CENTRE FOR RESEARCH IN ETHNIC RELATIONS

It’s Our Health Too: Asian men’s health perspectives

Summary report

The SAHARA Project

by *Mark Johnson*

and *Chaman Verma*

Research Paper in Ethnic Relations No.26

Its Our Health Too: Asian mens health perspectives

Summary report

The SAHARA Project

An Action research project sponsored by Southern Birmingham Community
Health NHS Trust and the NHS Executive Ethnic Health Unit

Mark R D Johnson June 1998
University of Warwick

With the help of

Chaman Verma
(Birmingham Health Promotion)

The Centre for Research in Ethnic Relations is a Designated Research Centre of the Economic and Social Research Council. The Centre publishes a series of Research, Policy, Statistical and Occasional Papers, as well as Bibliographies and Research Monographs. The views expressed in our publications are the responsibility of the authors.

Price: £4. 50 (including handling charge and VAT)

Orders for Centre publications should be addressed to, Centre for Research in Ethnic Relations, Social Studies Building, University of Warwick, Coventry CV4 7AL. Cheques and Postal Orders should be made payable to the **University of Warwick**. We also accept Visa, Delta, MasterCard, Eurocard and JCB (Japan Commercial Bank) cards.

ISSN 0266-6634
ISBN 0 948303 89 1

Mark R.D. Johnson is Reader in Primary Care, and Associate Director of the Mary Seacole Research Centre, De Montfort University, Leicester. He has developed a substantial body of research and publications relating to health and welfare service delivery sensitive to ethnic and cultural diversity, and regarding barriers to access. He has worked closely with practitioners and community groups and acts as a consultant with Health and Local Authority bodies and community voluntary organisations to develop appropriate models of service delivery and professional training. His recent publications include *Social Work and Minorities: European pespectives* (Routledge 1998), *Refugees and primary health care in the West Midlands* (CRER), *Dealing with Diversity* (Home Office DPI), book chapters on Culture, Race and Discrimination in Psychiatry and Equal Opportunities in Service Delivery, and journal articles on Occupational Therapy and Health Promotion.

Chaman Verma is co-ordinator of the Nexus Project. This is a Department of Health funded project whose aim is to demonstrate and promote best practice in the delivery of acute services for Black and Ethnic Minority communities. He has worked in the area of ethnicity and health for the past 20 years and has developed and implemented best practice in such areas as primary and secondary Health Care, Learning Disabilities, Health Education, Mental Health and Organisational Change.

Executive Summary: Health perspectives and health promotion needs of Asian men in Birmingham - The SAHARA Project

This report describes the findings of research undertaken in South Birmingham (Small Heath/Sparkbrook) supported by the National Health Executive Ethnic Health Unit and the Southern Birmingham Community NHS Trust, conducted in partnership with community-based organisations. The objectives of the study were to explore the dimensions of variation in health perceptions and needs within Asian ethnic groups. A broad definition of Asian included Arabic (Near East) and Chinese (Far East) groups.

The research used a qualitative interview strategy aimed specifically at men, and explored the degree to which men felt that they had a responsibility for their wifes or childrens health. We used both established groups and interviews with individuals following a topic guide developed from concerns expressed by the Birmingham Community Health Trust and Health Promotion Unit, the research literature, and the suggestions of the steering group. It was crucial to the interviewing process that the interviewers were matched to the people with whom they would be conducting the focus group interview. The project worked very closely with community organisations. All interviewers were given a full days training and monitored for quality checking.

Findings:

Most groups had a fairly instrumental approach to their health - seeing it as necessary to perform their duties of care for the family and to earn money for their upkeep. Good health was seen as a gift from God, but the responsibility of the individual to maintain his health, and that of the family, was also highly salient. Age, however, was seen as leading inevitably to poorer health, and poverty and environmental deprivation were also constraints on the individuals capacity to affect health. There were very clear differences between the groups interviewed, with some being more likely to express health in physical terms, and others more aware of mental and aesthetic issues. Nearly all those interviewed were enthusiastic about the possibility of learning more about health and health services, but sought such information from within existing community networks and settings - as for example through classes in community centres. There was a clear Islamic view, but members of other religions also spoke of the religious and cultural beliefs and the need for certain elements of these to be observed and respected by the system. The most commonly expressed concern here was for gender separation - but it should be noted that this was not only a

desire for women to be seen separately and by female staff, and also concerned the mens own feelings of propriety.

