

# Health ASERT Programme Wales

Enhancing the health promotion evidence base on Minority Ethnic Groups, Refugees/Asylum seekers, and Gypsy Travellers

## I. Main Findings and Recommendations

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## Foreword for series

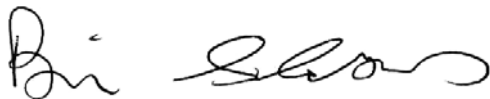
As Minister for Health and Social Services, I am pleased to present the Health ASERT Programme Wales report series to you. This report series details the findings and the recommendations arising from this important research programme examining health promotion issues for minority ethnic groups, refugees/asylum seekers and Gypsy Travellers living in Wales.

This research programme demonstrates the commitment shown by the Welsh Assembly Government to promoting equality of opportunity in all aspects of Welsh life and reducing inequalities in health faced by ethnic minority and marginalised groups. In order for us to meet this commitment and develop appropriate policies and practices, it is imperative that we have access to a solid evidence base, drawn from the available literature and the views of those directly affected by our policies. The research reported here involved community members as well as key stakeholders at the national and local levels. This input, combined with the extensive review of the literature on the health beliefs and health status of these groups and their use of services and on appropriate health care interventions has culminated in a comprehensive piece of work.

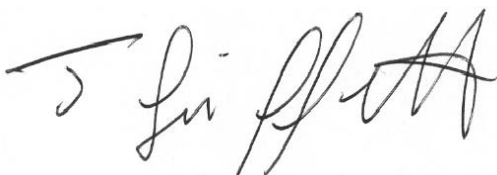
One of the key conclusions of the research is that promoting good health is the responsibility of individuals, communities and Government. I wholeheartedly endorse this sentiment, which forms the approach behind the recent launch of Health Challenge Wales, a call to all people and organisations in Wales to work together for a healthier nation.

I trust that you will find this report series both enlightening and thought provoking, as indeed the Deputy Minister and I have. Furthermore we hope that you will use the report series as a source of reference material for your work.

**Brian Gibbons AM**  
**Minister for Health and Social Services**



**John Griffiths AM**  
**Deputy Minister with responsibility for older people**



# Health ASERT Programme Wales Report Series

Health ASERT Programme Wales. Enhancing the Health Promotion evidence base on Minority Ethnic Groups, Asylum seekers/Refugees, and Gypsy Travellers.

1. Main Findings and Recommendations.
2. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Gypsy Traveller Population, and of appropriate Health Care Interventions. (to be published 2005)
3. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Minority Ethnic Group Population, and of appropriate Health Care Interventions. (to be published 2005)
4. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Refugee and Asylum Seeker Populations, and of appropriate Health Care Interventions. (to be published 2005)
5. A Review of Databases and other Statistical Sources Reporting Ethnic Group and their Potential to Enhance the Evidence Base on Health Promotion. (to be published 2005)
6. Summary Primary Research Report. (to be published 2005)
7. Full Length Primary Research Report. (to be published 2005)

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**The views expressed in this report are those of the authors and not necessarily those of the Welsh Assembly Government**

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# I. Introduction

The Health ASERT Programme Wales is a research programme commissioned by the Office of the Chief Medical Officer, Welsh Assembly Government to investigate health promotion issues among minority ethnic groups, refugees/asylum seekers, and Gypsy Travellers. The acronym ASERT stands for **A**sylum **S**eekers, **E**thnic minorities, **R**efugees and **T**ravellers. Research was undertaken by the Research Centre for Transcultural Studies in Health, Middlesex University and the Centre for Health Services Studies, University of Kent at Canterbury between February 2003 and March 2004.

## I.1 Aims and objectives

This study aimed to enhance the evidence base on health promotion issues related to minority ethnic groups, refugees/asylum seekers and Gypsy Travellers in Wales in order to inform policy and programme development in the Welsh Assembly Government's Health Promotion Division and elsewhere in the Office of the Chief Medical Officer.

### The study objectives were to:

- identify gaps in the existing evidence base of health needs and health promotion issues for the study groups;
- identify existing good practice of health services and promotion for the study groups;
- explore ways of delivering health promotion policy/programmes targeting these groups in a culturally and socially sensitive manner;
- identify issues for further research.

## I.2 Methodology

Qualitative methods were used for the primary research. The principles of participation and empowerment of community groups being researched were fundamental to the study.

### The following data collection methods were used:

- **Fourteen focus groups with the three study groups (N=96 participants);** (African-Caribbean community; Indian community; Pakistani community; Chinese community; Somali asylum seeker community; Iranian asylum seeker community; Gypsy Traveller community; New Age Traveller community; Refugee women; Women from minority ethnic groups; Gypsy Traveller women.)
- **A consultation exercise with key informants (N=8);** (These were the focus group facilitators who were members of the study groups and in the main, also deliverers of health promotion services.)
- **Semi-structured interviews with local key stakeholders (N=9);** (These were senior members of statutory and voluntary organisations involved with health promotion.)
- **A self-completion questionnaire was used with national key stakeholders who worked for UK-wide organisations (N=8).** (Senior members of these organisations.)

Health promotion policy, strategy, and practices were explored to determine the factors that facilitate and hinder meeting the health promotion needs of the study groups, and the nature of good health promotion practice in relation to the study groups.

Focus group participants were residents of Swansea, Grangetown (Cardiff), Wrexham, West Midlands, Queensferry (Flintshire), Pontypool, and Newport.

In addition, systematic reviews of the literature relating to the study groups were undertaken as well as a review of ethnically coded data held on databases and other statistical sources reporting ethnic group and the potential of this information to enhance the evidence base for health promotion.



## 2. Findings

### 2.1 Systematic literature review findings

Three comprehensive literature reviews, based mainly on the UK literature, were undertaken on Gypsy Travellers, refugees and asylum seekers and minority ethnic groups. Each focused on health status, health related behaviour, use of services, wider determinants of health and health and social care interventions.

The size of the Welsh Gypsy Traveller population living in Wales is largely unknown. The health status of this group is not well documented and there is a paucity of robust evidence. However there is fragmentary data on life expectancy being lower than average and stillbirths, perinatal and infant mortality and Sudden Infant Death Syndrome (SIDS) being higher than average. Also there is evidence of high levels of anxiety and depression. Poverty and low socio-economic position have a major effect on this population's health.

There is a lack of robust information on the size, distribution and country of origin of the asylum seeker and refugee population living in Wales. Mental health problems, sexual health needs, a high incidence of HIV and AIDS, and self-reported injury and torture are some of the problems affecting health status, documented for this population. There is evidence to suggest that this population frequently live in poor housing, have high levels of unemployment and poor access to education.

The 2001 Census recorded a minority ethnic population in Wales of 2.1 per cent. The largest minority ethnic group in Wales was Pakistanis (0.29 per cent) followed by Indians (0.28 per cent), Chinese (0.22 per cent) and Mixed: White and Black Caribbean (0.21 per cent). The unitary authority with the highest proportion of its population in minority ethnic groups (other than white) is Cardiff (8.42 per cent), followed by Newport (4.83 per cent), The Vale of Glamorgan (2.16 per cent), Swansea (2.15 per cent) and Ceredigion (1.39 per cent). Self reported poor health, mental health problems, unmet family planning needs, high levels of Sexually Transmitted Infections (STIs), type 2 diabetes and high levels of Coronary Heart Disease (CHD) are some of the problems affecting health status documented for this population.

This represents a very brief summary of some of the findings. Please refer separately to the systematic reviews for the full findings and in depth analysis of the type and quality of evidence available. The findings from these reviews underpinned the primary research.

