Chronic Illness

Accessing primary health care: a meta-ethnography of the experiences of British South Asian patients with diabetes, coronary heart disease or a mental health problem

Charlotte R Garrett, Linda L Gask, Rebecca Hays, Andrea Cherrington, Christine Bundy, Chris Dickens, Waquas Waheed and Peter A Coventry

Published by:

$SAGE

http://www.sagepublications.com

>> Version of Record - May 10, 2012

OnlineFirst Version of Record - Mar 13, 2012

What is This?

Accessing primary health care: a meta-ethnography of the experiences of British South Asian patients with diabetes, coronary heart disease or a mental health problem

Charlotte R Garrett,[1] Linda L Gask,[1] Rebecca Hays,[1,2] Andrea Cherrington,[1] Christine Bundy,[1] Chris Dickens,[1,3,4] Waquas Waheed[1,5] and Peter A Coventry[1]

Abstract

Objectives: To develop an explanatory framework of the problems accessing primary care health services experienced by British South Asian patients with a long-term condition or mental health problem.

Methods: This study used meta-ethnographic methods. Published qualitative studies were identified from a structured search of six databases and themes synthesized across studies to develop a new explanatory framework.

Results: Initial searches identified 951 potentially relevant records from which a total of 27 articles were identified that met inclusion and exclusion criteria. Twelve of these articles were chosen on the basis of their quality and relevance. These 12 articles described themes relating to the cultural, spatial and temporal dimensions of patient experiences of accessing and using health care. Our interpretive synthesis showed that access to primary care among British South Asians with

[1]Greater Manchester Collaboration for Leadership in Applied Health Research and Care, Health Sciences Research Group and Manchester Academic Health Sciences Centre, University of Manchester, Manchester, UK
[2]Personal Social Services Research Unit, University of Manchester, Manchester, UK
[3]Peninsula Medical School, University of Exeter, UK
[4]Devon Partnership NHS Trust, UK
[5]Lancashire Care NHS Foundation Trust, UK

Corresponding author:
Charlotte R Garrett, Greater Manchester Collaboration for Leadership in Applied Health Research and Care (GM CLAHRC) and Manchester Academic Health Sciences Centre, Williamson Building, Oxford Road, University of Manchester, M13 9PL, UK
Email: charlotte.garrett@manchester.ac.uk

diabetes, coronary heart disease and psychological health problems is co-constructed and negotiated over time and space along the key domains of the candidacy model of access: from help-seeking to interactions at the interface to following treatment advice. In the case of each condition, British South Asians' claims to candidacy were constrained where their individual as well as broader social and cultural characteristics lacked fit with professionals' ways of working and cultural typifications.

Conclusion: Interventions that positively affect professionals' capacity to support patient claims to candidacy are likely to help support British South Asians overcome a broad range of barriers to care for physical and mental health problems.

Introduction

Long-term conditions (LTCs) such as coronary heart disease (CHD) and diabetes pose a large public health threat across the world. It is estimated that around 15 million people in England suffer from a LTC.[1] People with LTCs use a disproportionate amount of healthcare and it is estimated that the treatment and care of those with LTCs accounts for 70% of the primary and acute care budget in England.[1]

Depression is also a major public health concern. In the UK, it is the third most common reason for consultation in primary care[2] and, in 2007, the total cost of depression in the UK was estimated to be £1.7 billion in service costs and £7.5 billion in lost employment.[3] Evidence suggests that, for many, depression takes a chronic relapsing course[4] and it has been demonstrated that care models used in the management of physical LTCs can also be useful in the management of depression.[5] Depression may exacerbate the perceived severity of symptoms and distress among patients with LTCs, leading to further increases in the use of primary and secondary services and increased treatment costs in the NHS.[6]

In high-income countries, LTCs and depression are not distributed evenly throughout the population, and there are widespread disparities in health status and outcome between ethnic groups. For example, in the UK, British South Asian communities (people originating from the Indian subcontinent) form the largest and most established minority ethnic groups, comprising 4% of the population.[7] Whilst acknowledging that British South Asian communities comprise heterogeneous populations that are differentiated by religion, culture, lifestyle and social position, there is evidence that British South Asian populations experience higher rates of diabetes, cardiovascular disease and depression than other ethnic groups. In England, diabetes is 2.5 to 5 times more common among British South Asian populations compared with the general population,[8] and British South Asians are more likely than white British people to experience co-morbidities such as renal disease.[9] Compared with the general population, British South Asian people also have a 40% to 60% higher risk of CHD.[10] Evidence concerning the prevalence of depression in British South Asian populations has been mixed.[11] Some early studies demonstrated sampling bias through under or over-representation of particular British South Asian sub-groups who were not differentiated in analyses and measurement

bias through use of diagnostic instruments that are not culturally sensitive. More recent, better-designed studies suggest higher prevalence of depression, at least in certain sub-groups of the British South Asian population: Bhui et al.[12] found a higher prevalence of depression in Punjabi subjects than white-British subjects; Gater et al.[13] found the same in Pakistani women; Weich et al.[14] found specific groups of British South Asians, middle-aged Pakistani men and older Indian and Pakistani women had significantly higher rates of depression compared with their white-British counterparts.

Even though genetic and lifestyle differences partly explain health differentials and excess morbidity between different ethnic groups across the United Kingdom, it is also possible that these differentials are exacerbated by inequities in access to healthcare among different generations of British South Asians.[15] However, reasons for this are complex and poorly understood and interpretation of findings is complicated by differences in sample composition between studies and methodological limitations. For example, Bhui et al.[16] found that patients of Punjabi descent were less likely to have their mental health problem recognised in primary care, but it is unclear how far this generalises to the rest of the British South Asian group. In the case of diabetes, Nazroo et al.,[17] who looked at ethnic/racial inequities in access to and quality of healthcare through analysis of Health Survey for England data, also found that Carribean, Indian, Pakistani and Bangladeshi individuals with diabetes were more likely to have visited a GP in the last 2 weeks. However, this measure does not capture the processes that take place in the consultation, which may facilitate or hinder the effectiveness of care for the patient. In the context of cardiovascular disease, it has been shown that Indian and Pakistani men are more likely than white British men to seek medical help earlier for cardiac chest pain[18]; patients of Indian descent with CHD may wait longer for referrals to specialist care than white Europeans,[19] and Bangladeshi patients are less likely to receive revascularisation procedures than the general population.[20] Although ethnic disparities between British South Asians and white British people have started to be addressed in primary care,[21] we would argue that inequality in health outcomes between these ethnic groups may still be partly attributable to suboptimal access and use of health services by British South Asians.

Defining access to healthcare – Conceptual and theoretical models

'Access' is a difficult concept to define and operationalize in empirical work. In a normative sense, equity of access is understood in terms of the relationship between the supply and availability (e.g. doctor to patient ratios) and the costs (e.g. financial and personal inconvenience) of care given to people of equal need and equal means.[22] This definition has antecedents in a behavioural model of healthcare utilisation in which access and the use of healthcare hinges on the degree of fit between the characteristics of providers (i.e. practitioners) and healthcare systems and the characteristics and expectations of patients.[23] Where there is fit along enabling dimensions of access such as availability and affordability, health systems are able to meet the needs of patients. Here, access has therefore been simply characterised principally in terms of what people choose to do to secure entry to a health care system. In this sense, access can be evaluated by measuring healthcare utilisation and activity, but in our view this is insufficient.