Most men attempted some actions to maintain health, although this was largely related to eating good (i.e. freshly prepared, natural) food, and taking light exercise, mainly by walking, prayer, and working. Younger men were more likely to be aware of, and take recreational exercise, but poverty and absence of suitable facilities locally were seen as barriers. Several mentioned the cold or cold weather. A wide range of facilities, including environmental health and sports, were seen as health services.

A more detailed analysis, referring to each of the groups interviewed, is also available and contains greater detail about their specific requirements.

Conclusions and Recommendations

There are often subtle differences between the expressed priorities of the different communities. One of the key recommendations is that each wishes to be seen as having its own specific cultural identity, and any action taken to seek to work with them towards improved health and better service use, will need to recognise and act on this.

It is necessary that health services are seen to be taking action: simple measures such as provision of translated literature send signals that concerns are being attended to.

Cheaper / accessible leisure service provision should be encouraged and publicised.

Wherever possible, single sex (male and female-only) provision should be available.

Interpreters and/or bilingual staff should be recruited and used widely.

Receptionists should be recruited from the minority communities, and training provided also in cultural sensitivity, and perhaps in some language skills.

Most groups needed more information on professions and services allied to medicine.

Outreach visits, both to the home, and to temples and community centres to offer health check-ups and advice, will meet a need and raise the visibility of key services.

There is a high level of demand for information about certain diseases: arthritis or joint pain were mentioned most commonly: also smoking, cancer and bowel disorder.

There was a consensus among most groups that they wanted to learn more - and that a mixture of practical demonstration and culturally specific advice was most effective.

While Diabetes was well-known at a basic level, there was a severe lack of appropriate technical knowledge: NIDDM was poorly understood; Asian dietary advice is needed.

The concept of prevention is accepted but poorly understood and needs reinforcement.

Loss of income affects service use: evening or weekend provision, outreach, and home visits or provision through schools, may help raise uptake of preventive services

Transport was rarely seen as a problem except for elders, who may be reached through community centres and day-care provision: these could use any support offered.

Health promotion initiatives should build on Asian values, including key features of the diverse cultures (Yoga, anti - tobacco or -alcohol feeling etc) and where possible provide classes by language and culture-competent staff in community centre settings.

Recruitment of staff from within communities will raise incomes as well as awareness and decrease barriers to access.

Mark R D Johnson & Chaman Verma April 1998

Introduction:

This report describes the findings of an innovative research project undertaken in South Birmingham (Small Heath/Sparkbrook) as part of a health promotion and community development activity supported by the National Health Executive Ethnic Health Unit and the Southern Birmingham Community NHS Trust. The research was conducted in partnership with community-based organisations from within the Asian population of the city, and particularly worked closely with the Muath Welfare Trust. The origins of the research were located within the perception, supported by research (cf. Fenton, Hughes & Hine 1995; Lip, Luscombe, McCarry, Malik and Beevers 1996), that there are significant variations, not simply between White (majority) and Asian (populations deriving from the sub-continent of India) perspectives on health, but also within that latter category. Because of the community-based setting and inputs from the partner agencies, a broad approach was taken to the definition of Asian including both Arabic (Near East) and Chinese (Far East) groups.

The Topic Guide used for this study is incorporated in the appendix to this report. It was developed from concerns expressed by the sponsors of the research (Birmingham Community Health Trust and Health Promotion Unit), with guidance from the literature relevant to the subject, and the suggestions of the steering group. It was then tested (piloted) by CV with some members of the Asian communities, members of the project management group and the steering committee, before being agreed with the community organisations and steering group. The layout of the document used in the field was slightly different, using larger print and spread over several pages in order to allow facilitators to add a few notes of conversations at appropriate points, without producing a thick and off-putting script.