## 2.2 Findings from the review of databases and other statistical sources

- Ethnic coding on the Patient Episode Database for Wales (PEDW) (of hospital episode statistics) is substantially incomplete.
- The Pilot GP Morbidity database in Wales is not populated by ethnic group and such data is seldom collected in primary care.
- There are few other routine collections that include ethnicity, with the exception of the Pupil Level Annual School Census (PLASC).
- The Welsh Health Survey does not capture a sufficiently large minority ethnic population (around 1.5 per cent) to merit analysis.
- The Labour Force Survey in Wales and PLASC collection demonstrate the popularity of a 'Welsh' national identity.

## 2.3 Focus group findings

The focus groups conducted with the study groups resulted in six themes, which are summarised and presented below. The organisation of these main themes and their sub-themes can be found in the summary charts presented as an appendix.

### Theme 1 – Main Health Problems

- The health problems described by focus group participants related to cultural issues, socio-economic and environmental factors, mental and physical disease, age related problems, barriers accessing services and lifestyle factors.
- The different population groups suffer from all common conditions to a variable extent depending on the above factors that vary within and between groups. Gypsy Travellers for example, who tend to have poor housing and sanitation suffer frequent infectious diseases particularly among children, whereas asylum seekers and refugees were more likely to describe problems related to stress caused by previous torture and to migration.

### Theme 2 – Access to Health Promotion

### Theme 3 – Problems Accessing Health Promotion

- These two themes have been collapsed and presented together here due to their similarity but are discussed separately in both the summary primary research report and the full length primary research report.
- Participants described varying degrees of access to sources of health promotion from the NHS and Governmental sources, non-Governmental sources, personal and other informal sources and the mass media.

- Problems accessing health promotion related to service provision including a lack of interpretation services, health promotion materials and events not being in community languages, not being culturally appropriate, and lack of female practitioners and interpreters. Problems related to health professionals were a lack of cultural awareness, discrimination such as GPs refusal to register, and lack of time and patience on the part of the doctors during consultations. Problems relating to the communities themselves included cultural factors such as fatalistic attitudes, social isolation, socio-economic deprivation, lack of knowledge as to available services, and poor literacy or command of English.

#### **Theme 4 – Culturally and Linguistically Appropriate Health Information and Advice**

- Preferred formats of health promotion depended on the focus group participants degree of fluency in English, literacy, age, culture, and access to technological media. For example, generally, the Gypsy Travellers liked TV and videos as sources of health information, Asians (Pakistani and Gujarati Indians) liked TV and cinema, the Chinese liked the radio, and only Somalis and African Caribbeans reported liking the Internet as a source of health information. Written formats of health information were not preferred, but when they are used the participants wanted them written simply in community languages with culturally appropriate images to support the message.
- Preferences as to information givers also varied between groups, with Indian and Pakistani participants seeming to like information from health professionals, whilst others placed equal or greater value on personal sources of information such as family and friends, books and the Internet. The media and information technology were seen to be useful in disseminating health promotion to those who can access it, such as telephone advice lines when there was someone available who spoke their language.
- The information needed, related to disease diagnosis, treatment and prevention, how to access health services and how to live a healthier lifestyle.
- Venues for health promotion that were preferred by the study groups were generally community based in their locality, such as existing community centres for their own specific cultural group. Gypsy Travellers also wanted health promotion on site to run alongside general education such as literacy classes.
- According to the study groups, the benefits of health promotion were improved uptake of disease prevention interventions such as cervical screening, greater confidence in the services, healthier lifestyles, improved health, better knowledge of how to access health promotion and health care and improved self-care/treatment and less dependency on the NHS.

## **Theme 5 – Good Practice in Health Promotion**

- The study groups identified various experiences and examples of what they felt to be good practice in health promotion. These were then classified as being examples of health education, health protection and disease prevention.
- Some of the services and instances talked about from these three broad areas included NHS Direct, community based projects, health education in schools for children, public anti-smoking measures, road safety, health visitors' practice and midwifery practice.

## **Theme 6 – Actions for Health Improvement**

- The study groups described a number of actions that are needed for their health improvement including improved socio-economic circumstances; improved environment; better facilities and access to healthcare for Gypsy Travellers; facilitation of positive lifestyles; racism and discrimination addressed; public health policies on drugs, smoking and advertising (especially food); and the provision of culturally competent health promotion services through training of health promotion workers.
- Health promotion providers on the front line need to be involved, as well as service users, in developing the policy and planning of health promotion.
- Evidence is needed as to what health promotion activities are most effective for minority groups. Evaluations of health promotion should include the views of service users.

## **2.4 Local and national key stakeholder findings**

The local stakeholder interviews and national stakeholder questionnaires resulted in five themes, which are presented below.

### **Theme 1 – Health Promotion Policy and Strategy Development**

- Strategies were reported to attend to inequalities in health by promoting access to services, promoting culturally competent and anti-racist policies, promoting the use of advocates and interpreters, and promoting the delivery of information in different languages.

- Local and national key stakeholders identified the following obstacles to developing policies that address inequalities in health:
  - lack of time/resources;
  - small numbers of people of the groups in question;
  - lack of data about the groups in question;
  - assumptions about social integration;
  - reticence to provide services for specific and/or small communities;
  - principle of equality: one strategy for all (as a held value by some);
  - lack of mainstream expertise and the application of the notion of ‘the expert for ethnicity issues’;
  - institutional racism.
- Strategies and policies to address the health promotion needs of the study groups should straddle all public services, their implementation should be adequately resourced, be long term and evidence based. Developing the leadership of relevant community organisations and involving them in developing strategy and policy, were advocated.
- Adopt strategies that address the needs of those who do not access public services in the usual ways (Gypsy Travellers/New Age Travellers).

## **Theme 2 – Health Promotion Assessment**

- There was little systematic assessment of the study groups’ health promotion needs. Various methods were used by different organisations. Difficulties included lack of reliable data on population sub-groups, lack of relevant detail in data and a lack of ethnic monitoring.
- Assessing the health promotion needs of the study groups would be facilitated by better co-ordination and sharing of data, data on population trends, ethnic categorisation for Gypsy Travellers for monitoring purposes, and greater cultural awareness.

## **Theme 3 – Health Promotion Activities**

- Provision of health promotion for the study groups was hindered by the following factors:
  - lack of funding/resources/staff;
  - language/communication barriers;
  - lack of appropriate data and detail in data;
  - lack of experience of health promotion workers in working with the study groups;
  - GP health promotion targets may lead to exclusion of some groups;
  - existence of institutional racism and discrimination;
  - cultural differences and lack of knowledge of UK health care system by study group participants particularly by asylum seekers/refugees;
  - regional variation in provision/resources reflecting size of minority groups (problem for those who are scattered);
  - mobility of Gypsy Traveller groups;
  - non prioritisation of the study groups on organisations’ agendas;
  - lack of trust in health professionals.

## **Theme 4 – Partnerships and Client Involvement**

- The involvement of clients in service planning and development/delivery requires strategies, political drive and leadership. Involvement can be fostered by gaining the trust of community members and demonstrating that their involvement makes a difference.

## **Theme 5 – Culturally Competent Health Promoting Organisations**

- The importance of cultural competence of health promotion organisations was a key finding of this study. Features of such organisations include:
  - works in partnership with other organisations;
  - involves user groups and recruits them into the organisation fostering empowerment;
  - has systems for harnessing appropriate data and ethnic monitoring;
  - ensures staff have opportunities to develop knowledge and expertise in cultural issues;
  - have adequate resources to enable culturally competent health promotion;
  - can address the needs of non-English speaking and illiterate people;
  - deal with racism and discrimination appropriately;
  - provides information to aid clients' access to health promotion resources;
  - undertakes health promotion needs assessment;
  - targets health promotion at identified need;
  - locates events and materials in appropriate places for the target group;
  - is a learning organisation.
- The Welsh Assembly Government's approach to improving the health of the nation by reducing social inequalities, holistic pan-agency strategies, inter-agency partnerships, user involvement/partnership and capacity building, strengthening of the systems for data collection relevant to health and evidence-based practice and policy, have been endorsed by this study, as is the aim of having client-led/client-centred and community based services.