In advanced health economies, where quality improvement has become key to

delivering efficient and effective services, there has been a shift away from simply measuring costs and activity to assessing *quality* of care.[24] Quality is proposed to have two core dimensions: access and effectiveness. That is, do patients get the care they need and if so, is their care effective? We propose that access is itself a composite concept relating to both the ability of an individual to gain entry to a healthcare system and access the *processes* of care *plus* the sometimes complex processes by which that care is delivered. Unlike healthcare utilisation, therefore, which is often measured quantitatively, measures of process that draw on stakeholder perspectives and experiences are often qualitative. Dixon-Woods et al.'s model of the stages involved in negotiating entry and access to care in underserved groups[25] incorporates these stakeholder perspectives, and we will return to discuss this model in detail later in framing our findings.

The notion that access encompasses many elements over and above gaining entry to a service is supported by recent work on barriers to care among British South Asians which have included more contextual and qualitative understandings about whether patients can make use of healthcare.[26] However, given small sample sizes, the impact of methodological choices and contextual specificity, it is difficult to make recommendations for practice from the findings of individual qualitative studies alone.[27] Meta-ethnography, a method of qualitative synthesis, allows for more interpretative rather than aggregative syntheses that privilege the generation of theory grounded in the empirical data of the studies included in the review.[28]

The context of our work is the NIHR-funded Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in Greater Manchester, which has a particular focus on chronic vascular conditions (diabetes, heart disease, kidney disease and stroke). Within this programme, the Practitioner Theme is concerned with improving access and quality of care for people with co-morbid depression and diabetes/CHD. In order to inform the design of quality improvement interventions for British South Asian people with co-morbid depression and chronic vascular disease, we have synthesised the findings of qualitative studies about the experiences of British South Asians accessing primary care services in the UK for diabetes, CHD and depression.

Method

Our methods were informed by meta-ethnographic approaches, originally devised by Noblit and Hare,[29] but since adapted and used to order the collection and synthesis of qualitative data in healthcare research.[28,30,31] The method we employed consisted of a number of stages: (1) a systematic literature search to identify relevant literature; (2) quality and relevance assessment of retrieved articles; (3) data extraction; (4) translation of themes across articles and (5) a line of argument (LOA) synthesis based on these findings. We took care to look for emerging patterns within themes by sample characteristics with the intention of highlighting any sub-group differences. When referring to first-, second- and third-order constructs, we define these in the same way as they are defined by Britten et al.[31]

Searching and selecting studies

We systematically searched six electronic databases (Embase, PsycInfo, ASSIA, CINAHL, WoK and Medline) from inception until end of 2009. We examined reference lists of all potentially relevant articles and of any reviews we identified. The search was later updated on all databases to end of August, 2011.

Our search strategy was developed by an experienced medical librarian and consisted of medical subject headings and text words organised in four blocks: (i) CHD, diabetes and mental health problems; (ii) primary healthcare; (iii) British South Asians and (iv) qualitative research methods. Only full-text, peer reviewed studies that met the following criteria were considered for inclusion in the final synthesis:

(i) Used qualitative methods of data collection (structured and unstructured interviews, group interviews and focus groups, observational techniques and documentary sources) and analysis (thematic content analysis, narrative analysis and systematic frameworks such as 'grounded theory') to explore stakeholder perspectives about accessing and using healthcare.

(ii) Where participants were adult patients with CHD, diabetes and/or mental health problems (including sub-threshold psychological distress but excluding postnatal depression and gestational diabetes).

(iii) Were conducted in the United Kingdom, focused on primary care settings in the NHS.

(iv) Where participants were British South Asian using the definition operationalized in the UK 2001 Census[32] – people born in India, Pakistan, Bangladesh and Sri Lanka and their descendants, but excluding those born (or descended from those born) in Nepal, Bhutan, the Maldives, Tibet, Afghanistan or the Islamic Republic of Iran.

(v) The British South Asian population should be considered separately in the study, rather than as part of a larger group of minority ethnic participants.

(vi) Papers should present data relevant to the issue of access to primary care services. As discussed, we took a broad definition of access not limiting it to issues affecting utilisation of services but also factors potentially limiting ability to benefit from healthcare received for example personal models/ understanding of health and illness, understandings of drug effects and social norms.

CG, PC, AC, RH, CB and CD were involved in all the screening stages, in each case CG acting as first reviewer with PC, AC, RH, CB and CD acting as second reviewers. Disagreements were resolved through discussion within the group.

Procedures

Appraising reports of qualitative studies

Judgements about the inclusion of articles were based on both their methodological quality and relevance.[33] To standardize quality assessment, each reviewer assessed quality with the CASP checklist.[34] Quality was independently assessed by each reviewer. Assessments of relevance drew on our inclusion criteria. Papers were then categorised using the framework outlined in Dixon-Woods et al.[33] Numbers of papers excluded and reasons for their exclusion at abstract and full-text screening phases are presented in Figure 1.

