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## Editorial

# Is diversity equality a local concern, or an international marker of quality for public health?

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The year we are now leaving, 2010, was reputedly the International Year for the Rapprochement of Cultures as well as a year to celebrate biodiversity, but in fact it seems to have been a year in which the environment, or Gaia, as Lovelock and Golding characterised and embodied Nature, hit back (Lovelock, 1990; Johnson and McGee, 2010). The environmental disaster of the BP oil spill in the Gulf of Mexico led to international concern and action. Although it now appears that the oil leak has been stemmed and that the spilled oil has disappeared faster than could have been expected, the longer-term health effects, including the mental distress and disturbance to traditional ways of life around the coastal regions, have yet to be assessed. As if that were not enough for residents of the Caribbean, Haiti was ravaged by an earthquake of almost unprecedented strength and impact. The populations of the Punjab and indeed other regions of Pakistan and India also suffered devastating floods and loss of resources. Similarly, as we go to press we hear rumours of an earthquake, tsunami and volcano impacting on life in Indonesia, a country that is still recovering from earlier stresses of the same kind in December 2004. Nor have we seen much evidence of cultural gulfs being filled or of purely metaphorical oil being poured on troubled relational waters, with the possible exception of President Obama's current short visit to Indonesia.

These events highlight the interconnectedness of the environment with society and social organisation, and the need for a well-ordered public health system to anticipate and manage situations in order to avoid outbreaks of disease further exacerbating natural catastrophes, as appears at present to be happening in Haiti. This possibility was clearly in the minds of the Pakistani authorities and third-sector bodies, which worked tirelessly to ensure clean water supplies and to prevent major disease epidemics following the flood waters. In our first issue of 2010, we did indeed draw upon the expertise of our local Institute of Occupational and Environmental Medicine (Lam *et al,* 2010) to draw attention to the problems of indoor air pollution. This is, of course, also an area where there is much scope for improved practice, especially in developing economies where the west would like to see the move away from solid fuel (wood and dung) to cleaner oil-based fuels reduced in order to halt the rising carbon footprint of those states. Wood (even if cut from endangered forests) and cow dung are, after all, 'renewable' in theory, whereas oil and gas are not, and there does seem to be some political recognition of the threat to us all from global warming! However, investment in cleaner and more efficient simple technology for use in emergent economies, as espoused by Ernst Schumacher and the former 'Intermediate Technology Development Group' (now 'Practical Action'; http://practicalaction.org/about-us) is realistically the best way forward for all of us. In very truth, no man (or woman) is an island – and of course, pandemics care little for borders or ideologies. Public health is a worldwide responsibility, and inequalities threaten us all, a fact recognised by one of the few more cheering pieces of published research that we have monitored this year.

For indeed (and remaining in the field of public health) we have celebrated some more positive benchmarks, even if their main complaint or finding was often that not enough had been done. Among these, we include the UK 'Marmot Review' (Marmot Review Team, 2010), the WHO International Commission on the Social Determinants of Health (www.who.int/social_determinants/en), which was also headed by

Sir Michael Marmot, and the publication by the new Coalition Government in the UK of an 'equality impact assessment' on their plans for the 're-disorganisation' (yet again) of the National Health Service (Smith *et al*, 2001). All of these events or publications have, we believe, highlighted the essential integration of knowledge and the need to assess diversity of populations as this affects equality and equity in health and care provision. Indeed, the equality impact assessment (Department of Health, 2010) emphasises that the new White Paper (Cm7881) includes 'Equity' as part of its title, and that 'fairness be a cornerstone of the new direction', since equality is integral to quality. The same, we would argue, is true in reverse. Quality services are not of high quality unless equity and equality of outcomes are embedded, and not just equality of opportunity, since as has been noted on many occasions, and as the Marmot Reviews make clear (Hart, 1971), those who already have any advantage will benefit more from improvements in services than those who need them most.