## 3. Recommendations

### 3.1 Recommendations from the systematic literature reviews

Although the size of the minority ethnic group population in Wales (2.1 per cent) is much smaller than that in Great Britain as a whole, its composition and characteristics require policies that address the particularity of its diversity and distribution. In particular, the largest minority ethnic group, in Wales, is the Pakistani community (0.29 per cent) which – along with the Bangladeshi group – is the most deprived in national studies of the health and socio-economic position of minority ethnic groups in England. The second largest minority ethnic group in Wales – the Indian community (0.28 per cent) – has emerged in Britain in recent years as a more prosperous group, approaching the position of the white population on some socio-economic measures. The Chinese group in Wales, the third largest (0.22 per cent) has its own particular needs. There is evidence of the use of a bicultural health model amongst migrant members of this community. Moreover, as the Chinese community is widely dispersed, its needs frequently get overlooked as area-based initiatives miss most members of the group. Finally, there is also an emergent mixed population (notably white and Black Caribbean) in Wales that may have its own specific health and health care needs which may or may not be intermediate between the white and Black Caribbean groups. The diversity in this minority ethnic group population is added to by groups not enumerated in the census, notably, Gypsy Travellers and a large population of both settled and dispersed asylum seekers/refugees.

The reviews of the literature on the health of minority ethnic groups in Britain revealed a wide range of health issues, some specific to particular groups (such as Gypsy Travellers) and some occurring across all groups. The evidence base suggests that it would be appropriate to concentrate programmes and resources on those diseases and conditions that account for the main burden of morbidity and mortality in both minority ethnic groups and the population as a whole, notably, cardiovascular disease and cancers (and their associated risk factors), mental health, and diabetes. Studies show that coronary heart disease is moderately higher in South Asian groups than in the population as a whole, there is evidence that the poorest groups, of Pakistani and Bangladeshi origin, have the highest rates. The causes of the elevated rates in the South Asian groups are incompletely understood. Of particular concern is our lack of knowledge about the prevalence of these conditions and associated risk factors in the Gypsy Traveller and asylum seeker/refugee populations. Similarly, our knowledge of the disease burdens associated with cancer in the minority ethnic group population is limited. Mortality ratios for lung cancer are known to be elevated for both migrant men and women from Scotland and Ireland living in England and Wales. However, they are low in both men and women in other migrant groups (E Africa, W Africa, Caribbean, and S Asia). There is evidence from US data that the incidence of prostate cancer is higher in the black population. Generally low rates of mortality from breast cancer are reported for women from migrant groups. Again, there is a substantial lack of evidence relating to Gypsy Travellers and refugees/asylum seekers. Since studies report low uptake of breast and cervical screening in minority ethnic groups, programmes are needed that address the specific cultural requirements of these underserved populations.

Health promotion interventions may be especially effective in terms of addressing lifestyles that are detrimental to health, although these need to be culturally competent and sensitive to ensure good outcomes. Across all the national surveys there are substantial differences between minority ethnic groups and the white group in smoking patterns, for example, self-reported smoking prevalence amongst Bangladeshi men was 44 per cent in the 1999 Health Survey for England (HSE) vs. 27 per cent of men in the general population and 17 per cent in Chinese males. However, there are some significant inconsistencies in reported rates across surveys. The consistently reported high prevalence of smoking in the Bangladeshi group is of particular concern. Major national surveys in England also show

substantial differences in reported prevalence of alcohol consumption compared with the white population (for example, the Policy Studies Institute's Fourth National Survey of Ethnic Minorities (1993–1994) found that only 4 per cent of Pakistani men reported drinking more than once a week compared to 69 per cent of white men) and also variations across the different ethnic groups. Again, there are inconsistencies. According to the 1999 HSE, Bangladeshi men and women were least likely to eat fruit six or more times a week (15 per cent men, 16 per cent women) and Pakistani men (7 per cent) and women (11 per cent) least likely to eat vegetables with this frequency. There are, too, well documented differences in participation in exercise. As in measures of health status, the Pakistani and Bangladeshi groups are frequently found to be the most disadvantaged of all the minority ethnic groups.

Finally, many of the wider determinants of health are amenable to health-enhancing intervention programmes. While Indians, African Asians and Pakistanis have the highest levels of owner-occupation, followed by the white population and the Chinese, it is the Caribbeans and, again, the Bangladeshis who have the lowest levels of occupation. Data from Government social surveys show that white people are much more likely to be economically active (in employment or seeking jobs) than minority ethnic groups, with the exception of 'black other' women who have the highest female economic activity rates. Bangladeshi, black and Pakistani pupils achieve less well than other pupils at all stages of compulsory education. In terms of the Welsh context, there may be specifically local factors that need to be taken into account, notably, the structure of the housing market and availability of affordable housing, issues of access related to affordable transport in rural areas, and the availability of services tailored to the needs of minority ethnic groups that are more likely to be found in areas where these communities are concentrated (for example, interpreters, link workers and health advocates).