Data extraction

In a meta-ethnography, the findings of each study represent the primary data.[28] CG extracted the key findings from each of the selected articles including key aspects of study design. We adopted a method employed by Atkins et al. to tabulate and display themes within and between studies.[30] At this stage of data extraction, an attempt was made to preserve the findings as they appeared in the original article; interpretation of findings was avoided at this stage.
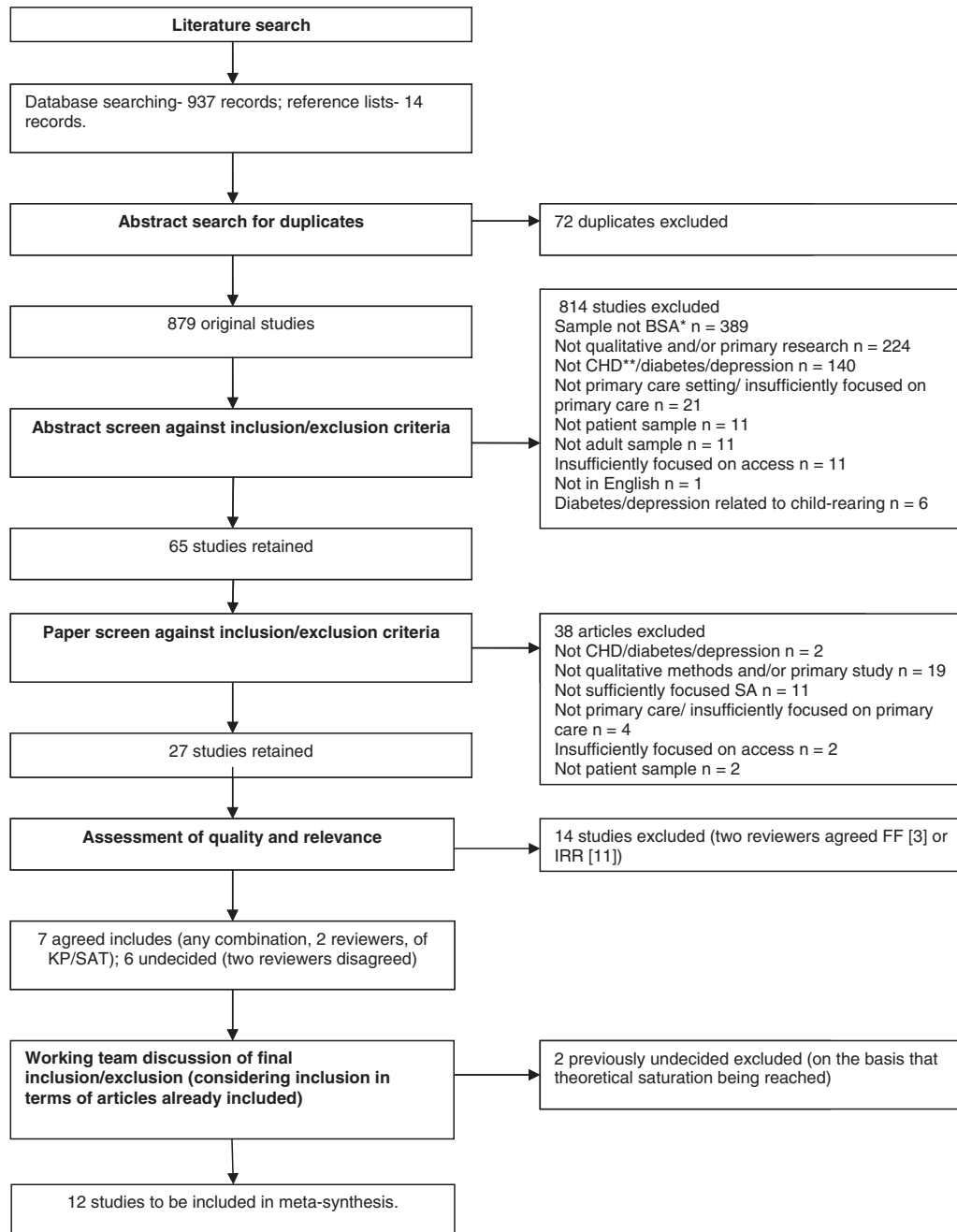
Literature search

Database searching- 937 records; reference lists- 14 records.

Abstract search for duplicates → 72 duplicates excluded

879 original studies

814 studies excluded
Sample not BSA* n = 389
Not qualitative and/or primary research n = 224
Not CHD**/diabetes/depression n = 140
Not primary care setting/ insufficiently focused on primary care n = 21
Not patient sample n = 11
Not adult sample n = 11
Insufficiently focused on access n = 11
Not in English n = 1
Diabetes/depression related to child-rearing n = 6

Abstract screen against inclusion/exclusion criteria

65 studies retained

Paper screen against inclusion/exclusion criteria →
38 articles excluded
Not CHD/diabetes/depression n = 2
Not qualitative methods and/or primary study n = 19
Not sufficiently focused SA n = 11
Not primary care/ insufficiently focused on primary care n = 4
Insufficiently focused on access n = 2
Not patient sample n = 2

27 studies retained

Assessment of quality and relevance → 14 studies excluded (two reviewers agreed FF [3] or IRR [11])

7 agreed includes (any combination, 2 reviewers, of KP/SAT); 6 undecided (two reviewers disagreed)

Working team discussion of final inclusion/exclusion (considering inclusion in terms of articles already included) → 2 previously undecided excluded (on the basis that theoretical saturation being reached)

12 studies to be included in meta-synthesis.

*SA = British South Asian
**CHD = Coronary Heart Disease

Figure 1. Search and screening phases of meta-synthesis (updated search).

Identifying and translating themes across studies

The process of developing secondary concepts in meta-ethnographic studies is analogous to that of thematic framework analysis in primary qualitative research,[35] except that the unit of analysis in this case is the article rather than individual accounts. Themes were identified for each article from the extracted findings. The next part in the process is the translation of themes into each other to form a framework of themes for the articles as a whole – known as reciprocal translation.[36] Themes identified from the first article provide the initial framework. We synthesised themes from the articles in chronological order from earliest to most recent. During this process, we took care to look for emerging patterns within themes by sample characteristics with the intention of highlighting any sub-group differences. CG and RH led this process which involved feedback from the wider team. These synthetic constructs were further grouped into categories. Neither these synthetic constructs nor the groupings into which they were placed would be themselves considered third-order constructs.

Tertiary analysis/LOA analysis

An LOA synthesis, as originally conceptualised by Noblit and Hare,[29] involves building up a picture of the whole (i.e. a culture, organisation etc.) from studies of its parts. Subsequent authors[28,31] have suggested that the focus of meta-ethnography should be the development of a new conceptual understanding that involves a re-interpretation of themes (or 'secondary constructs') to develop new theoretical models with greater explanatory power, so-called 'third-order constructs'. The extent to which these models exhibit the characteristics of third-order constructs is however controversial.[36]

Having extracted the key themes identified by the authors of each of the studies (second order constructs) as well as information on key aspects of study design, we brought together these themes into a single model, a tertiary analysis of the data which explains how access for this group plays out over time and space.

Results

Twelve studies were included that met criteria for relevance and methodological quality (Table 1). There were insufficient numbers of qualitative studies related to access to healthcare in British South Asian sub-groups for us to produce a synthesis on a single ethnic sub-group within the category of 'British South Asian'. We were unable to identify any qualitative studies of co-morbid mental health problems and diabetes or cardiovascular disease in this population.

Five studies[37–41] focused on diabetes, one on CHD,[42] one on both diabetes and CHD[43] and five on depression/distress.[44–48] Three of the five depression studies[45–47] only included female British South Asian participants. Four studies from the whole set had mixed-ethnicity samples (British South Asian participants as focus of the study but with white-British and other Black and Minority Ethnic [BME] comparison groups)[37,38,42,48] and eight had British South Asian only samples.[39–41,43–47] In most studies, more than one ethnic sub-group within the category of British South Asian was represented.[39–41,43–45,48] Of those with studies with mixed ethnic sub-group samples, most had a majority of one particular ethnic sub-group.[39–41,45–48] In studies that reported the generation of participants,[37,39–41,46,47] all samples consisted of first-generation migrants with a small number of second generation migrants. Religion of participants was reported in 9 of the 12 studies[39–43,45–48] where all study

Table 1. Characteristics of studies synthesised

Source article	Sample N (age and gender)	Illness	Mixed/British South Asian only sample	Composition of British South Asian sample	Research design	Aim
Greenhalgh et al.[37]	50 (21-80 yrs, sex not reported)	Diabetes (type not specified).	Mixed white-British (16%), Afro-Caribbean (14%) and British South Asian (80%).	100% Bangladeshi; 98% first generation; religion not reported.	Purposive sampling from GP practices in East London; mixed qualitative methods: narratives, semi-structured interviews, focus groups and pile-sorting exercises; analysed using grounded theoretical approach.	To explore the experience of diabetes in British Bangladeshis.
Kai and Hedges[44]	104 (16-65 yrs; 37% men)	Depression	British South Asian only.	47% Pakistani, 53% Bangladeshi; generation not recorded; religion not reported.	Purposive and snowball sampling through Community Project Workers; semi-structured interviews; grounded theoretical approach to analysis.	To promote community participation in exploring perceptions of psychological distress among Pakistani and Bangladeshi people to develop appropriate services.
Chew-Graham et al.[45]	31 (17-50 yrs; all women)	Distress and mental health problems	British South Asian only.	3 of 4 focus groups Pakistani, 1 group Bangladeshi, one participant Indian; generation not reported; all but one Muslim, one Sikh.	Purposive sampling (homogenous sample type) of four existing South Asian women's groups; focus groups; Framework analysis.	To investigate the self reported needs of South Asian women suffering distress and mental health problems which might lead to self-harm and suicide.
Hussain and Cochrane[46, 47]	10 (age not reported; all women)	Depression	British South Asian only sample.	Ethnic sub-group not reported; 70% first	Systematic non-probabilistic sampling of patients through specialist mental health services in	46- To explore perceptions of causes and cures of depression in South Asian women.

