personnel in the period 1997-1998 and data were collected using a questionnaire (n=249). Most (95%) of the White women had heard of folic acid compared with 46% of Bangladeshi women (p<0.001) and White women were nearly six times more likely than Bangladeshi women to have taken folic acid supplements before conception (p<0.001). The authors controlled for the effects of age, school-leaving age,

social class, parity, planned pregnancy and having heard of folic acid on the probability of having taken folic acid, though ethnicity was still a significant predictor of use of folic acid. The authors point out that notions of 'planned pregnancy' may be different between the two groups and that 'innovative forms of health promotion' are warranted to ensure greater use of folic acid among Bangladeshi women planning pregnancy.

**Majeed, F. A., Cook, D. G., Anderson, H. R., Hilton, S., Bunn, S. and Stones, C. (1994). Using patient and general practice characteristics to explain variations in cervical smear uptake rates. *BMJ* 308, 1272-1276.**

The authors present the findings of a study of variation in cervical screening rates between 126 general practices in Merton, Sutton, and Wandsworth Family Health Services Authority area. A number of socio-demographic variables were computed (from electoral ward census data) for each general practice, including age, sex, residence, deprivation and ethnicity and the outcome variable was the proportion of women aged 25-64 who had had a cervical smear in the five years before 1992.

The results indicate that use of cervical smear tests vary throughout the area. Of 174 724 women eligible for a smear, 111 749 (64%) had undergone a cervical smear test during the five and a half years before March 1992. Correlation between socio-demographic variables and uptake rates showed a negative relationship between ethnicity ( $r=-0.42$ ) and the Jarman UPA 8 score for the practices ( $r=-0.39$ ) and uptake. Ethnicity was not entered into the stepwise logistic regression model (five variables—presence of a female partner, children aged under five, overcrowding, number of women aged 35-44 as percentage of all women aged 25-64 and change of address in past year—were predictors of uptake rates and explained 52% of variation). These findings are consistent with other research showing that practices in deprived areas and where there are large proportions of minority ethnic populations have low uptake of cervical smear tests. The limitations of the study are noted: the principle one being the use of electoral ward data and the inaccuracy of some of the data on the health services register.

**McAvoy, B.R. (1988). Asian women: contraceptive services and cervical cytology. *Health Trends* 20, 14-17.**

McAvoy describes the findings from a survey of Asian (Muslim, Hindu and Sikh) women's use of contraception and services in Leicester (n=337) in the period 1985-1986. Respondents' details were taken from general practice lists in the area and were selected on the basis of their names.

Of the 235 women who had used contraception at some time, most (63%) said that they had enough information to make a choice about which contraceptive method to use. Most women said that they consulted their general practitioner (GP) or a family planning clinic doctor (79%) for advice about contraception, though 46% of the respondents said that they were not sure if their GP provided such services. Most (55%) of the women said that they preferred to discuss contraception in their own language, 55% expressed no preference about the ethnicity of the doctor and 80% said that they would prefer an all-female clinic environment in which to discuss their use of contraception. Muslims are more likely to prefer an all-Asian clinic environment than the other two groups. Most (65%) of the respondents had seen birth control posters or leaflets, mostly in their GP's surgery. When asked to assess a birth control leaflet, comments varied among the women. Those women who did not find the leaflet useful attributed this to not being able to read it (37%) or not having any need for the information (29%). Asked about how services could be improved, provision of interpreters, information in the work place and information in local newspapers were all cited. The women showed less knowledge of cervical smears (over half had not heard of them and 59% had never had one). The effect of factors other than religious/ethnic group membership is not considered (there is no discussion of the educational status of the respondents, for example).

**McAvoy, B.R. and Raza, R. (1991). Can health education increase uptake of cervical smear testing among Asian women? *BMJ* 302, 833-836.**

The authors assess the effectiveness of three different interventions on a random sample of Leicester-based, general practitioner (GP)-registered Asian women who had never had a smear test. 263 were visited and shown a video, 219 were visited and shown a leaflet and a fact sheet, 131 were posted a leaflet and fact sheet and 124 were not contacted at all and were given no information. Data were collected by questionnaire from each respondent and uptake of screening was measured

by checking with a cytology laboratory computer two and four months after the final interview. Most of the women were Hindu and married.