### **3.2 Recommendations from the review of databases and other statistical sources**

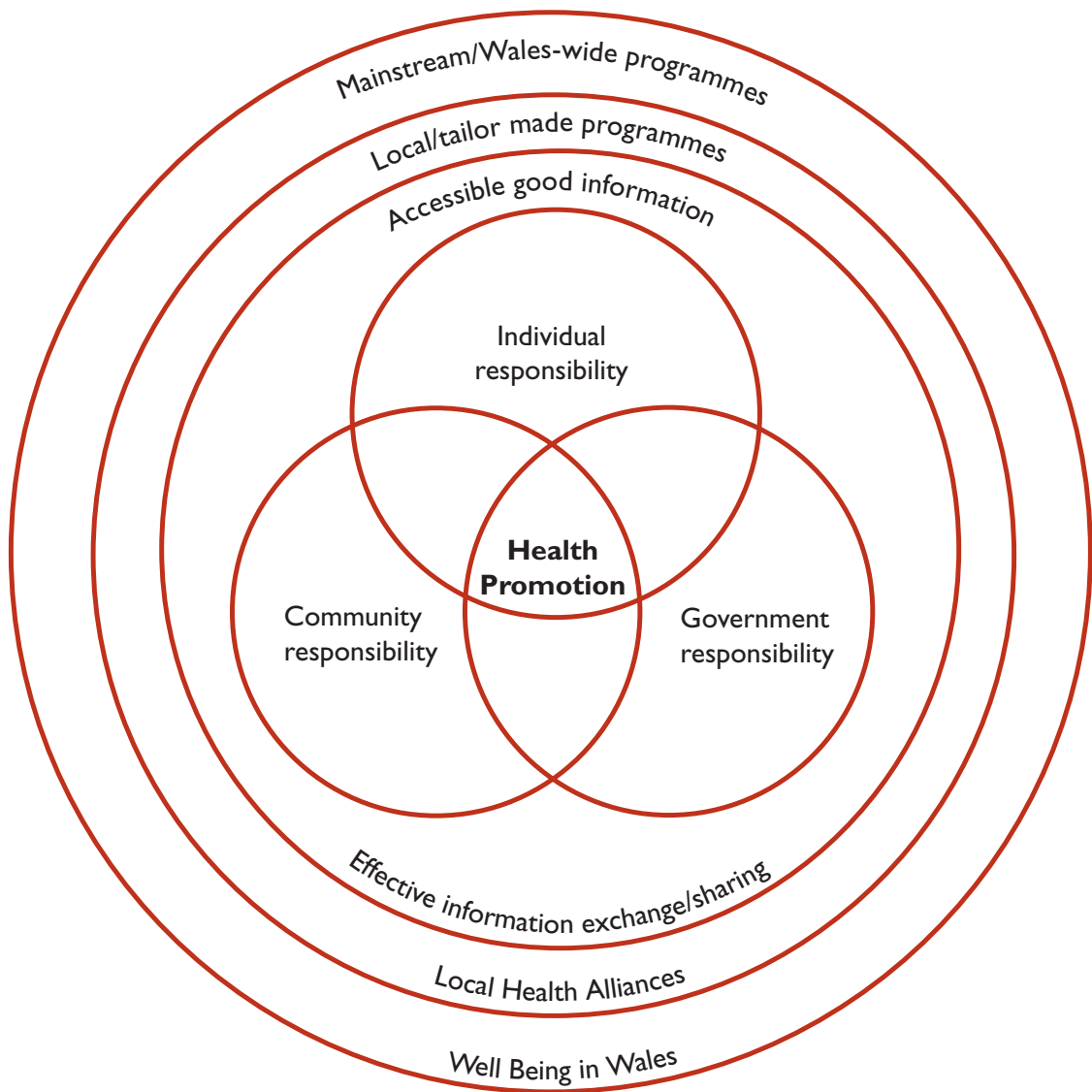
- An ethnic health intelligence strategy is needed to decide the scope of ethnicity data collection and population profiling.
- Given the findings of the 2001 Census, Labour Force Survey in Wales and the Pupil Level Annual School Census, it is recommended that a 'national identity' question (as recommended by the Office for National Statistics) is also used in ethnic monitoring.
- Given the substantial incompleteness of ethnic coding on the PEDW database (of hospital episode statistics), targets should be set for completeness and NHS trust boards should be required to report such completeness in Clinical Governance reports.
- As the Pilot GP Morbidity database in Wales is not populated by ethnic group and ethnic group is seldom collected in primary care settings, it is recommended that ethnic group be added to this database.
- As the Welsh Health Survey does not capture a sufficiently large minority ethnic population (around 1.5 per cent), it is recommended that this survey contains a minority ethnic boost sample or appraisal of a customised survey option.
- It is recommended that the potential of synthetic estimation techniques be investigated in the short term with respect to both disease frequency and the prevalence of different behavioural risks.
- It is recommended that the findings of the 2001 Census on limiting long-term illness, general health and permanently sick/disabled should be exploited to develop ethnic-specific standardised prevalence ratios and the use of specialised techniques (such as funnel plots) to identify statistical outliers.



### 3.3 Recommendations from the primary research

The findings from the primary research were assimilated and drawn together to construct a model for the implementation of health promotion. This model centres on the need for three agencies required for the successful implementation of actions to promote good health: the individual, the community and the Government. In order for the agencies to function effectively they require reliable information and collaboration. In addition the findings strongly indicated that tailor-made programmes based on local assessment of need and local health alliances are more likely to succeed. However, these need to be part of a Wales-wide health promotion vision and strategy, as well as Wales-wide programmes.

## Health Promotion Implementation Model: Structures and Processes



It has become apparent during the course of this study that there is a high level of awareness that health is affected by all aspects of life, ranging from the impacts of advanced science, such as genetic modification of crops to culturally mediated spiritual and health beliefs. There is also an understanding that health is promoted by a healthy environment, social acceptance, self-esteem and adequate relative wealth, as well as preventive measures such as access to vaccinations and advice about healthy lifestyles. The findings also show that the study groups are suffering discrimination and racism and that this has a negative effect on their health as well as their use and response to health promotion.

Whilst it is recognised that attention to all aspects of social life are important in the effort to reduce health inequalities, our recommendations only provide detail on those activities which are undertaken with the primary purpose of enhancing health and wellbeing. For example, one of our key findings was that responses to health promotion depend on its relevance and appropriateness to the 'recipients'; we therefore advocate ways of involving the minority community groups in health promotion to make it more culturally competent.

The box below summarises some of the good practice points identified by the service providers and focus group participants:

### Key features of good practice in health promotion

- Health promotion activities are culturally acceptable and appropriate.
- Health promotion is accessible to diverse cultural groups (e.g. in appropriate languages, venues etc).
- Health promotion policy/strategies are based on reliable information.
- Health promotion is targeted and tailored according to reliable information following assessment of need.
- Health promotion work is multi-disciplinary and multi-agency and is inclusive of all relevant sectors (e.g. statutory, voluntary, users' groups etc.).
- Services have clear leadership but enable a 'bottom up' approach.
- Health promotion activities/strategies harness opportunities to empower the public.
- Mechanisms for user/public involvement (e.g. recruitment, partnership working, networking, consultation, representation, advocacy etc).
- Minority groups' views are seen to influence practice.
- Initiatives build the capacity of the community/service users (e.g. as health advocates, interpreters, researchers, health advisers, cultural mediators etc).
- Targeting services at identified need following culturally competent Health promotion assessment.
- Monitoring and audit of service use, processes and outcomes includes an ethnic dimension.
- Services have working practices that do not discourage minority ethnic groups from entering the workforce or progressing within it.

People's health behaviours depend on knowledge, beliefs, socialisation, peer pressure, self-esteem, wealth and their access to health improving resources. We propose that improvements in health promotion (and therefore in health) are dependent on three premises:

- Knowledge (as to what needs to change and how change is best achieved)
- The means (resources to affect change)
- The will to change

These three dimensions of any health promotion effort need to be addressed if it is to be effective. As each of these dimensions are associated with the Government, the community and the self, each recommendation stated in this report outlines the activities required by each to reach the desired outcome. However, the reader is advised to refer to the full length primary research report for further detail and contextualisation of the recommendations.

Our literature reviews have revealed that much work has already been done to improve the health of Welsh minority groups. However, we hope the recommendations from the Health ASERT Programme Wales will further these attempts to fulfil the needs of our study groups.

### 3.3 Table of recommendations

These recommendations arise from the primary research undertaken; please refer to the full length primary research report for further detail and contextualisation of the recommendations. In addition to these, recommendations regarding the evidence base are detailed in each of the systematic reviews.

Issue 1: Socio-economic and Health Promotion Inequalities	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Social and economic deprivation leads to poorer health and poorer access and response to health promotion thus perpetuating health inequalities.</b>	Socio-economic determinants of health inequalities to be addressed.	Take up support that is available.	Support socio-economically disadvantaged groups to raise standard of living and self-esteem.	Ensure social policies help reduce relative poverty.
	Inequalities in access to health promotion to be addressed.	Make an active contribution to community activities through involvement in consultation, advocacy, volunteering etc.	Involve community members in self-help initiatives.	Invest in projects (including research) to raise the quality of life of the disadvantaged.
			Join health alliances and share expertise in working with minority groups with 'mainstream' services.	Improve living conditions of Gypsy Travellers, including safety aspects.
				Provide leadership and clear strategies for the improvement of health promotion.  Invest in projects (including research) that will raise the quality of life for disadvantaged groups.

Issue 2: Information	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Health promotion policy and practice needs a stronger evidence base.</b>	Health promotion interventions based on best evidence.	Individuals participate in research/evaluation activities in health promotion.	Undertake/participate in research and evaluation of health promotion and activities designed to reduce health inequalities.	Provide leadership and resources to promote research and evaluation of projects and services related to health promotion (economic, social, environmental and health).
<b>Lack of a strategic and co-ordinated health and welfare information system to enable monitoring, comparisons/audit/evaluation in health promotion.</b>	Implementation of the 'Informing Healthcare' strategy.  Develop and operationalise a set of indicators of good practice in health promotion across Wales, to include criteria to measure its cultural competence.	Participate in public consultation during development of system.	Contribute to the development of the ICT system in health and social care.  Contribute to the development of key indicators/variables for monitoring, research and evaluation.	Provide direction and resources for the development and implementation of ICT policies and strategies.