Table 1. Continued

Source article	Sample N (age and gender)	Illness	Mixed/British South Asian only sample	Composition of British South Asian sample	Research design	Aim
				generation; 60% Muslim.	Birmingham; brief semi-structured interviews; grounded theory with constant comparison.	47- To explore coping strategies used by South Asian women living in the UK suffering from depression
Stone et al.[38]	20 (aged 33-80; 45% men)	Type 1 and 2 diabetes (95% for type 2 diabetes)	Mixed (75%) British South Asian sample; 25% white-British	All British Indian; generation not reported; religion not reported.	Purposeful sampling from two volunteer GP practices in Leicester; semi-structured interviews; grounded theoretical approach with constant comparison and thematic analysis.	To explore experience and attitudes of primary care patients with diabetes living in a UK community with a high proportion of South Asian patients of Indian origin
Lawton et al.[39]	32 (aged 30-80, 47% men)	Type 2 Diabetes.	British South Asian only.	72% Pakistani, 18% Indian; 81% first generation; 69% Muslim, 3% Christian, 14% Hindu; 17% Sikh.	Purposive sampling of patients from five GP practices in Edinburgh and local communities through snowball sampling; in-depth interviews; grounded theoretical approach to analysis with constant comparison and deviant case analysis.	To explore perceptions and experiences of taking oral hypoglycaemic agents in British Pakistani and British Indian patients.
Lawrence et al.[48]	110 (65->90 yrs; 35% men)	Depression	Mixed- 30% British South Asian; 41% white-British; 29% Black-Caribbean.	61% Indian, 21% East African, 9% Pakistani, 3% other; generation not stated; 61% Hindu, 15% Muslim, 15% Sikh, 9% Christian.	Stratified purposive sampling from 7 GP practices, day centres and lunch clubs in London; in-depth individual qualitative interviews; grounded theoretical approach with constant comparison.	To explore older adults' attitudes and beliefs regarding what would help someone with depression, and to consider how these might facilitate or deter older people from accessing treatment.
Lawton et al.[40,41]	32 (30-80 yrs; 47% men).	Type 2 diabetes	British South Asian only	72% Pakistani, 18% Indian; 81% first	Purposive sampling of patients from 5 GPs in Edinburgh	40- To explore barriers to physical activity amongst

(continued)

Table 1. Continued

Source article	Sample N (age and gender)	Illness	Mixed/British South Asian only sample	Composition of British South Asian sample	Research design	Aim
				generation; 69% Muslim, 3% Christian, 14% Hindu; 17% Sikh.	known to have a high proportion of Pakistani and Indian communities; Single in-depth interviews; grounded theoretical approach with constant comparison	people of Pakistani and Indian origin with type 2 diabetes; 41- To explore Pakistani and Indian patient's experiences of, and views about, diabetes services to inform the development of culturally sensitive services.
Sriskantharajah and Kai[43]	15 (26-70 yrs; all women)	Coronary heart disease and Type 2 diabetes	British South Asian only	33% Indian, 27% Pakistani, 7% Bangladeshi, 15% East African Asian, 20% Sri Lankan; generation not reported; 47% Muslim; 33% Hindu; 20% Sikh.	Purposive sampling of patients from three GP practices in Nottingham; semi-structured interviews analysed using a grounded theoretical approach using constant comparison and deviant case analysis.	To explore influences on, and attitudes towards, physical activity among South Asian women with CHD and diabetes to inform secondary prevention strategies.
Darr et al.[42]	65 (40-83 yrs; 55% men)	Coronary heart disease	Mixed sample- 69% British South Asian, 31% British-European.	44% Pakistani; 56% Indian; 44% Muslim (all Pakistani); 27% Sikh (all Indian); 29% Hindu (all Indian); generation not reported.	Convenience sample of patients from 3 hospitals in West Yorkshire semi-structured interviews; framework analytic approach to analysis.	To examine and compare the illness beliefs of South Asian and European patients with coronary heart disease about causal attributions and lifestyle change.

samples contained participants from a number of different religions.

Second-order constructs and descriptive syntheses

From the 41 themes identified across the 12 studies, 24 second-order synthetic constructs were identified and analytically organised under five headings. The relationship between these headings and the second-order constructs, along with summary translations of these constructs, is shown in Table 2. Included studies and the themes generated from these could be organised into two inter-related sets. The first centred on how exposure to social and cultural practices and belief systems underpin community life and ways of knowing about health and illness among British South Asians living in the United Kingdom. These themes are captured by the first two synthetic headings: (i) early experiences and exposure to South Asian cultures and (ii) explanatory models of health and illness. The second set centred on how these culturally specific frameworks and contexts become operationalised and problematized through interactions with formal and informal health care. These themes are captured by the final three synthetic headings: (iii) help seeking and helper models; (iv) interactions at the healthcare interface and (v) adherence to treatment advice.

Line of argument

We synthesised the findings of the 12 included studies and arranged these synthetic themes under 5 sub-headings that loosely mapped onto different cultural, spatial and temporal elements of British South Asian patients' experiences of accessing and using healthcare. Here, we present an LOA that moves beyond description to a tertiary level of analysis not found in the individual papers. This seeks to build a more generalizable and theoretical understanding about potential barriers faced by British South Asians, especially those with diabetes, CHD or a mental health problem.