As outlined above, an important facet of the process of the project was the intention to empower, train and support local community organisations to actually carry out the research. It was crucial to the interviewing process that the interviewers were matched (i.e. male, and from the same ethnic, religio-cultural and linguistic background) to the people with whom they would be conducting the focus group interview (Rhodes 1994). Consequently, from an early stage the project worked very closely with the community organisations, who were responsible for providing both the focus groups and the recruits who were to be trained (and subsequently paid) to collect the information required.

As has been remarked by an increasing number of commentators, the broad label of Asian covers at least as many cultural groupings as can be found in Europe. On the Indian subcontinent alone it disguises several nationalities, at least five language groups or families, and four major religious traditions, each of which has its sects or sub-groups. All of these are likely to hold divergent health beliefs, in terms of models of causation and values. Without fuller understanding of these differences, effective transmission of health promotion messages is likely to be more problematic (Johnson 1996).

Seven groups were located as partners (see appendix), and they identified twenty-four men who were willing to undergo the training. There was no formal interviewing or qualification screening of these men, but it was apparent that several of them had quite impressive credentials yet were in many cases unemployed or only working as community workers in a voluntary role. At least two had postgraduate qualifications from UK universities, and others had been made redundant or taken early retirement from a variety of occupations; another was a qualified priest. All were approved by the project co-ordinator (CV) and worked closely with him and the project support officer (Mr A Kamruzzaman) who provided additional liaison and guidance in the field. Quality assurance was also ensured by the attention of Chaman Verma, who checked transcripts and tapes before their submission for analysis.

The use of focus groups as an accepted method of social scientific qualitative research has grown enormously in recent years. Much of their use has been involved in the fields of sociological and political research but there is also precedent for their application in health-related sciences. The approach, with its bringing together of expertise and community representatives, also contained some elements of the approach used in France and known as sociological intervention: this was in a sense correct, since it was an explicit expectation, or at least hope, that this form of action research would in itself begin the process of change and raise awareness in the communities. Some researchers insist that it is better to use groups that already exist, rather than creating artificial settings, where members of the group are possibly presenting formal positions although it might also be argued that established groups will have established norms which may over-ride individual views, and that people may feel more free to express uncertainty or controversial opinions in the safety of an anonymous unfamiliar setting. Other studies of ethnic minority community research suggest that there may be a stronger fear of expressing unorthodox feelings in front of strangers who

may be critical, and that such mixed groups are more likely to lead to the expression of conventional positions. We have adopted an approach that combines both the use of established groups and interviews with individuals, which may include a selected number of members of the original groups to establish whether there are such changes, or to tease out issues which are not fully explored in a group setting. This, by a form of triangulation, should overcome the problems of typicality and peer pressure: age-separated groups also reduce expression of conformity to established norms.

Findings

The research has shown the potential for using locally recruited interviewers from within minority communities, with suitable training, and hopefully will present an alternative form of community consultation which can be used to the mutual benefit of both health (and other) authorities and agencies, and the communities themselves. We believe that at least some of the insights, and the ethno-cultural specificity displayed in this analysis, would not otherwise have been easily established and that the distinctive-ness of the communities is highlighted, providing valuable guidance for future policy and practice development. It would be of interest, and of considerable value, to adopt a similar approach in respect of other minority communities, particularly the African-Caribbean and refugee groups of the city, which also contain a much higher level of internal diversity than is sometimes acknowledged. Similarly, we would insist that the perspectives of women should not be neglected - we have deliberately examined those of men, since it was our understanding that these had hitherto been neglected, but we are also aware that few studies have considered this level of disaggregation, frequently treating all Pakistani women, or even all Asian women, as being similar. The analyses presented here demonstrate how dangerous such homogenisation can be.

The following summary looks at the analysis in two ways - firstly, topic by topic, to consider questions of significance to the policy makers in respect of overall priorities. Secondly, we examine the differences between the minority mens communities, insofar as this may be of value in prioritising action on each of the major dimensions, and in respect of their specific organisations or communities.