Issue 2: Information	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Inadequate categorisation of ethnic groups hinders monitoring and targeting of health promotion related services.</b>	Review of ethnic categories to consider group for Gypsy Travellers.	Participate in consultation regarding relevant ethnic categories.	Support socio-economically disadvantaged groups to raise standard of living and self-esteem.	Lead consultation on ethnic categorisation within Wales.
<b>Health promotion information is not always current, relevant or accessible.</b>	Health promotion information needs to be culturally appropriate, up to date, relevant and easily accessible for all groups.	Contribute to knowledge to help ensure health promotion is relevant, current and accessible.	Contribute to knowledge to help ensure health promotion is relevant, current and accessible.	Provide resources to enable the development of culturally competent information in various formats and to increase use of ethnic media.
			To raise awareness about health promotion information and disseminate same.	Ensure systems are in place to ensure the currency, relevance and accessibility of health promotion information.

<b>Issue 2: Information</b>	<b>Solutions/ Recommendations</b>	<b>Individual Responsibility</b>	<b>Community/ Community Organisation Responsibility</b>	<b>Government Responsibility</b>
<b>Deficiencies in communicating health promotion information to Gypsy Traveller communities e.g. appointments for screening/dentist etc.</b>	Review of problem and potential solutions/sharing good practice.	Travellers to contribute to generation of solutions to communication problems.	Co-ordinate the activities that will contribute to generation of solutions to communication problems with Travellers.	<p>Promote use of hand held medical records.</p> <p>Support research into best ways of ensuring communication between health services and Travellers to help establish an efficient two-way communication system.</p>

Issue 3: Unmet Education Needs	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Poor level of cultural competence of some health promotion workers.</b>	Training to be available in cultural competence*.	Ensure attendance at courses aimed at enhancing cultural competence.	Support socio-economically disadvantaged groups to raise standard of living and self-esteem.	Provide adequate funding for the commissioning and promotion of cultural competence training for staff involved in health promotion.
<b>Poor adult literacy and English language skills in some groups.</b>	Culturally competent adult education in literacy and English for Speakers of Other Languages courses (ESOL) available in accessible venues.	Attend ESOL/literacy classes if needed.	Learn by sharing good practice/expertise.  Work in partnership with statutory agencies to encourage educational attendance. Provide venues and other resources for education when possible.	Produce, implement and resource strategies that will improve child and adult literacy and English language skills and access to courses.
<b>Child and adult education services are hard to access for some groups.</b>	Gypsy Traveller children's education needs to be urgently addressed.  Awareness of health promotion to be raised (using community languages).	To encourage children to attend school regularly.  Gypsy Traveller children and parents to feel able to report maltreatment/ racism in schools.	Children of Gypsy Travellers to be better supported in schools.  Suggest ways Gypsy Travellers can be supported with their school work on Traveller sites.	Lead action to reduce racism and discrimination in schools.



Issue 3: Unmet Education Needs	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<p><b>Some groups have low uptake of health promotion because of poor knowledge of services.</b></p>	<p>Health promotion to be more culturally appropriate and sensitive.</p>	<p>Inform service providers of unmet needs and how best to meet their needs.</p>	<p>Advocate on behalf of disadvantaged groups to help get their needs met. Empower users to voice their needs.</p>	<p>Provide new migrants/asylum seekers with guidance on public services on entry, in culturally appropriate formats.</p>
	<p>Health promotion to be available in community localities/easily accessible.</p>			
<p><b>Some groups have poor uptake of health promotion if services are not culturally competent/easily accessed.</b></p>	<p>Patient information about GP practices to include gender of GPs, languages spoken and services provided.</p>	<p>To gain relevant information before registering with a GP practice.</p>	<p>Encourage use of premises for health promotion events if appropriate. Publicise health promotion on premises.</p>	<p>Ensure policies promote ease of access to health promotion.</p>
			<p>Contribute to the development of culturally competent services.</p>	<p>Ensure Gypsy Traveller sites are not remote and are in reach of public transport.</p>

<p><b>Issue 3: Unmet Education Needs</b></p> <p><b>Some health promotion providers/ policy makers have poor knowledge of roles and actions of other health promotion providers.</b></p>		<p><b>Solutions/ Recommendations</b></p> <p>Health alliances with good systems of communication and opportunities for interaction are formed.</p>		<p><b>Individual Responsibility</b></p> <p>Individuals join health alliances/partnerships.</p>		<p><b>Community/ Community Organisation Responsibility</b></p> <p>Encourage public to join health alliances. Contribute to capacity building for health alliances.</p>		<p><b>Government Responsibility</b></p> <p>Encourage inter-sectoral and inter-agency working/ public involvement.</p>
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Issue 4: Cultural Difference/ Language Barriers	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Health education/ information not always available in community languages.</b>	Health information to be available in diverse media and in languages of the community. Greater use of ethnic media.	Actively seek health promotion information/ make services aware of unmet needs.	Contribute to production of health information in community languages.	Provide resources to produce health information in diverse (and ethnic) media and in community languages.
<b>Interpretation is not always available and workers and users not always aware of its availability.</b>	Adequate level of provision of appropriate interpretation for health promotion interventions.	Inform service providers of own/family's need for language support services.	Contribute to development and provision of interpretation and translation services as appropriate. Ensure staff are aware of such services and how to access them.	Assess and monitor level of need and languages needed for interpretation/ translation.
<b>Health promotion workers unaware of cultural factors that impact on health promotion.</b>	Staff and users aware of what is available and how to access it.	Workers actively seek training in cultural competence.	Publicise the availability of interpretation/translation services.	Provide/commission training programmes for professional interpretation and translation provision and ensure adequate resources.
<b>Health promotion workers unaware of cultural factors that impact on health promotion.</b>	Culturally competent health promotion workforce. Training in cultural competence available for health promotion workers.	Workers actively seek training in cultural competence.	Encourage workers to attend cultural competence courses. Contribute to courses if possible/ appropriate.	Provide adequate resources to enable on-going training in cultural competence for workers in health promotion. Evaluate the impact of cultural competence training.

Issue 5: Health Protection	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Use of paan** and khat*** in some communities.</b>	Raise awareness of the dangers of paan and khat use. Make paan and khat illegal substances.	Seek information about paan and khat, their effects and dangers and how to stop use.	Actively participate in campaigns to raise awareness of paan and khat dangers/addiction.	Fund campaigns to raise awareness of paan and khat addiction.  Legislate to make paan and khat illegal substances.
<b>Adults and especially children are exposed to too much advertising of unhealthy foods.</b>	Reduction of advertising of unhealthy foods.  Promotion of healthy foods.  Improved labelling of packaged foodstuffs.	Parents to seek information on healthy eating and educate themselves and their children.	Initiate campaigns to raise awareness of healthy eating.	Regulate advertising of foodstuffs.  Legislate for improved food labelling.  Ensure healthy eating campaigns are culturally competent.
<b>High level of accidents on Gypsy Traveller sites.</b>	Safer environment on Gypsy Traveller sites.	Take responsibility for helping ensure safety on sites.	Contribute to/initiate activities that enhance the environment on sites and promote safety.	Local authorities to review inspection/site management procedures.  Improve street lighting and road safety in and around sites.