As described, in formulating our LOA we recognised the potential to draw upon, and further develop (see below), an existing theoretical model of access to healthcare in vulnerable groups – the candidacy model proposed by Dixon Woods et al.[25] Candidacy is an emergent process that relates to 'the ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services'. Meeting eligibility criteria for candidacy takes work on the part of patients and professionals and in this sense, access to and receipt of effective healthcare is co-constructed by patients and health professionals. The candidacy model has been used successfully to account for barriers to care for other minority ethnic groups,[49] and it has potential utility to explain barriers across different hard-to-reach groups.[50]

In the descriptive synthesis, barriers to accessing effective healthcare fell into five major categories: early experiences and exposure to South Asian culture; explanatory models of health and illness; help-seeking and helper models; interactions with the healthcare system and staff and adherence to treatment advice. These categories can be ordered according to the point at which they impact the patient's illness journey: decisions to seek help; interactions with health professionals at the healthcare interface and following treatment advice. These three stages in the patient's illness journey correspond to the key transition points in the candidacy model of access (points at which a patient's candidacy for care is negotiated as outlined by Dixon-Woods et al.[25]): decisions to seek help (identification of candidacy and navigation); interactions with health professionals at the healthcare interface (presentation,

Table 2. Translated second-order constructs arranged in temporal sequence

Synthetic heading	Second-order constructs	Summary definition of second-order construct	Articles contributing to second-order construct (those making most significant contribution in bold)
1. Migration and exposure to South Asian culture	a. Other healthcare systems	Prior and/or ongoing experience with other healthcare systems in Indian subcontinent.	**Lawton et al.;[39] Lawton et al.[41]**
	b. Migration	Migration as a significant and challenging life event.	**Chew-Graham et al.;[45] Hussain and Cochrane.[46]**
	c. Social exclusion	Experience of racism, racially motivated violence and crime post-migration.	Greenhalgh et al.;[37] **Kai & Hedges;[44] Chew-Graham et al.[45]**
	d. Family	Family experienced as a key source of support but sometimes of stress. Differences and tensions may arise, often along gender and generational lines.	Greenhalgh et al.;[37] **Kai** and **Hedges;[44] Chew-Graham et al.;[45] Hussain** and **Cochrane;[46]** Hussain and Cochrane;[47] Stone et al., 2005;[38] **Lawrence et al.[48]**
	e. Community	Community an important source of support but access might be limited by the need to maintain a positive image of the family in the eyes of the community.	Greenhalgh et al.;[37] **Chew-Graham et al.;[45] Hussain** and **Cochrane;[46]** Hussain and Cochrane;[47] Stone et al.,;[38] Lawton et al.[40]
2. Explanatory models of illness	a. 'Balance' model	Culture-specific model of health and illness based on the concept of 'balance' used to explain illness. These more traditional beliefs may be more likely to be held by first generation migrants.	Greenhalgh et al.;[37] **Hussain** and **Cochrane;[46] Lawton et al.[39]**
	b. Religion	Importance of religious beliefs in personal narratives and understandings of illness. Religious explanations may be used to justify fatalism but also the need to take responsibility.	Hussain and Cochrane;[46] Hussain and Cochrane;[47] Stone et al.,;[38] Lawrence et al.;[48] Lawton et al.;[48] **Darr et al.[42]**
	c. Spiritual models	Spiritual beliefs about symptom causation (more often psychological symptoms) that differ between religious and ethnic sub-groups but may conflict with Western scientific beliefs.	**Hussain** and **Cochrane;[46]** Hussain and Cochrane.[47]
2. Explanatory models of illness (con.)	d. Attribution of symptoms and responsibility	Tendency for individuals to attribute causation of symptoms (physical and psychological) to external rather than internal factors. However, fear that psychological symptoms would be attributed by others as the result of a personal flaw or failing.	Greenhalgh et al.;[37] **Kai** and **Hedges;[44] Chew-Graham et al.;[45] Lawton et al.[41]**

(continued)

Table 2. Continued

Synthetic heading	Second-order constructs	Summary definition of second-order construct	Articles contributing to second-order construct (those making most significant contribution in bold)
3. Help-seeking and helper models	a. Outside help	A reluctance to communicate about 'personal issues' outside the family, related to the expectation that confidentiality will be broken and also valuing support networks within the community. Accentuated in the case of psychological health issues and where the health professional is also of South Asian ethnicity. Use of strategies outside formal healthcare system (engaging in family activities, religious strategies) perhaps in women.	**Kai** and **Hedges;**[44] **Chew-Graham et al.;**[45] Hussain and Cochrane;[46] Hussain and Cochrane;[47] Lawrence et al.[48]
3. Help-seeking and helper models (con.)	b. Social and community-oriented solutions	Desire for socially-oriented solutions- Related to the poor social circumstances of many individuals in the South-Asian community.	**Kai** and **Hedges;**[44] **Hussain** and **Cochrane.**[46]
	c. Talking therapies	Openness to talking therapies but lack of experience.	**Hussain** and **Cochrane;**[46] Hussain and Cochrane;[47] Lawrence et al.[48]
	d. Cultural norms of gender interaction	Cultural taboo against women being alone with unrelated men.	**Kai** and **Hedges;**[44] Stone et al.;[38] **Lawton et al.**[41]
	e. Understanding	Understanding as a key concern that might, however, conflict with need for confidentiality. Professionals with similar socio-demographic characteristics, language, ethnic profile and cultural background as the patient may be considered most likely to understand but also most likely to break confidentiality.	**Kai** and **Hedges;**[44] **Chew-Graham et al.;**[45] **Hussain** and **Cochrane;**[46] Lawton et al.[41]
3. Help-seeking and helper models (con.)	f. Physical health focus	Expectation of a physical health focus in the consultation related to patient's beliefs about the role of the primary care health professional.	**Kai** and **Hedges;**[44] Lawton et al.[41]
4. Interactions at the healthcare interface	a. Deference	Adoption of a deferential communication style with healthcare professionals. May be more likely among first generation or older immigrants who have experience of interacting with healthcare systems other than the NHS.	**Greenhalgh et al.;**[37] Stone et al.;[38] Lawton et al.;[39] **Lawrence et al.**[48]

(continued)

Table 2. Continued

Synthetic heading	Second-order constructs	Summary definition of second-order construct	Articles contributing to second-order construct (those making most significant contribution in bold)
	b. Language	The language barrier between health professionals and patients which can compound pre-existing difficulties in understanding. How these problems are solved has implications which might not be fully appreciated by professionals.	**Chew-Graham et al.;**[45] **Hussain** and **Cochrane;**[46] Stone et al.,[38] **Lawton** et al.[41]
	c. Health literacy	Lack of familiarity with the structure of the NHS as well as key concepts employed in Western medicine e.g. 'self-management' and 'preventative medicine.'	**Greenhalgh et al.;**[37] **Chew-Graham** et al.[45]
5. Following treatment/advice	a. Nutrition and medication beliefs	Beliefs about nutrition and medication derived from the culturally-specific 'balance' model of illness which may not necessarily square with self-management advice.	**Greenhalgh et al.;**[37] **Hussain** and **Cochrane;**[46] **Lawton et al.**[39]
	b. Social norms around food	Role of sugary/fatty foods in South Asian customs and traditions.	Stone et al.;[38] **Darr et al.**[42]
	c. Exercise as 'alien'	Lack of a historical tradition of exercise and lack of fit with cultural norms.	**Greenhalgh et al.;**[37] **Lawton et al.,**[40] **Sriskantharajah** and **Kai;**[43] Darr et al;[42]
	d. Fear of harm	Fear of being unable to ask for help if unwell or in difficulty.	**Lawton et al.;**[41] **Sriskantharajah and Kai.**[43]
	e. External environment	Barriers related to the socioeconomic circumstances in which many British South Asian individuals might live- e.g. poor environment, risk of crime.	**Darr et al.;**[42] **Greenhalgh et al.**[37]

appearance and adjudication) and following treatment advice (navigation and offers and resistance). Additionally, the process of negotiating candidacy differs (unsurprisingly) with presentation of physical and psychological problems.