The following represent the key points arising from the SAHARA project. In many cases there are subtle differences between the expressed priorities of the different communities. One of the key recommendations is that each wishes to be seen as having its own specific cultural identity, and any action

taken to seek to work with them towards improved health and better service use, will need to recognise and act on this.

It was also apparent that several of the communities appeared to have a low self-image and that any approaches to them would need Confidence building measures in the strategy - giving them greater ability to deal with officialdom and professionals.

What is Good Health

Opinions varied but most groups had a fairly positive, albeit instrumental approach to health. While there were expressions of the God gives it variety, most men did recognise their own responsibility for health maintenance. They were however perhaps more likely to expect and accept a deterioration in mobility and comfort with age: expectations could be raised through education, as long as these were kept achievable! Their main objective was to enjoy life, to be able to work to keep their families - and participate in community based activity.

Services used and seen as important

There was general recognition of Health Centres/General Practice, and Dentists, Hospitals and Clinics were all frequently mentioned. A very significant number also mentioned services such as parks, leisure centres, exercise facilities and in some cases, the emergency services, environmental health department and cleansing department: a very wide view of services to maintain health was apparent, although certain groups had very much narrower fields of vision or were less aware of what was provided.

Access in terms of physical transport was rarely mentioned as a problem: people walked, took the bus, or drove (or were driven by family members) to GP, Hospital etc. Any suggestion that this prevents people from using (e.g. dentists) is probably due to a lack of priority being given to the activity, i.e. an excuse! Some day centres, (such as those run by community groups) offered transport to elders, which was appreciated.

How to make access to services easier

Working unsocial (night-restaurant) hours makes access to provision of all sorts problematic for Chinese and Bangladeshi groups: this includes exercise facilities. Weekend and afternoon provision was suggested.

Several groups indicated that they wanted men-only exercise and other activities. This was part of a wider concern for cultural recognition - notably respect for their own traditions such as the distinction between what is Halal and Haram (Islamic precepts).

A major barrier was the rudeness or cultural incompetence of receptionists, who seemed to give a bad impression: language barriers arose here too. There may be scope for training courses, and this might include (?S38 exemption) access courses to increase recruitment of counter staff from the minority communities?

Use of Other Staff at medical centres

In general, most respondents mentioned the receptionists and nurses, specifically in conjunction with travel vaccinations and flu jabs. Most seemed happy with the services of the nurses, but there was a widespread lack of awareness of their role, and even of their existence. A large number of men suggested that they only really trusted the Doctor - but equally, nearly all those who had experienced the services of the nurses (etc) were very positive about them, especially the greater amount of time they could spend. There may be scope for increasing this use, but care will need to be taken as there was also a dislike among some men of being seen by women. On the other hand, female attached staff were very highly valued for their work with women.

Most groups did seek female (language-competent) workers, including reception and nurse/therapy staff for their wives and daughters. As a general rule, other staff were seen as there for (and known more by) the women of the family.

Health Visitors (performing the outreach role by coming to the home) were very highly appreciated.

Most groups needed more information on professions and services allied to medicine (Therapies etc).

Suggestions also included visits by the Primary Health Care Teams to temples and community centres to offer health check-ups and advice, and raise their visibility.

Perceptions of Key Diseases

As a general rule, the perceptions of key diseases were fairly predictable, although there was less awareness among some groups than would be desirable. Diabetes, heart disease and arthritis or joint pain were mentioned most commonly: certain

groups appeared to be more concerned about asthma. Mental health was less commonly highlighted but (for example) the Pakistani Punjabi group spoke at some length about family problems and the effects of deprivation, which might be read as stress etc.

There was a considerable level of concern about smoking, cancer and bowel disorder.

Diabetes

Was known to be linked to sugar intake but prevention was very poorly understood, and the link to obesity and exercise virtually unknown. There was a sense in which it was seen as an inevitable consequence of age, and insulin well known: the NIDDM variant, which is probably more important, was not much in evidence from replies.