Issue 6: Power and Policies	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Some services' capacity to empower users is inadequate.</b>	Community development model of health promotion promoted whereby the public is empowered.	Become effectively involved in service planning and delivery.	Encourage community involvement and provide opportunities for development of relevant skills.	Foster concept and use of community development model.
<b>Minority ethnic groups' input and impact on policy and service planning is inadequate.</b>	Increase capacity of the study groups effectiveness in contributing to policy/ service development.	Take opportunities to develop skills that enable effective contributions.	Participate in the production of policies and strategies.	Lead by example.
		Contribute to policy development/reviews.		
<b>Some policies hinder the success of other policies.</b>	'Joined up working' between sectors (statutory, voluntary and community/commercial).			Maintain overview of all social/environmental and health policies ensuring they work in the same direction taking a whole systems approach.
<b>Some minority ethnic groups, women and Gypsy Travellers poorly represented in some health/welfare roles.</b>	More minority ethnic groups, women and Gypsy Travellers in positions of power in health/welfare services.	To consider health and welfare work as a career.	Encourage recruitment of more people from minority ethnic and Gypsy Traveller groups and women.	Provide resources for recruitment drives to increase numbers of minority ethnic and Gypsy Traveller groups and women.

Issue 7: Issues for Further Research and Development	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
<b>Health ASERT Programme Wales has provided considerable research evidence on the health promotion needs and problems of our study groups.</b>	Focus on implementation of the Health ASERT Programme Wales' recommendations through action research and service development.	To contribute to the success of the Research and Development (R&D) projects.	To provide advice, facilitation and be actively involved in the R&D projects.	Provide leadership and resources to enable the R&D projects.
	1. Wales-wide scheme for cultural competence training for health promotion workers.			
	2. Establish a Wales-wide working party to develop indicators for systematic collection of health promotion data and monitoring/auditing of services.			

Issue 7: Issues for Further Research and Development	Solutions/ Recommendations	Individual Responsibility	Community/ Community Organisation Responsibility	Government Responsibility
	<p>3. Establish a Gypsy Traveller Health Promotion action group to prioritise and act upon the Health ASERT Programme Wales' findings that relate to them.</p> <p>4. Establish a 'Health Promotion Information for Users' task force to prioritise and act upon the Health ASERT Programme Wales' findings.</p> <p>5. Appoint an advisor specialising in Health Promotion for minority ethnic groups (at Welsh Assembly Government level).</p>			

### **\* Definition of cultural competence:**

*‘Cultural Competence is the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs. Cultural Competence requires a commitment for the promotion of anti-oppressive, anti-discriminatory practices. It also emphasises the importance of empowering clients to participate in health care decisions, therefore it is imperative that health care professionals must recognise how society constructs and perpetuates disadvantage’ (Papadopoulos I (2003): The Papadopoulos, Tilki and Taylor model for the development of cultural competence in nursing. JHSEI, 4, 1, 5-7.*

### **\*\* Definition of paan:**

*Paan is a green leaf and is chewed with a paste made of limestone and betel nuts, which sometimes also includes coconuts or cloves. It is not uncommon for tobacco to be added. Chewing is very widespread amongst Bangladeshis.*

[http://www.nhsinherts.nhs.uk/hp/health\\_topics/ethnic/ethnic\\_smoking.htm](http://www.nhsinherts.nhs.uk/hp/health_topics/ethnic/ethnic_smoking.htm)

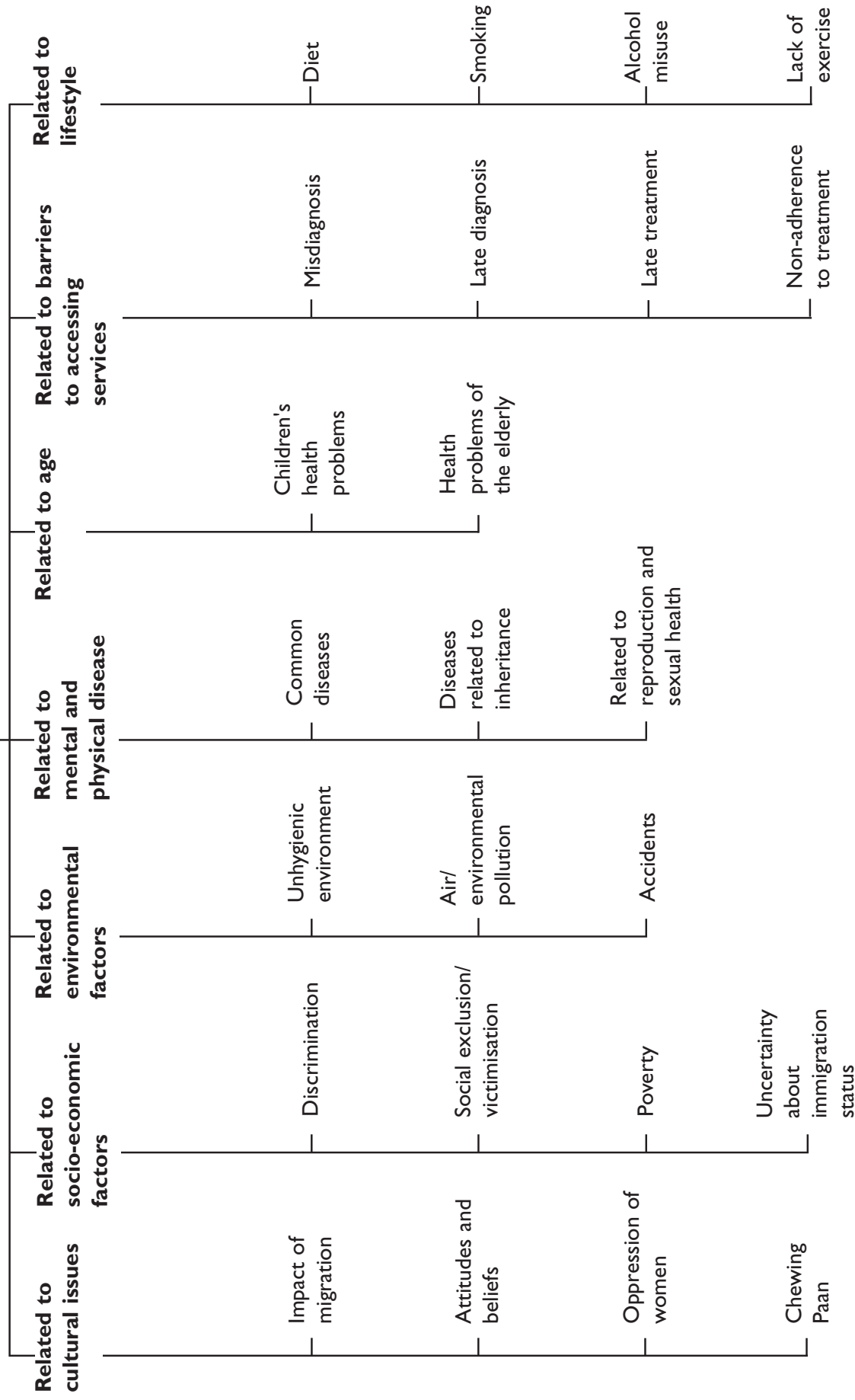
### **\*\*\* Definition of khat:**

*Khat [qat] is a green-leafed shrub that has been chewed for centuries by people who live in the Horn of Africa and Arabian Peninsula. It is a stimulant drug with effects similar to amphetamine.*

[http://www.drugscope.org.uk/druginfo/drugsearch/ds\\_results.asp?file=%5Cwip%5C11%5C1%5C1%5Ckhat.html](http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=%5Cwip%5C11%5C1%5C1%5Ckhat.html)