Consequently, all interventions need to be equality assured as an intrinsic part of their design. This conclusion is usefully buttressed by a recent paper from the leaders of the Cochrane and Campbell Collaborations, those international networks of health and social policy scientists and practitioners wherein 'best practice' is scrutinised and defined, and whose reviews are commonly regarded as the 'gold' (or platinum) standard of evidence for evidence-based practice. Tugwell *et al* (2010), responding to the findings of the WHO Commission, state quite clearly what will be music to the ears of many of this journal's community, namely that until recently most 'systematic reviews' have neglected the role of qualitative and community-based inquiry. They argue that systematic reviews will in future require tailoring to assess 'fitness for purpose' of evidence, rather than being driven by some mechanistic and rigid definition of a 'hierarchy of evidence', asking therefore whether the research that they review has in fact questioned and assessed the diversity of the populations under study and taken into account the factors identified therein, such as poverty, ethnicity, faith, gender and identity. Studies therefore should consider and evaluate processes as well as inputs and outcomes, and consider context, using where appropriate qualitative methods in harness with the so-called 'harder' forms of data. They then lay out the 'PROGRESS+' characteristics of populations and people, which form a simple and memorable list of axes of diversity that are likely to have an impact on health. These are place of residence (or location/geography), race/ethnicity, occupation, gender, religion, education, socio-economic status, and 'social capital', along with age, sexual orientation and disability. We may remark in passing, perhaps, that we feel this list mirrors remarkably the founding list of themes which we hoped and continue to encourage our authors to address in their submissions! To facilitate and encourage this, we are at present considering a review of our article indexing strategy, and we hope that the authors of future submissions will consider using some of these terms as 'keywords' listed at the end of their abstract and in the 'What this paper adds' section at the head of articles, which is where most search engines look.

In this issue, however, we start with a consideration of the issues involved in replenishing the professional workforce of social care, which is a constant worry for service providers, educators and policy makers (and probably for the prospective recipients of such care). Shereen Hussein and Jill Manthorpe at the Social Care Workforce Research Unit are able to draw upon some highly detailed administrative monitoring data to reveal interesting and disturbing facts about the new entrants to this sector, drawing our attention to a possible lessening of cultural competence in the workforce if its own diversity is seen to be a critical asset. It does remain to be seen what the impact of current changes to higher education and employment opportunities may mean to the next generation, but while social care remains a low-paid and unfavoured sector, there must be some concern that pressures for recruitment and retention cannot be allowed to lead to poorer care delivery. Another concern in terms of workforce planning and equality impact analysis is the poor quality of data actually recorded and returned by employers to this major national database. There is clearly more to be done in this area, and we are glad to have been able to bring this data set and field of research to the attention of our readers.

Once recruited, new entrants need to be trained and socialised to perform their roles in accordance with best practice. We therefore complement this opening paper, and close this issue's set of peer-reviewed papers, with another in our new series of Education Papers, in which Mary Pat Sullivan and colleagues look across occupational and professional groups, noting the relatively restricted horizons of certain health professions compared with their social work and physiotherapy students. The latter were more prepared to engage in meaningful dialogue with 'users' as service development partners, an approach officially espoused in both health and social care. The 'widening participation' agenda in higher education should, naturally enough, provide further opportunities for learners to encounter peers (and potential users of their future services) from an ever-widening pool of social milieux or 'life-worlds', including, of course, international students. This also presents us, as educators, with both challenges to our pedagogy and opportunities in both the formal and informal curriculum. However, less encouragingly, the authors report that a significant minority of students had

experienced or witnessed discrimination (not just in the 'outside world') and, probably to no one's surprise, the majority were of black and minority ethnic (BME) origin. They also report highly variable and somewhat selective levels of 'cultural desire' (Campinha Bacote, 2003) or readiness to encounter diversity, especially in relation to religious or sexual orientation. What is even more concerning is that staff in these professional formative settings reported considerable difficulty, or even distaste, with regard to working with this diversity. Meanwhile, the policy rhetoric extolling the merits of diverse learner bodies continues, but this may be possibly putting 'diverse' (and minoritised) students at increased risk in the classroom, as they are being exploited both as learners and as teaching objects. Perhaps it is time to consider re-educating the teachers as well.

Meanwhile, in the Research Papers section, a refreshingly distinctive perspective from Canada is presented by Ingrid Waldron, which also follows the focus on the social determinants of health and the challenges of diversity. The so-called 'Euro-Western' epistemology of healthcare has faced multiple challenges there from both racialised and indigenous group perspectives, but is being responded to as an opportunity. Inter-professional working is proposed there, too, as a solution to the embedded problems of inequality. Although primarily based on Canadian models, there are many insights which can be generalised to a wider North American, European or English-speaking context. A key point is understanding and not being afraid to use the term 'racialisation', recognising (as perhaps the teachers in the previous study's institution did not) that the processes of *othering* distinctive groups, over and above the obvious, need to be considered alongside other processes of social segmentation, including gender, and tackled by alliances of professionals who are willing to confront their own prejudices and comfort zones. What might appear to be 'common sense' (a term that also appears in the Sullivan paper) is highly embedded in the social world of the individual and the teacher, and only once we recognise and challenge this can we bring about change.