Stress

Was fairly freely discussed by most groups, and linked to work, family, and routine: Yoga, a sense of community and participation were seen as helpful, as was religion. Many of the causes of stress were seen as being outside their control, but there were considerable differences between the groups in their response to this disease.

Heart Disease

The link between heart disease and diet was almost universally recognised, and while some people knew that exercise was a means of prevention, others felt that it could be cured by an operation (bypass). Stress and mental pressures were also widely blamed.

Depression

There were, in general, few distinctions drawn between depression and stress, but some groups did speak about one more than the other. Again, the most effective preventive behaviour was to be interested in things, and to take part in community activity or have a wide circle of friends. The clinical element was known to some, but not widely mentioned, although psychiatry, taking doctors advice etc were spoken of.

Asthma

This was seen as a major problem by most groups, and known to be treated by pumps (inhalers) etc: it was largely attributed to pollution, dust and smoke, and often seen as something that

young people grew out of. You cannot avoid pollution. Cleanliness and pride in keeping the home clean, warm and dry were the main preventive actions.

Other Named Worries

There was a lot of concern about arthritis or joint pains; kidney disease and cancers were also mentioned, as were some other bowel disorders: again, there was some variations between the groups, which may be due to the individuals or genuine ethnic concerns. Bangladeshi (restaurant workers) for example seemed very concerned about bowel disorders, stomach cancers etc. Flu and sexual health were also mentioned.

How can men learn about these issues

There was a consensus among most groups that they wanted to learn more - and that a practical approach, with demonstrations and culturally specific advice, was most effective. This, for example, Yemenis wanted advice on the effects of Qat; Bangladeshis on Paan. Sikhs, exceptionally, mentioned sexual health issues.

Own-language (generally single sex, and sometimes age-specific) classes at weekends or evenings, generally facilitated by a member of the community and based at a community centre (sometimes but not always a religious centre) with simple health messages about first aid and nutrition were often requested.

Overall Summary

It is clear that all groups felt in some way left out, and that their language needs were not being met - normally in respect of their wives and perhaps daughters, but sometimes they would admit to problems in explaining things - usually because they did not feel that the doctor or other health professional fully understood their culture.

There was a high level (generally) of support for the idea of classes, which generally were looked for to be held in their own language, with suitable support materials, and held in familiar surrounding such as a community centre or religious building, perhaps after prayer, and in evenings and/or at weekends - with key exceptions (notably Chinese and Bangladeshi restaurant workers who had restricted times of availability).

Explicit recognition to each culture, and language group, will reassure users. It is still helpful to provide printed

materials in those languages - Arabic speakers noticed that theirs were missing - but it would be dangerous to assume high levels of literacy - especially in Chinese and non-written dialects of South Asian languages.

Sport and Exercise facilities were under-known and under-used, and excuses made included their absence, or cost. These may perhaps be overcome by better information, but gender segregation seemed a common request for men as well as women.

Overall, interpreter facilities, or preferably availability of bilingual reception and health visitor (outreach) staff, were widely requested - gender sensitivity was a factor here.

Most men expressed satisfaction with their GP, especially when they had managed to get a female to treat their wives and a male for themselves, and if the GP spoke their language or was familiar with their culture. There were varying opinions about appointment systems, and longer consultations would be popular, but this need might also be met by giving greater direction and status to the role of attached staff (nurses etc) should the doctor explicitly refer to them - and if they too were culturally aware.

There is considerable scope for training lay/barefoot/peer outreach health promotion workers to facilitate discussion groups and bring together groups for speakers to address - these should wherever possible be internally homogenous and targeted.

The mens groups who took part in this exercise were all universally interested and keen to see how their communitys health might be improved, although some were lacking in self-esteem and needed convincing that they could make a difference. There is a considerable reservoir of interest and concern, and willingness to be involved.

Group-by-group analysis

The following represent the key points arising from each of the specific groups who took part in the SAHARA project. In some cases there is a repetition, but in many cases there are subtle differences between the expressed priorities of the different communities.

Arab (Non-Yemeni)

Were very concerned about the distinction between what is Halal and Haram (Islamic precepts).