The steps in the pathway are not simply sequential but recursively interrelated – candidacy is a dynamic process that is best understood not in cross-sectional terms but as the product of contingent processes that are expressed and re-expressed *over both time and space*. Decisions to seek help in the future may be affected by experiences at the interface and/or experiences with following treatment advice, which has particular salience for understanding help-seeking in the context of LTCs.[51] Furthermore, decisions to seek and use healthcare, along with experiences at and beyond the healthcare interface, are embedded within and partly structured by the co-presence of wider socio-cultural and family and community contexts.

Decisions to seek help. We can unpack this expanded model of candidacy by first looking at how decisions to seek healthcare (i.e. identifying candidacy) among British South Asian patients intersect with and are shaped by South Asian cultural norms and beliefs. The extent to which British South Asians are exposed to beliefs and norms considered to be more traditionally South Asian varies within and between ethnic sub-groups, and especially between generations. This is illustrated in the way that many British South Asian patients draw on a mixed economy of explanatory models about health and illness – religious and spiritual understanding are sometimes used to explain illness – but Western biomedical explanations can also coexist alongside more traditional beliefs, leading to different responses to illness by different individuals from different generations. Relationships within British South Asian family and community life are

similarly diverse and complex. The family and wider community can be a source of social support but equally a source of stress. In the context of mental health problems, claims to candidacy are constrained where patients' decisions to seek formal help outside of family and community networks invoke complex cost-benefit calculations and create vulnerabilities: being identified as a candidate for healthcare can bring shame to the family and induce a sense of guilt, but by not availing themselves of help some people might adopt maladaptive coping strategies, thereby exacerbating the original (psychological) problem.

Interactions with health professionals at the healthcare interface. Access to healthcare among British South Asians can also be shaped by appearances and processes of adjudication at the healthcare interface. Barriers emerge where there is a lack of alignment between patients' helper models and communication styles and the helper models and consultation styles used by health professionals. For example, drawing on our second-order constructs, some British South Asians may adopt a more deferential style of communicating with their GP that is aligned with top-down notions about power and expertise that lack fit with the model of 'patient led' services now advocated in healthcare systems such as the NHS.[52] This more deferential style might reflect experiences of first generation British South Asians on the Indian sub-continent where doctor-patient relationships are more asymmetrical and less patient-centred, but may restrict British South Asian patients' ability to articulate and construct equitable claims for candidacy. This may contribute to both doctors and patients avoiding talking about emotionally sensitive issues related to mental health problems, focusing instead on less-contested concerns such as physical health.

Following treatment advice. In the final phase of the model, we identified conceptual and practical barriers that can compromise British South Asian patients' ability to successfully navigate health systems and take up offers of candidacy. Opportunities to fully engage with treatment advice, especially for diabetes/CHD, are partly constrained by the presence of cultural norms and practices that privilege community and family more than self. Here, patients' ability to respond to medical advice that demands change at an individual level (e.g. diabetes self-care) might be more difficult at times and in spaces where a more collectivist identity is strongly expressed. Medical advice given by health professionals is frequently bounded by Western cultural assumptions and so, although presented as unproblematic, might in fact bring the individual into conflict with social norms and behaviors that have significance for British South Asian identity. Acting on medical advice can then constitute an 'identity threat'.[53]

Additional barriers to following treatment advice arise where the demands and characteristics of treatments outstrip the practical resources and health literacy available to many first generation British South Asian patients. Where these resources are at a premium, patients might find it difficult to navigate complex care pathways in the NHS for LTCs and/or mental health problems. Problems navigating the NHS and following treatment advice are compounded by the absence of culturally competent services. Additionally, high levels of socioeconomic disadvantage can compromise the ability of some British South Asian patients to materially access care (e.g. lack of transport). Problematic and negative outcomes following medical advice are likely to shape future decisions about help seeking and also affect the content and quality of future consultations with healthcare practitioners.

Discussion

Summary and main findings

We synthesised the findings of 12 qualitative studies that explored the experiences of British South Asians using primary care services for diabetes, CHD or mental health problems. By first examining commonalities between studies (reciprocal translation), we identified five major themes (and 24 sub-themes) that described and mapped barriers to effective clinical and inter-personal care at various points along patient journeys, from early experiences through to following treatments. In developing our LOA, we have drawn on and further developed the candidacy model of access devised by Dixon-Woods et al.[25] to understand the complex interplay between the individual and contextual and the temporal and spatial factors that characterise barriers to (clinical and inter-personal) healthcare at various points along these patient journeys.

The difference in negotiating candidacy with presentation of physical and psychological problems is unsurprising, and is likely to be true in other populations, not just British South Asian. However, the presence of additional barriers to help-seeking and accepting offers of treatment may exacerbate differences in certain sub-groups of this population. In the presence of psychological problems, it seems that candidacy for some British South Asians can be a scarce resource – opportunities to make legitimate claims for help from formal healthcare can be limited as can be opportunities to effectively use offers of help. By contrast, where British South Asians present in primary care with physical health problems levels of candidacy may initially be high, but can decay as patients move along and exit care pathways, comprising efforts to effectively use healthcare.

British South Asians constitute a heterogeneous group and obstacles to a patient's claims to candidacy will vary according to a

number of parameters including sex, age, generation, time since immigration (if first generation), English language ability and education, as well as by health condition. For example, candidacy of an older female first generation immigrant with diabetes who has limited English language ability and education may be impacted negatively where there is a failure to provide formal translation or to take into account cultural norms around gender in planning consultations. These factors are likely to be less relevant to a young, second or third generation male British South Asian with mental health problems whose claim to candidacy may instead be undermined if health professionals fail to show an awareness of the specific stressors which may operate within some British South Asian families. Differences noted in studies with sub-groups support the suggestion that these differences will impact on the process of determining and negotiating candidacy. More primary qualitative studies examining differences between sub-groups of the British South Asian population would be useful and would allow further refinement of the candidacy model.

We had hoped to illuminate possible ethnic sub-group differences further by comparing themes from studies with different samples. However, no coherent patterns emerged.

Theoretical implications – developing the notion of candidacy

The concept of candidacy draws on situated action models that emphasise the emergent, contingent and co-constructed nature of human activity.[54] In doing so, candidacy moves away from problem solving models of human agency that are implicit in rational choice and behavioral models of access.[23,55,56] Candidacy is not a static or universally available currency. It has emergent and recursive properties – it is co-created, with varying degrees of success, during the course of social action. This action is situated *and located in time and space*. Here we argue that time is interactively and inter-subjectively constituted and separate from abstract clock time. We experience time in embodied ways through social action and through our engagement with the material world and with institutional forms such as belief systems, moral and cultural codes. Space draws together the social, the cultural and the (physical and material) geography in which we live and act over time. Again, this is not about some static or ready made environment. Rather space is better understood as a frame of reference within which situated action takes place[57] and is continually reformed in response to our lived and embodied experiences played out over daily, institutional and generational (or biographical) time.[58]