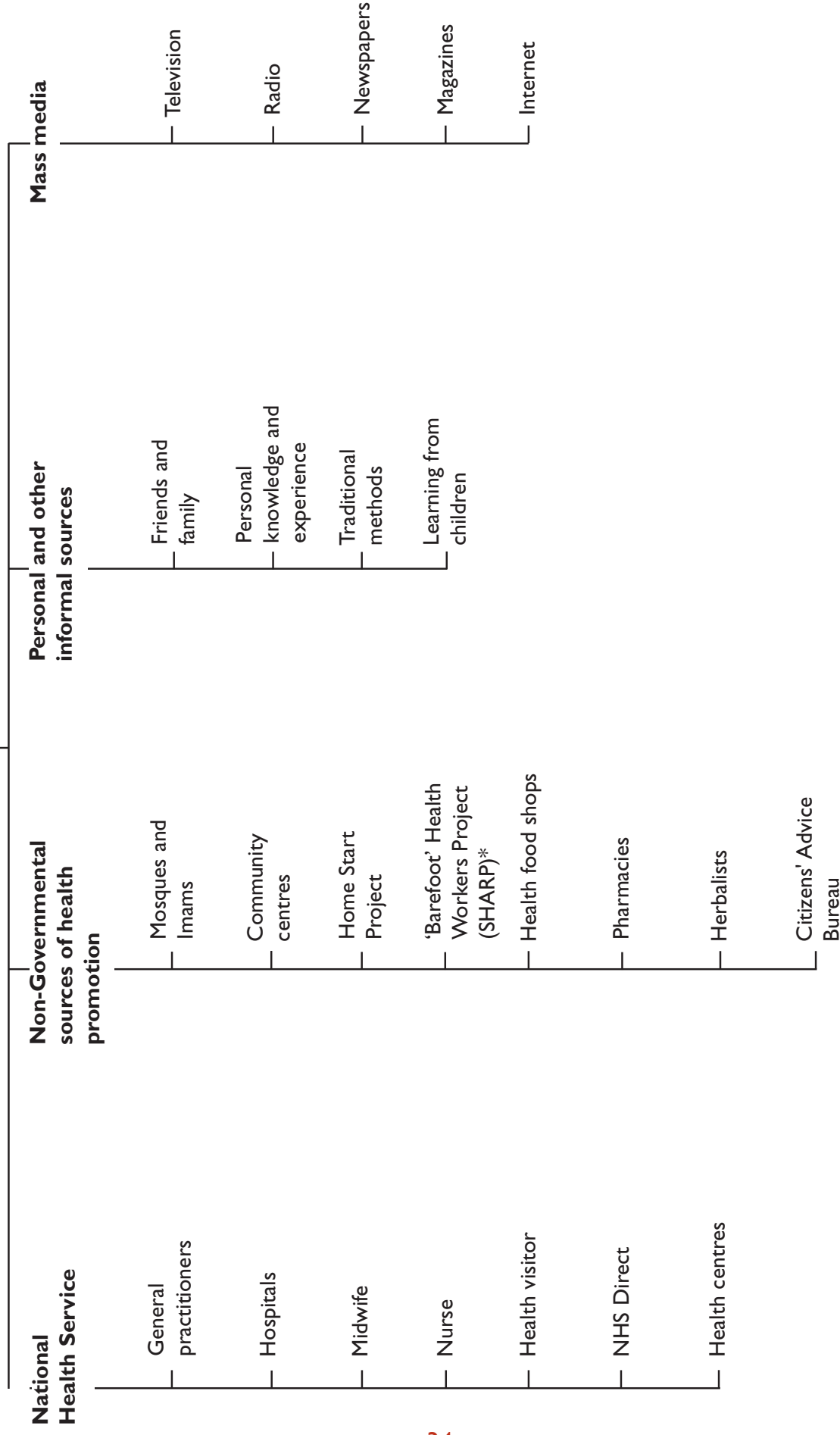


## Summary Chart I Main Health Problems

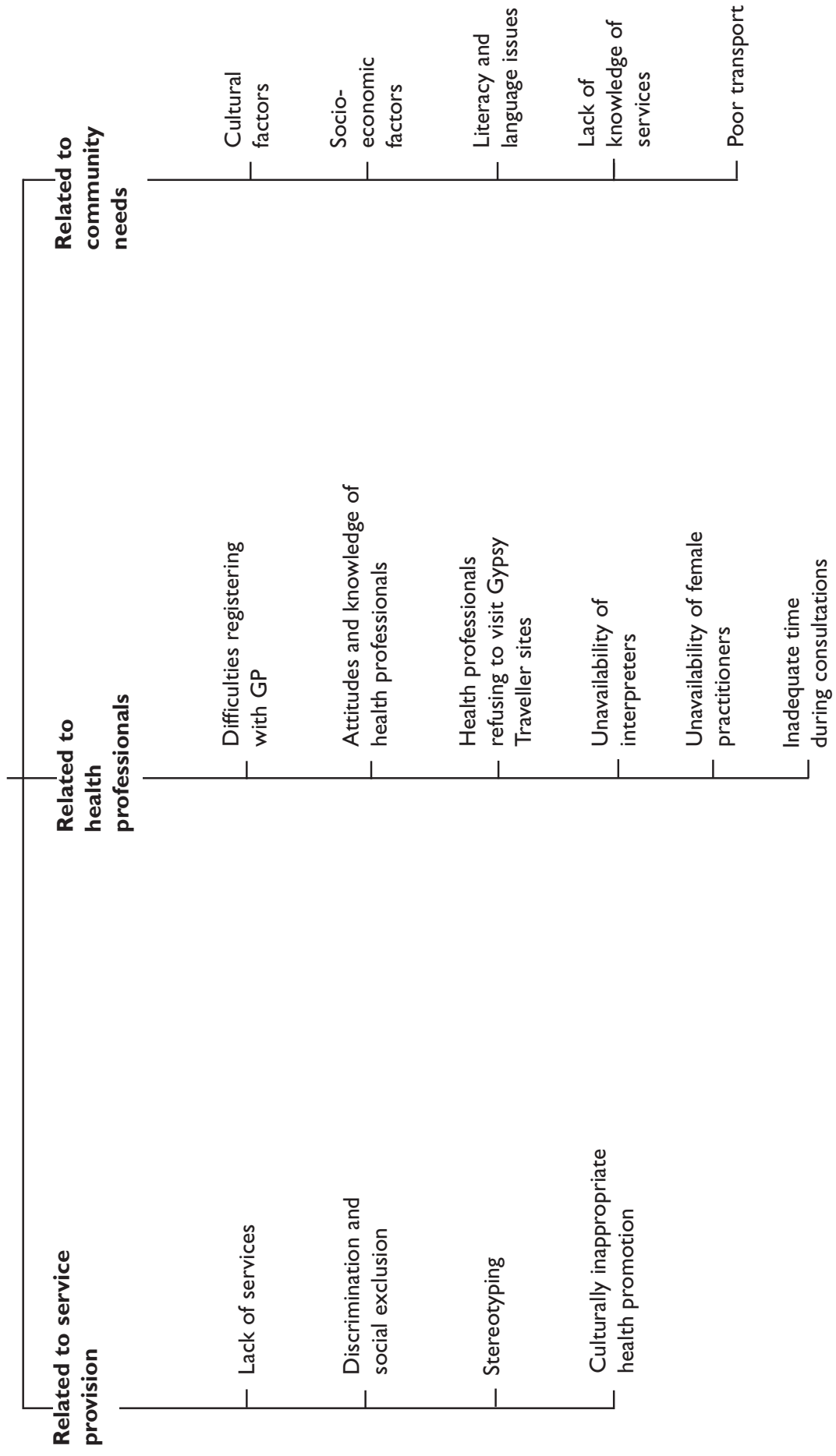


## Summary Chart 2

## Access to Health Promotion

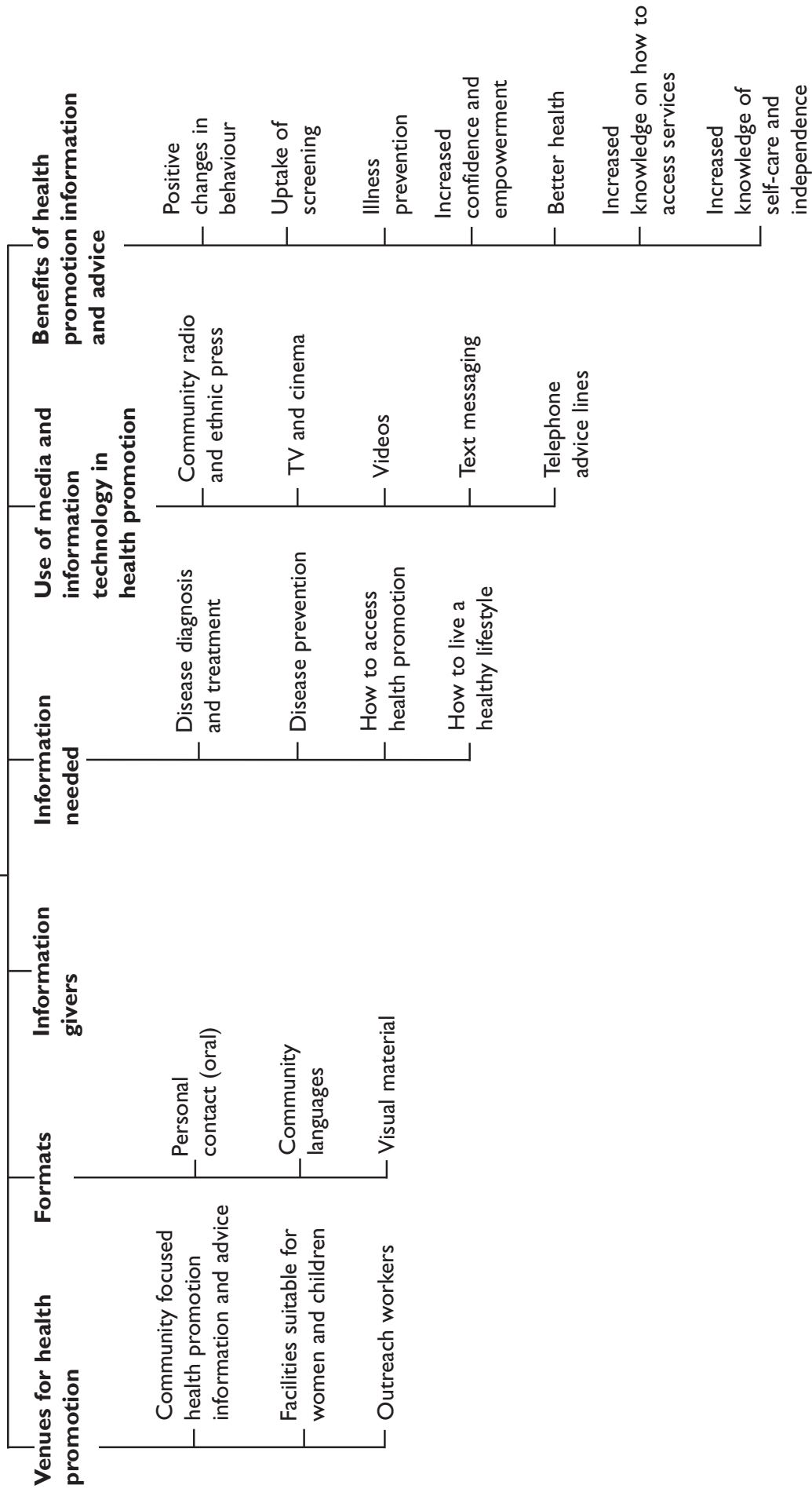


## Summary Chart 3 Problems Accessing Health