

It is obvious that the most important message to be given to anybody taking blood samples is to adhere to the local recommendations and that no samples should be left unlabelled or improperly labelled. The importance of training to ensure appropriate identification of donor and patient samples cannot be overemphasised. The minimum information that should go on the tube consists of the patient's name, date of birth or identification number (Danish social security number or hospital number in Britain), and the date when the sample was drawn. There are hospitals in Australia where no sample will be accepted for pretransfusion testing if the label has not been checked and countersigned by the patient. If the patient is unable to sign, then the reason has to be stated in writing by the person drawing the sample.

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1 Szama K. Reports of 355 transfusion associated deaths: 1976 through 1985. *Transfusion* 1990;30:583-90.

Health education and ethnic minorities

SIR,—Drs K Elliott and J Fuller emphasise that the health education needs of ethnic minorities may differ but the techniques do not.¹ This view could perpetuate the current imbalance in the provision of health education services and is not supported by McAvoy and Raza, whose research shows that the home visit and the home video, unusual techniques, were the most effective interventions.²

The health knowledge of some ethnic minority groups is low.^{3,5} Their need for health education is great, but are the topics to be addressed very different? The health problems of ethnic minorities are similar to those of the general population as rankings of the common causes of death, as both hospital and general practice morbidity show⁶; this causes surprise to professional audiences. Apparent differences in health of ethnic minority groups mainly result from current and past social and environmental deprivation.^{8,9}

The trap that must be avoided is to meet the specific needs of ethnic minorities at the expense of the general and more important ones. This trap is dramatically illustrated by the table (which updates published tables^{6,7}) based on resource

catalogues listing health education materials published by the Wandsworth Council for Community Relations and by the Health Education Authority. Health education issues of importance such as appropriate health service utilisation, cultural awareness, communication, alcohol, tobacco, exercise, heart disease, and hypertension have received little or no specific attention, while birth control, food hygiene, headlice, and even spitting have found a place.

To accelerate developments the perception that the "needs of ethnic minorities are different" must be swept away. This perception is widespread among professionals,⁸ as I find in my seminar teaching. Specification of priorities must be based on research. Health education materials for ethnic minorities have been developed to solve immediate and obvious problems.⁷ Priorities have been influenced by traditional generalisations about disease patterns, and by aetiological studies emphasising differences in disease patterns in ethnic groups.^{6,7} Political, media, and social pressures have been important—for example, on the matter of birth control, a favoured topic for health education.

A nationally coordinated health education strategy is required to develop effective health education materials for ethnic minority groups.⁷ The difference between a coordinated and uncoordinated approach is illustrated in the Health Education Authority's latest catalogue. The materials produced in Britain are a mix, with much duplication and little sense of coherence. By contrast, the wide ranging materials prepared by the Hong Kong Central Health Education Unit have no duplication and cover many important topics.

The immense technical problems in educating a heterogeneous, complex population require imaginative solutions.⁷ The techniques will follow the principles of health education,¹ but the details will differ. Imaginatively illustrated written material and audiovisual aids will probably dominate. Dubbing will need to become an art form. Careful selection of actors will be needed. Rigorous evaluation of acceptability and effectiveness of materials will be essential, together with much more survey research.⁷

Drs Elliott and Fuller estimate that for each language the added cost of health education material development is £750. If so, let there be no piecemeal work or duplication and let the tasks be shared by health authorities with the appropriate expertise. How sad that only five of 97 district

health authorities provided special leaflets for ethnic minority women being invited for a cervical smear test,¹ particularly as the problems of this service have been highlighted.^{5,10}

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Training for minor surgery in general practice

SIR,—The work of Dr Pringle and colleagues on the training that preregistration house officers receive in minor surgery is timely.¹ The new general practice contract may require general practitioners to be proficient at minor surgical procedures, but I fear that future changes in hospital practices may prevent this. The ward commitment on my own house job has until recently prevented all but brief visits to theatre and certainly not provided enough time to learn. Fortunately, recent reorganisation has enabled me to discover how educational, interesting, and rewarding a frequent visit to theatre can be. However, if juniors start to work a shift system to reduce the hours I fear that again ward work will dominate the day's activities and this potential to learn will be lost. We must progress slowly with care and thought if standards are to be maintained.

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Preventing the spread of HIV infection

SIR,—Dr P D French and colleagues report an increase in rectal gonorrhoea among homosexual men in London, which may indicate continuing unprotected sexual intercourse.¹ A recent increase in the number of women with gonorrhoea attending the sexually transmitted disease clinic at this hospital suggests a similar trend in heterosexuals. Since 1985 there has been a general decline in the numbers of women with gonorrhoea, but in 1990 *Neisseria gonorrhoeae* was isolated in nearly twice as many women as in 1989 (table). This increase has continued in 1991: 45 women were diagnosed with

Pamphlets and leaflets on health education topics available in four time periods

	No (%) available on each topic			
	1977 (n=41)	1984 (n=115)	1987 (n=151)	1990 (n=179)
Infant care and feeding	12 (29)	20 (17)	20 (13)	17 (9)
Diet (including vitamin D)	6 (15)	11 (10)	13 (9)	16 (9)
Occupational hazards (and legislation)			3 (2)	14 (8)
Birth control	3 (7)	24 (21)	29 (19)	12 (7)
Sickle cell anaemia		7 (6)	13 (9)	12 (7)
Pregnancy/MCH	2 (5)	11 (10)	13 (9)	10 (6)
Using health services	2 (5)	5 (4)	5 (3)	8 (4)
Infectious diseases (and immunisation)		2 (2)	7 (5)	5 (3)
Dental health			6 (4)	5 (3)
Diabetes			4 (3)	5 (3)
Lice	1 (2)		3 (2)	5 (3)
Cervical smears	1 (2)	2 (2)	1 (1)	5 (3)
Language or phrase books	3 (7)	3 (3)	1 (1)	5 (3)
Food hygiene	3 (7)	3 (3)	5 (3)	4 (2)
Breast examination or problems		6 (7)	1 (1)	4 (2)
Heart disease				4 (2)
Traditional mineral remedies (surma, sikar)	1 (2)	2 (2)	1 (1)	4 (2)
Medicines			2 (1)	4 (2)
Alcohol		1 (1)	1 (1)	3 (2)
Accidents	5 (12)	6 (7)	5 (3)	2 (2)
Social Security	2 (5)	1 (1)	5 (3)	2 (2)
Others		11 (13)*	13 (9)†	33 (18)‡

Sources: 1977 figures—Wandsworth Council for Community Relations; others—Health Education Authority.

*Colostomy, race relations (3), spina bifida, skin and hair, general health, background information on ethnic minorities (4).

†Adoption, antibiotics, colostomy, foot care, race relations (2), spina bifida (2), skin and hair (2), school (1), warmth (2).

‡Racism, equality, and immigration (4), spina bifida (3), foster care, caesarean section, gender of babies, footcare, patients' rights, malaria, warmth (4), general health, asthma, tuberculosis and immunisation with BCG, bronchitis and emphysema, legionnaires' disease, skin care (2), back problems, physical education, marriage and separation, mental health (2), genetic disorder (2).