Wanted men-only swimming and exercise activities

Arabic-speaking professionals and literature (posters and leaflets) were a priority: the Arabic script is distinctive and used for religious reading: its use sends a clear message.

Arabic-language classes at weekends or evenings, with simple health messages such as first aid and nutrition were requested.

A list of common medical terms (bilingual - English and Arabic) would make communication with medical professionals easier.

Bangladeshi (Sylhetti)

Working unsocial (night-restaurant) hours makes access to provision of all sorts problematic: this includes sports club or exercise facilities.

Men-only provision (notably for exercise) was desirable

Confidence building measures are needed with this community

There was enthusiasm for informal discussions around health issues at times when they are not working.

NB Sylhet dialect is not generally written but spoken.

Bangladeshi (Dhaka)

Some overlap with Sylhetti group but a distinct linguistic (dialect) group

Also working anti-social hours: demand for weekend and afternoon surgeries.

Felt need for female Bengali speakers for their wives benefit.

Support for home visits by Health Visitors (less clear about need for language here).

Chinese

Reported that their day off when available for clinics and classes is Tuesday

Health promotion materials should be highly pictorial, few words even in Chinese.

Keen to make links with Chinese health centres in London, Manchester, Liverpool
Demand for Chinese speaking, or interpreter provision at, dentists.

Hindu Gujeratis

Were generally well informed and educated but still require interpreter support for older generation

Want firm advice and to be called in for check-ups. Provision of these through Hindu temples and community centres would be highly acceptable. Positive outreach wanted.

Needed information on professions and services allied to medicine (Therapies etc).

Suggested weekend classes at which videos are shown would be popular, provided it was organised as a social event.

Hindu Punjabis

Recommended visits by the Primary Health Care Teams to temples and community centres to offer health check-ups and advice.

Language was less of an issue with this group but cultural sensitivity critical.

Bilingual services in sports centres would be desirable.

Unusually, were encouraging of mixed (male and female) groups, notably in parentcraft and child health issues.

Pakistani Kamalpuris

Poverty was an issue specifically raised

Locally recruited community members trained in health extension work wanted.

Local cheap (?subsidised) exercise and library facilities were a priority, preferably staffed with Muslim workers who would understand religious requirements.

Classes might need to be stratified by age as well as sex, and offered at the Mosque on Fridays and weekends.

(Pakistani) Mirpuri/Kashmiris

Community development activity to raise a sense of empowerment was a necessity (cf. Sylhetti group)

Any activity would need to be positive about Islam, and make explicit recognition that Mirpuri culture was valued and distinctive (this includes linguistic/dialect issues).

Outreach to those attending the night prayers during Ramadan was suggested
Provision should separate men and women, and be culturally (Islam) sensitive.

Pakistani Punjabi

Offered less support for courses (though some would like these) but focused more on the development of day centre provision which could provide a locus for HPU work.

Observed that practice of religion could provide opportunity for exercise

Felt that Sparkbrook area was discriminated against in terms of sports/exercise facility provision and wanted a football pitch etc: may be scope to pressure Local Authority or advertise existing facilities better.

Female doctors and Punjabi-speaking reception staff a priority for surgeries/clinics

Pakistani Pathans

Were positive about Asian language videos shown in health centre reception area

Wanted women interpreters (for women patients)

Suggested a rota of visiting speakers making outreach to the mosques

Indoor exercise or recreation facilities for female members of community

Punjabi Sikhs

Suggested Sikh days as well as gender segregation (men only) in leisure and other service facilities. Tobacco smoking widely seen as offensive in sports centres, and acted as a deterrent to access.

Punjabi speaking Health Visitors wanted

Dietary advice should be tailored to eastern foods and tastes - and could be usefully offered to the langar (Gurdwara communal kitchen)

Classes in cooking and exercise should be offered in evenings or weekends at the Gurdwara

Yemeni (Arabs)

Were looking for (culturally sensitive) advice and support on cutting down smoking

Needed somewhere for older men to meet for recreation and social interaction, especially in cold weather times

Suggested an Arabic-speaking female doctor (and telephone helpline)

Information should be provided in Arabic, subjects including Qat.