Promotion

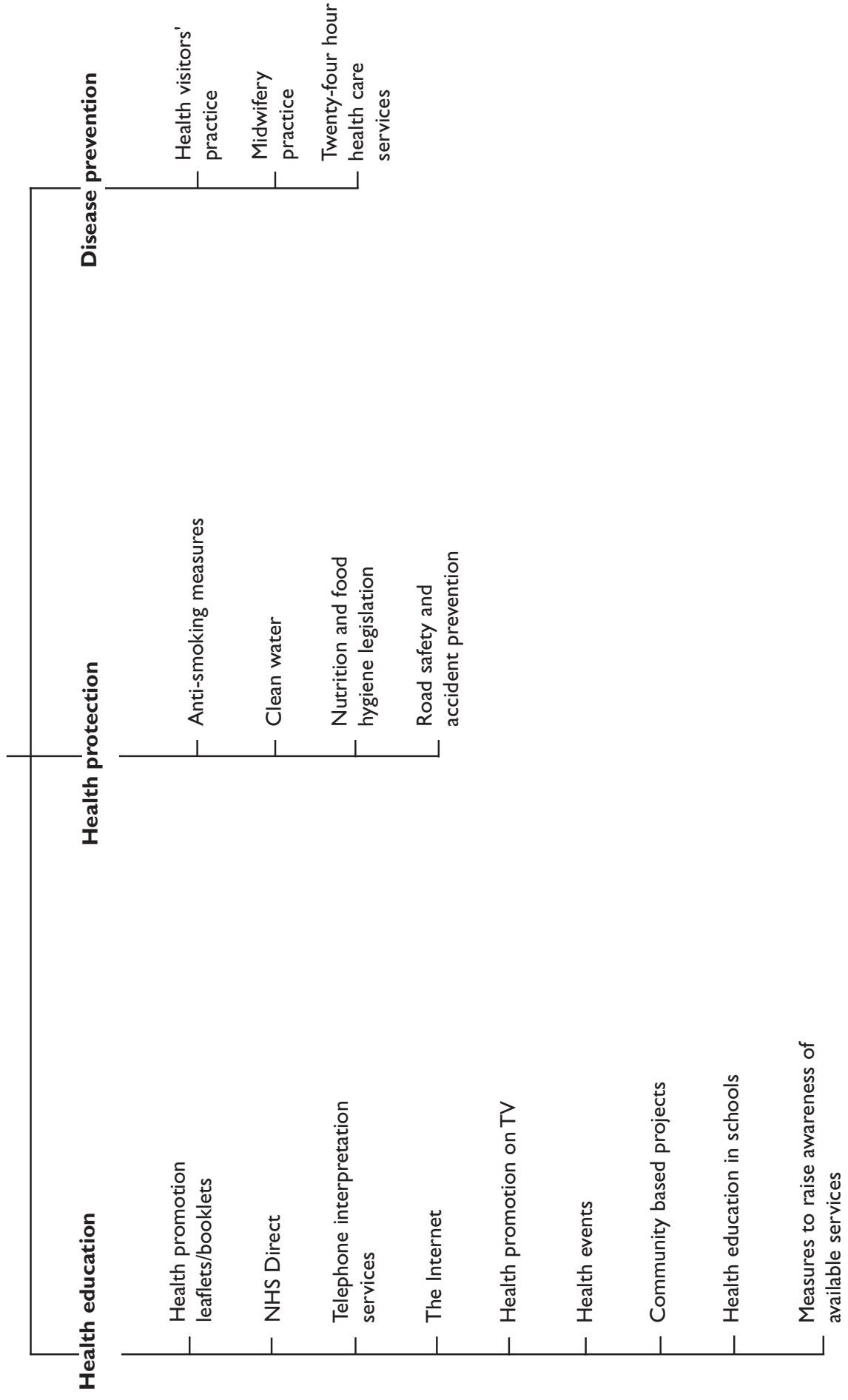


# Summary Chart 4

## Culturally and Linguistically Appropriate Health Information and Advice



## Summary Chart 5 Good Practice in Health Promotion



## Summary Chart 6

## Actions for Health Improvement