Practical implications

For healthcare services to be accessible and effective for British South Asians (and perhaps other BME groups), they must positively affect professionals' roles as gatekeepers and adjudicators of candidacy and enhance British South Asian patients' claims to candidacy at all phases of seeking and using health care. This must move beyond the issues of simply providing better interpretation services[59–61] to addressing the mismatch or dissonance between professionals' and patients' understandings about the causes, life-course and treatment of illness.[62] Educational interventions aimed at broadening British South Asian patients' opportunities to identify and articulate candidacy and to navigate and take-up offers of candidacy are a priority. For both physical and mental healthcare, the importance of health literacy is increasingly recognised.[63] Community outreach workers and independent advocates could work with

professionals to educate and empower British South Asian patients when they present at health services, and to support them after they have received offers of care. For their part, health professionals might engage in educational interventions that seek to enhance understanding about British South Asian patients' illness beliefs and behaviours leading to more culturally competent care.[12]

Strengths and limitations

Much of the data on help-seeking for mental health problems was drawn from studies that only included women. Furthermore, the majority of studies did not explicitly examine cultural, social and economic diversity within and between British South Asian communities. We accept that by referring to Indians, Bangladeshis, Pakistanis and other Asians as 'British South Asian' we might have duplicated this aggregative approach and overlooked important differences between these ethnic groups. Additionally, the absence of qualitative research on co-morbidity in British South Asian people meant we were not able to evaluate whether the candidacy model has utility in settings where illnesses interact, as with depression and diabetes and depression and CHD. We also only included studies of patient perspectives, mainly because of the complexities of synthesising across multiple stakeholder perspectives using meta-ethnographic approaches alone. We were able to identify material from the papers which though ostensibly concerned with experience of a condition was highly relevant to the process of health care encounters and the negotiation about access to effective healthcare for that condition.

A more nuanced and balanced account of barriers among underserved groups that draws on different perspectives could be achieved by adopting novel and alternative review methods that allow for the generation

and synthesis of multiple sources of evidence.[64]

Meta-synthesis techniques have been criticised for drawing out similarities rather than differences and thereby duplicate the aggregative approaches they seek to replace.[65] Our team was multi-disciplinary and multi-ethnic and sensitised to conceptual differences between race and culture and between religious and fatalistic understandings about illness.

The understanding produced from LOA syntheses has been considered by some authors to reflect Schultz's notion of a 'third-order' construct, that is a new model or theory about a phenomenon.[30] However, the extent to which meta-synthesis is able to produce these novel understandings is controversial.[66] As for the products of other meta-syntheses, it may only be possible to determine the true value of our candidacy model of access among British South Asians by assessing the results of its practical application (i.e. in the context of interventions to improve access).

Conclusion

This synthesis has drawn on and adapted the candidacy model of access to identify, map and characterise barriers to healthcare among British South Asians with LTCs or mental health problems. British South Asian patients' individual as well as broader social and cultural characteristics will shape how they avail themselves of candidacy. For their part, professionals' ways of working and cultural typifications will inform their role as adjudicators of claims to candidacy. In this sense, candidacy is co-constructed, over time and space, by patients and professionals. Interventions that positively affect patients' claims to candidacy are most likely to help overcome a broad range of barriers to care in this vulnerable population.

Acknowledgements

Conflict of interest

None Declared.

Funding

References

1. Department of Health [internet]. Ten things you need to know about long term conditions, http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm (2011 accessed 2 Sept 2011).
2. Gilbody S and Whitty P. Improving the recognition and management of depression in primary care. *Effect Health Care* 2002; 7: 1–12.
3. McCrone P, Dhanasiri S, Patel A, et al. *Paying the price: the cost of mental health care in England to 2026*. London: King's Fund, 2008.
4. Andrews G. Should depression be managed as a chronic disease? *BMJ* 2001; 322: 419–421.
5. Richards RA, Lovell K, Gilbody S, et al. Collaborative care for depression in UK primary care: a randomized controlled trial. *Psychol Med* 2008; 38: 279–287.
6. Chisholm D, Diehr P, Knapp M, et al. Depression status, medical comorbidity and resource costs: Evidence from an international study of major depression in primary care (LIDO). *Br J of Psychiatr* 2003; 183: 121–131.
7. Office for National Statistics Census. *General Report for England and Wales*. Basingstoke: Palgrave Macmillan, 2005.
8. The Information Centre for Health and Social Care. Statistics and Data Collection. Health Survey for England Vol. 1, The health of minority ethnic groups (Internet), http://www.ic.nhs.uk/webfiles/publications/healthsurvey2004ethnicfull/HealthSurveyforEnglandVol1_210406_PDF.pdf (2004, accessed 2 Sept 2011).
9. Lanting LC, Yong IMA, Mackenbach JP, et al. Ethnic differences in mortality, end-stage complications, and quality of care among diabetic patients: a review. *Diabetes Care* 2005; 28: 2228–2280.
10. Bhopal R, Fischbacher C, Vartiainen E, et al. Predicted and observed cardiovascular disease in British South Asians: FINRISK, Framlingham and SCORE models to Newcastle Heart Project data. *J Publ Health* 2005; 27: 93–100.
11. Hussain F and Cochrane R. Depression in South Asian women living in the UK: A review of the literature with implications for service provision. *Transcult Psychiatr* 2004; 41: 253–270.
12. Bhui K, Dinesh B, Goldberg D, et al. Assessing the prevalence of depression in Punjabi and somatic symptoms. *Transcult Psychiatr* 2004; 41: 307.
13. Gater R, Tomenson B, Percival C, et al. Persistent depressive disorders and social stress in people of Pakistani origin and white Europeans in the UK. *Soc Psychiatry Psychiatr Epidemiol* 2009; 44: 198–207.
14. Weich S, Nazroo JY, Sproston K, et al. Common mental disorders and ethnicity in England: the EMPIRIC study. *Psychol Med* 2004; 34: 1543–1551.
15. Davey-Smith G, Chatuvedi N, Harding S, et al. Ethnic inequalities in health: a review of UK epidemiological literature. *Crit Publ Health* 2000; 10: 375–408.
16. Bhui K, Bhugra D, Goldberg D, et al. Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychol Med* 2001; 31: 815–825.
17. Nazroo JY, Falaschetti E, Pierce M, et al. Ethnic inequalities in access to and outcomes of health-care: analysis of the Health Survey for England. *J Epidemiol Commun Health* 2009; 63: 1002–1027.
18. Galdas P, Cheater F and Marshall P. What is the role of masculinity in white and South Asian men's decisions to seek medical help for cardiac chest pain? *J Health Serv Res Pol* 2007; 12: 223–229.
19. Shaukat N, de Bono DP and Cruickshank JK. 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* 1993; 307: 717–718.
20. Mindell J, Klodawski E and Fitzpatrick J. Using routine data to measure ethnic differentials in access to coronary revascularization. *J Publ Health* 2008; 30: 45–53.
21. Verma A, Birger R, Bhatt H, et al. Ethnic disparities in diabetes management: a 10-year population-based repeated cross-sectional

study in UK primary care. *J Publ Health* 2010; 32: 250–258.

22. Goddard M and Smith P. Equity of access to health care services: Theory and evidence from the UK. *Social Sci Med* 2001; 53: 1149–1162.

23. Penchansky R and Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care* 1981; 19: 127–140.

24. Campbell SM, Roland MO and Buetow SA. Defining quality of care. *Social Sci Med* 2000; 51: 1611–1625.

25. Dixon-Woods M, Cavers D and Agarwal S. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Med Res Methodol* 2006; 6: 35.