Some men wanted evening classes on a variety of subjects.

Conclusions and Recommendations

Most groups had a fairly instrumental approach to their health - seeing it as necessary to perform their duties of care for the family and to earn money for their upkeep. Good health was seen as a gift from God, but the responsibility of the individual to maintain his health, and that of the family, was also highly salient. Age, however, was seen as leading inevitably to poorer health, and poverty and environmental deprivation were also constraints on the individuals capacity to affect health. There were very clear differences between the groups interviewed, with some being more likely to express health in physical terms, and others more aware of mental and aesthetic issues. Nearly all those interviewed were enthusiastic about the possibility of learning more about health and health services, but sought such information from within existing community networks and settings - as for example through classes in community centres. There was a clear Islamic view, but members of other religions also spoke of the religious and cultural beliefs and the need for certain elements of these to be observed and respected by the system.

The most commonly expressed concern here was for gender separation - but it should be noted that this was not only a desire for women to be seen separately and by female staff, and also concerned the mens own feelings of propriety.

Most men attempted some actions to maintain health, although this was largely related to eating good (i.e. freshly prepared, natural) food, and taking light exercise, mainly by walking, prayer, and working. Younger men were more likely to be aware of, and take recreational exercise, but poverty and absence of suitable facilities locally were seen as barriers. Several mentioned the cold or cold weather. A wide range of facilities, including environmental health and sports, were seen as health services.

There are often subtle differences between the expressed priorities of the different communities. One of the key recommendations is that each wishes to be seen as having its own specific cultural identity, and any action taken to seek to work with them towards improved health and better service use, will need to recognise and act on this.

- It is necessary that health services are seen to be taking action: simple measures such as provision of translated literature send signals that concerns are being attended to.

- Cheaper / accessible leisure service provision should be encouraged and publicised.

- Wherever possible, single sex (male and female-only) provision should be available.

- Interpreters and/or bilingual staff should be recruited and used widely.

- Receptionists should be recruited from minority communities, and training provided in cultural sensitivity, and perhaps in some language skills.

- Most groups needed more information on professions and services allied to medicine such as therapists, practice nurses and health visitors.

- Outreach visits, both to the home, and to temples and community centres to offer health check-ups and advice, will meet a need and raise the visibility of key services.
- There is a high level of demand for information about certain diseases: arthritis or joint pain were mentioned most commonly: also smoking, cancer and bowel disorder.

- There was a consensus among most groups that they wanted to learn more - and that a mixture of practical demonstration and culturally specific advice was most effective.

- While Diabetes was well-known at a basic level, there was a severe lack of appropriate technical knowledge: the specific characteristics of NIDDM were poorly understood; and in particular Asian dietary advice is needed.

- The concept of prevention is accepted but poorly understood and needs reinforcement.

- Loss of income affects service use: evening or weekend provision, outreach, and home visits or provision through schools, may help raise uptake of preventive services

- Transport was rarely seen as a problem except for elders, who may be reached through community centres and day-care provision: these could use any support offered.

- Health promotion initiatives should build on Asian values, including key features of the diverse cultures (Yoga, anti - tobacco or -alcohol feeling etc) and where possible provide classes by language and culture-competent staff in community centre settings.

- Recruitment of staff from within communities will raise incomes as well as awareness and decrease barriers to access.

Tabulation of Key Points regarding Health Promotion elicited with Sahara Project Groups

	Men-only	Interpreters	Speakers @	Islam	HP Class *	Posters/ leaflets	HV out-reach	Check-ups	Exercise	Mosque/ Temple	
Arab	#		#	#	#	#			#		1
B. Sylhetti	#			#	#				#		2
B. Dhaka				#			#				2
Chinese		#	#			#					2
H. Gujerati		#	#		#	#		#			
H. Punjabi			#		#		#	#	#	#	
Kamalpuri	#3		#	#	#				#	#	4
Kashmiri M	#		#	#	#					#	5
Punjabi (P)			#	#					#	#	6
Pathan		# 7		#	#		#		#7	#	8
Sikh Punjabi	#		#		#		#		#	#	9
Yemeni	#		#7	#	#	#					$