Significant results were found in a number of areas. Women who had not been visited and had not received any information were less likely to seek a smear test than women who had received information by post only (5% of the former had a smear test compared with 11% of the latter). Higher rates of uptake of cervical smear tests were found in the visited groups (30% of women who had watched the video had a smear compared with 26% of women who had been given a leaflet). These differences were not significant. Uptake of the test was not associated with age or education, though it was associated (not significantly) with ethnic/religious status; 49% of Hindus had a smear, compared with 34% of Muslims and 31% of Sikhs. Most women who had watched the video made favourable comments about it (72%). Smaller proportions of women who had seen the leaflet expressed positive comments about it (58%). McAvoy and Raza maintain that the results highlight the importance of personal instruction in health education campaigns; the usefulness of which has been demonstrated elsewhere. The authors discuss the problem of generalising from the study (since it draws on a local sample).

**McCourt, C. and Pearce, A. (2000). Does continuity of carer matter to women from minority ethnic groups? *Midwifery* 16 (2), 145-154.**

The authors describe the findings of a study of the maternity care experiences of minority ethnic women in west London. Respondents were selected from a list of women who had not responded to a postal survey of women's responses to care (n=20) and data were collected using semi-structured interview techniques. Half of the sample was receiving caseload midwifery ('one-to-one') care and half were receiving conventional 'shared' (not necessarily with the same midwife) care. The interviews were conducted between three and nine months postnatally.

The results suggest that continuity of care is an important issue for minority women, as are issues around communication and support. Women in the midwifery care group expressed the belief that supportive care is linked to knowing the midwife who is providing care. Women receiving traditional shared care were more likely to be attended in birth by midwives that they did not know, and were more likely to have experienced distress during the birth. They were also more likely than the midwifery care group to have expressed dissatisfaction with communication issues. Two women

in the sample could not speak English and this affected their ability to communicate their needs to health professionals. The authors believe that minority women are stereotyped by health professionals (so that, for example, Asian women are considered to be making a fuss when they ask for assistance).

The authors also mention issues of control; some minority ethnic women said that health professionals had talked 'at' them rather than 'with' them. The one-to-one care provided by midwives was invaluable for these women and allowed them to feel in control of the birth process. McCourt and Pearce maintain that midwives may be more important to women from minority ethnic groups because their expectations ('of support, good communication and care') are not always met in conventional services. They suggest that greater use of caseload midwifery care should be made. The authors note the limitations of the study. The small sample limits the study's generalisability.

**Naish, J., Brown, J. and Denton, B. (1994). Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening. *BMJ* 309, 1126-1128.**

Naish and colleagues explore the factors that deter minority ethnic women in east London from attending their general practitioner (GP) for cervical cancer screening. Data were collected during focus group discussions in the period 1993-1994. Respondents came from Bengali, Kurdish, Turkish, Urdu, Punjabi and Chinese speaking backgrounds. The findings suggest that some attitudinal barriers to cervical screening (such as fear of cancer) are not deterrents, and that administrative and language barriers might be more important. Minority women are enthusiastic about cervical screening once they understand the purpose of the test.

**Pearson, M. (1985). *Racial equality and good practice maternity care*. A report of two workshops held in Bradford organised by the Training in Health and Race and the Centre for Ethnic Minorities Health Studies. London: Training in Health and Race.**

The causes for the poor uptake of maternal health services by ethnic minority women are discussed and a number of recommendations are made. Considering the former, the author cites as important: inappropriate services (lack of screening for conditions that affect ethnic minorities, examination by male doctors is unsuitable for some women, forbidden or culturally inappropriate hospital food);

lack of information (the relevance of medical procedures is not always explained); communication difficulties; and staff attitudes (racism, lack of awareness of culture and religion by medical staff).

**Raja-Jones, H. (1999). Breast screening and ethnic minority women: a literature review. *British Journal of Nursing* 8 (19), 1284-1288.**

The author presents a review of the literature on the use of breast screening services by minority women. The National Health Service (NHS) introduced a Breast Screening Programme in 1988, but the use of screening services remains low among minority ethnic women. The principal reasons identified in the literature for low use of services include a lack of knowledge among women from ethnic communities about screening services and a low rate of referrals by health care professionals.