In our next research paper, Patience Seebohm also considers the contribution of workers trained in social and community work disciplines rather than in health, and in particular the innovative but contested role of community development workers (CDWs) in the national mental health strategic policy, Delivering Race Equality. This programme, led by the National Institute for Mental Health in England in the wake of a number of critical reports, was intended to be a bold approach to incorporating BME community perspectives into mental health services, although this year is likely to mark the final extinguishing of that spark as protected funding ceases and few of the CDW teams have been 'mainstreamed' as planned. It is therefore instructive to read this evaluative review, especially since innovative, community-based programmes have been much posited as a foundation of the Big Society and a solution to many welfare problems. However, it seems that 'projectitis' (Abrahamsson and Agevall, 2010) was at work in the UK as well, although individual workers did their best to make a difference, much as the earlier Community Development Project (CDP) attempted to overcome earlier (non-racialised) structural inequalities in deprived urban communities such as Benwell and Coventry (Community Development Project, 1977). Alarmingly, perhaps, Seebohm reports that a significant number of her CDWs did not feel that it was possible to support 'group' activities, and many of them spent much of their time in individual casework. This was perhaps an inevitable outcome of employing people committed to helping others, but it was not what was intended. It is also apparent here that any such initiatives (like the 'new public health') need to be more clearly focused, planned and coordinated, and maybe based on better theories of change.

Returning to health matters, Yu-Chu Huang and Nigel Joseph Mathers present an interesting and unusual account of culturally specific responses to childbirth. During the 1970s, the administration of the St Thomas Hospital Medical School in London was based in the 'Lying-In Hospital', a magnificent edifice adjacent to London's County Hall, and a reminder that 'doing the month' was not long ago also a common English (or British) practice. This paper reveals similarities, and a continuity in UK traditions, to a greater extent than might have been expected between cultures from so far across the globe. This is therefore not only a useful addition to a growing literature on research into childbirth from the perspective of migrant mothers, but also adds to our understanding of both minority and majority cultures, and hopefully will enable our educators in midwifery and nursing to reflect on the commonalities that underlie our culturally expressed responses to deep needs. Hopefully it will advance midwifery and obstetric/paediatric practice by opening up an understanding of women's own practices and beliefs, leading to real user-led services in the future.

The issue closes with our three regular feature items, all of which present novice authors and practitioners with an opportunity to get on to the publishing ladder, or to critique research, policy and practice from a grounded perspective by challenging a research or policy paper (in the Did you see? section), reflecting on an incident in the everyday workplace (in the Practitioner's blog) or writing a short description of some innovation or attempt to develop services (in the Knowledgeshare section). In this issue, we thank in particular Dr Joseph for demolishing what on the first

reading appeared to be an authoritative paper discussing gender identity, but which perhaps in fact ends up creating stereotypes with regard to internalised negative images of being gay. Sometimes the observer, or the practitioner, sees more of the game. This is clearly true in the Emergency Department (it isn't all like the TV version), where Wendy Martin and our regular contributor Mary Dawood observe a possibly related situation, when a young man overcomes the perceived potential stigma of being gay, to seek appropriate treatment.

To conclude, as a journal it has been one of our intentions to highlight and celebrate the learning that comes not just from diversity, but also from settings outside the conventional arenas of evidence generation, from South and Eastern Asia, Africa, Latin America and Oceania, the so-called 'emergent economies' and the 'Third World.' In this issue we hope that we have maintained that tradition and added to the learning that can come from diversity, from Taiwan to Canada, and in education as much as social care, mental health and community development, or midwifery. So, as we look forward to the new initiatives for inter-cultural dialogue signalled by the UN General Assembly's proclamation of the years between 2011 and 2020 as the United Nations Decade of Interreligious Dialogue and Cooperation for Peace, we hope that our readers, and the journal, will be able to look forward to further challenges to hypocrisy, complacency, institutional inertia and professional incompetence masquerading as expertise or taking refuge in outmoded and ill-considered theories and models of practice. In this we shall need all the help we can get, as it is our belief that wisdom is found not just in established research centres and the western world, and that its exponents should find in this journal a place where they can express themselves and challenge orthodoxy. We await your contributions.

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