B: Bangladeshi ; H: Hindu ; M: Mirpuri ; P: Pakistani. HP: Health Promotion ; HV: Health Visitor

@ i.e. professionals speaking appropriate languages, or culturally aware

** i.e. Classes held in community settings to provide training and advice on health issues*

1: suggested a bilingual checklist of key terms to facilitate consultations
2: anti-social working hours issue; confidence building measures required
3: Classes may need age as well as sex segregation
4: Suggested recruiting and training local health advocates
5: Community development needed
6: Day centre provision a priority
7: Specifically wanted female-oriented facilities
8: Positive about videos in waiting areas
9: Note role of the Langar (Communal kitchen)
$: Seeking advice on tobacco and Qat, telephone helpline also suggested.

APPENDIX: Partner Groups for the research

Organisation contracted	*Community Interviewed*
Muath Welfare Trust	Bengali (Sylhetti)
Muath Welfare Trust	Bengali (non-Sylhetti - i.e. Dhaka)
Muath Welfare Trust	Kamalpuri (Pakistan)
Muath Welfare Trust	Arabic (non-Yemeni)
Muath Welfare Trust	Pathan
Shri Gheeta Bawan Temple	Punjabi (Hindu)
Guru Nanak Gurdwara	Punjabi (Sikh)
Tysely Employment Resource Centre	Gujerati (Hindu)
Islamic Resource Centre	Pakistani Punjabi
Islamic Resource Centre	Mirpuri (Kashmiri)
Yemeni Education Project	Yemeni
Birmingham Chinese Society	Chinese

(It was intended to include the views of the Vietnamese Community but interviews from these were not returned in time for analysis)

Total number of Topic Guides (Questionnaires) 204
Total number of men interviewed 377

APPENDIX: The Topic Guide used in the discussion groups

Sahara Project - Health Needs for Asian Men - Topic Guide

This study will help the Health Authority plan its services, so that it can meet the needs of people in the community according to what they say their needs are. Your ideas will help - but your name and details about your family will not be given to anyone: the study is confidential. However if you have a particular problem we can help with, we will try to do that.

We do need some background information to help the researchers understand your answers:

Family structure (Age of man; household type, children etc)
Occupation; Religion and language/ ethnic group

I. What does having good health mean to you? Would you say you had good health?
   A. What do you do to keep your health good?
   B. How do you avoid diseases? (Any in particular??)
   C. What stops your health from being good?
   D. Are there things you would like to do for health, but cannot? (Why...)

E. Do you go to any place to keep fit or get help in healthy leisure activity

II. How much do you feel you are in control of your own health?
   A. What do you do to ensure your family stays healthy?

III. What services are most important to you to maintain your health? And your family?
   A. Which do you use most (how do you get to them)
   B. What are the barriers to (or problems in using) others
   C. How can (we) make services more easy to use,
   D. How can they be made more suitable for your family, community, lifestyle/culture?

IV. Have you heard of any services or activities to support the health of (ethnic group) elsewhere that you would like to see set up in this part of Birmingham? (Describe ...!)

V. Do you use the other (not-Doctor) staff working at or from the same place as your family doctor (GP) - how much do you like talking to/taking advice from, health workers who are not Doctors? .... How have they helped you ....

VI. What do you think are the main diseases/ health problems affecting (X) Community?

VII. What do you understand about preventing - or treating/curing - these problems:
   A. Diabetes
   B. Stress

C. Heart Disease
D. Depression
E. Asthma

VIII. How (and Where) can men like you most easily learn about these issues?
A. If tutors were trained to teach people to Look After Your Health:
B. - what would you like to learn from them
C. - Where (when) and how should such classes be arranged?

IX. Is there anything else you would like to say about your health? We may be able to get you some help: (personally) - we will try to make sure you get information you ask for.

I would like to thank you for talking with me about health and services: your contribution is important and very much valued.