26. Worth A, Irshad T, Bhopal R, et al. Vulnerability and access to care for South Asian Sikh and Muslim patients with life limiting illness in Scotland: prospective longitudinal qualitative study. *BMJ* 2010; 338: b183.

27. Finfgeld-Connett D. Generalizability and trans-ferability of meta-synthesis research findings. *J Adv Nursing* 2010; 66: 246–254.

28. Malpass A, Shaw A, Sharp D, et al. "Medication career" or "moral career"? The two sides of managing antidepressants: A meta-ethnography of patient's experience of antidepressants. *Social Sci Med* 2009; 51: 1087–1110.

29. Noblit GW and Hare RD. *Meta-ethnography: Synthesising qualitative studies*. London: Sage, 1988.

30. Atkins S, Lewin S, Smith H, et al. Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Med Res Methodol* 2008; 8: 8.

31. Britten N, Campbell R, Pope C, et al. Using meta-ethnography to synthesise qualitative research: a worked example. *J Health Serv Res Pol* 2002; 7: 209–215.

32. Office for National Statistics Census. *General Report for England and Wales*. Basingstoke: Palgrave Macmillan, 2005.

33. Dixon-Woods M, Sutton A, Shaw R, et al. Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *J Health Serv Res Pol* 2007; 12: 42–47.

34. Critical Appraisal Skills Programme, Milton Keynes Primary Care Trust. England: Public Health Resource Unit; 10 questions to help you make sense of qualitative research [internet]. http://www.sph.nhs.uk/sph-files/casp-appraisaltools/Qualitative%20Appraisal%20Tool.pdf (2006, accessed 2 Sept 2006).

35. Ritchie J and Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG (eds) *Analyzing qualitative data*. London: Routledge, 1994, pp.173–194.

36. Barnett-Page E and Thomas J. Methods for the synthesis of qualitative research: a critical review. *BMC Med Res Methodol* 2009; 9: 59.

37. Greenhalgh T, Helman C and Chowdhury AM. Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study. *BMJ* 1998; 316: 978–983.

38. Stone M, Pound E, Pancholi A, et al. Empowering patients with diabetes: a qualitative primary care study focusing on British South Asians in Leicester, UK. *Family Pract* 2005; 22: 647–652.

39. Lawton J, Ahmad N, Hallowell N, et al. Perceptions and experiences of taking oral hypo-glycaemic agents among people of Pakistani and Indian origin: qualitative study. *BMJ Online* 2005; 330(7502): 1247.

40. Lawton J, Ahmad N, Hanna L, et al. 'I can't do any serious exercise': barriers to physical activity amongst people of Pakistani and Indian origin with type 2 diabetes. *Health Educat Res* 2006; 21: 43–54.

41. Lawton J, Ahmad N, Hanna L, et al. Diabetes service provision: a qualitative study of the experiences and view of Pakistani and Indian patients with Type 2 diabetes. *Diabetic Med* 2006; 23: 1003–1007.

42. Darr A, Astin F and Atkin K. Causal attributions, lifestyle change, and coronary heart disease: Illness beliefs of patients of South Asian and European origin living in the United Kingdom. *Heart Lung* 2008; 37: 91–104.

43. Sriskantharajah J and Kai J. Promoting physical activity among South Asian women with coronary heart disease and diabetes: what might help? *Family Pract* 2006; 24: 71–76.

44. Kai J and Hedges C. Minority ethnic community participation in needs assessment and service development in primary care: perceptions of Pakistani and Bangladeshi people about psycho-logical distress. *Health Expectations* 1999; 2: 7–20.

45. Chew-Graham C, Bashir C, Chantler K, et al. South Asian women, psychological distress and self-harm: lessons for primary care trusts. *Health Social Care Commun* 2002; 10: 339–347.

46. Hussain FA and Cochrane R. Depression in South Asian women: Asian women's beliefs on causes and cures. *Ment Health Relig Cult* 2002; 5: 285–311.

47. Hussain FA and Cochrane R. Living with depres-sion: Coping strategies used by South Asian women, living in the UK, suffering from depres-sion. *Ment Health Relig Cult* 2003; 6: 21–44.

48. Lawrence V, Banerjee S, Bhugra D, et al. Coping with depression in later life: a qualitative study of

help-seeking in three ethnic groups. *Psychol Med* 2006; 36: 1375–1383.

49. Koehn S. Negotiating candidacy: ethnic minority seniors' access to care. *Ageing Soc* 2009; 29: 585–608.

50. Kovandžić M, Chew-Graham C, Reeve J, et al. Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work'. *Social Sci Med* 2011; 72: 763–772.

51. Gately C, Rogers A and Sanders C. Re-thinking the relationship between long-term condition self-management education and the utilisation of health services. *Social Sci Med* 2007; 65: 934–945.

52. Thompson AG. The meaning of patient involvement and participation in health care consultations: a taxonomy. *Social Sci Med* 2007; 64: 1297–1310.

53. Coyle J. Exploring the meaning of 'dissatisfaction' with health care: The importance of 'personal identity threat'. *Sociol Health Illness* 1999; 21: 95–123.

54. Suchman L. *Plans and situated actions*. Cambridge: Cambridge University Press, 1987.

55. Aday LA and Andersen RM. Access to medical care in the US: Realized and potential. *Med Care* 1978; 16: 533–546.

56. Andersen RM, McCutcheon A, Aday LA, et al. Exploring the dimensions of access to medical care. *Health Serv Res* 1983; 18: 49–74.

57. Werlen B. *Society, action and space. An alternative human geography*. London: Routledge, 1993.

58. Giddens A. *The constitution of society. Outline of the theory of structuration*. Cambridge: Polity, 1984.

59. Gill PS, Shankar A, Quirke T, et al. Access to interpreting services in England: secondary analysis of regional data. *BMC Publ Health* 2009; 9: 12.

60. Rhodes P and Nocon A. A problem of communication? Diabetes care among Bangladeshi people in Bradford. *Health Social Care Commun* 2003; 11: 45–54.

61. Coventry PA, Hays R, Dickens C, et al. Talking about depression: a qualitative study of barriers to managing depression in people with long term conditions in primary care. *BMC Fam Pract* 2011; 12: 10.

62. Lamb JD, Bower P, Rogers A, et al. Access to mental health in primary care: a qualitative meta-synthesis of evidence from the experience of people from 'Hard to Reach' Groups. *Health* 2012.

63. Protheroe J, Nutbeam D and Rowlands G. Health literacy: a necessity for increasing participation in health care. *Br J Gen Pract* 2009; 59: 721–723.

64. Dowrick C, Gask L, Edwards S, et al. Researching the mental health needs of hard-to-reach groups: managing multiple sources of evidence. *BMC Health Serv Res* 2009; 9: 226.

65. Heyman B. Reflecting on a meta-synthesis of qualitative papers concerned with pregnant women's decision-making about prenatal screening for Down syndrome: A commentary on Reid, Sinclair, Barr, Dobbs and Crealey. *Social Sci Med* 2009; 69: 1574–1576.

66. Finfgeld-Connett D. Generalizability and transferability of meta-synthesis research findings. *J Adv Nurs* 2010; 66: 246–254.