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**Culture-specific programs for children and adults from minority groups who have asthma**

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**ABSTRACT**

**Background**

People with asthma who come from minority groups often have poorer asthma outcomes, including more acute asthma-related doctor visits for flare-ups. Various programmes used to educate and empower people with asthma have previously been shown to improve certain asthma outcomes (e.g. adherence outcomes, asthma knowledge scores in children and parents, and cost-effectiveness). Models of care for chronic diseases in minority groups usually include a focus of the cultural context of the individual, and not just the symptoms of the disease. Therefore, questions about whether tailoring asthma education programmes that are culturally specific for people from minority groups are effective at improving asthma-related outcomes, that are feasible and cost-effective need to be answered.

**Objectives**

To determine whether culture-specific asthma education programmes, in comparison to generic asthma education programmes or usual care, improve asthma-related outcomes in children and adults with asthma who belong to minority groups.

**Search methods**

We searched the Cochrane Register of Controlled Trials (CENTRAL), the Cochrane Airways Group Specialised Register, MEDLINE, Embase, review articles and reference lists of relevant articles. The latest search fully incorporated into the review was performed in June 2016.

**Selection criteria**

Randomised controlled trials (RCTs) comparing the use of culture-specific asthma education programmes with generic asthma education programmes, or usual care, in adults or children from minority groups with asthma.

**Data collection and analysis**

Two review authors independently selected, extracted and assessed the data for inclusion. We contacted study authors for further information if required.
Main results

In this review update, an additional three studies and 220 participants were added. A total of seven RCTs (two in adults, four in children, one in both children and adults) with 837 participants (aged from one to 63 years) with asthma from ethnic minority groups were eligible for inclusion in this review. The methodological quality of studies ranged from very low to low. For our primary outcome (asthma exacerbations during follow-up), the quality of evidence was low for all outcomes. In adults, use of a culture-specific programme, compared to generic programmes or usual care did not significantly reduce the number of participants from two studies with 294 participants for: exacerbations with one or more exacerbations during follow-up (odds ratio (OR) 0.80, 95% confidence interval (CI) 0.50 to 1.26), hospitalisations over 12 months (OR 0.83, 95% CI 0.31 to 2.22) and exacerbations requiring oral corticosteroids (OR 0.97, 95% CI 0.55 to 1.73). However, use of a culture-specific programme, improved asthma quality of life scores in 280 adults from two studies (mean difference (MD) 0.26, 95% CI 0.17 to 0.36) (although the MD was less then the minimal important difference for the score). In children, use of a culture-specific programme was superior to generic programmes or usual care in reducing severe asthma exacerbations requiring hospitalisation in two studies with 305 children (rate ratio 0.48, 95% CI 0.24 to 0.95), asthma control in one study with 62 children and QoL in three studies with 213 children, but not for the number of exacerbations during follow-up (OR 1.55, 95% CI 0.66 to 3.66) or the number of exacerbations (MD 0.18, 95% CI -0.25 to 0.62) among 100 children from two studies.

Authors’ conclusions

The available evidence showed that culture-specific education programmes for adults and children from minority groups are likely effective in improving asthma-related outcomes. This review was limited by few studies and evidence of very low to low quality. Not all asthma-related outcomes improved with culture-specific programs for both adults and children. Nevertheless, while modified culture-specific education programs are usually more time intensive, the findings of this review suggest using culture-specific asthma education programmes for children and adults from minority groups. However, more robust RCTs are needed to further strengthen the quality of evidence and determine the cost-effectiveness of culture-specific programs.

PLAIN LANGUAGE SUMMARY

Culture-specific programs for children and adults from minority groups who have asthma

Background

People with asthma who come from minority groups have poorer asthma outcomes. Asthma education that is culturally specific may improve asthma-related outcomes.

Review question

Do culture-specific asthma education programmes (compared to generic asthma education programmes or usual care) improve asthma-related outcomes in children and adults with asthma who belong to minority groups?

What evidence did we find?

Seven studies with 837 participants, aged from one to 63 years old were included in this review update. This review was limited by few studies and the quality of evidence was very low to low. In adults, we found that culture-specific programmes did not improve any of our primary outcomes, but were better in improving quality of life (although the mean difference was less that the minimum important difference for the score) (secondary outcome). In children however, when data were combined from studies, culture-specific programmes reduced severe exacerbations requiring hospitalisation (primary outcome), while single studies showed improved asthma control, asthma knowledge and adherence outcomes for our secondary outcomes.

Conclusion

The available evidence showed that culture-specific education programmes for adults and children from minority groups are likely effective in improving asthma-related improvements. Although more robust evidence is required, asthma education programmes should be as culturally specific as possible in the context of chronic disease management and the complexity of health outcomes and culture. In the absence of any economic data, cost-effectiveness studies are also required.

Quality of the evidence

The quality of the evidence was very low to low for all outcomes.
### Summary of Findings for the Main Comparison

**Culture-specific asthma education program compared to Generic asthma education (or usual care) for asthma in children**

**Patient or population:** Children from minority groups with doctor diagnosed asthma  
**Settings:** Any  
**Intervention:** Culture-specific asthma education program  
**Comparison:** Generic asthma education program (or usual care)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Anticipated absolute effects* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk with generic asthma education or usual care</td>
<td>Risk with Culture-specific asthma education program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe exacerbations requiring hospitalisation over the study period follow-up: 6-12 months</td>
<td>434 per 1,000 (336 to 737)</td>
<td>OR 1.55 (0.6 to 3.66)</td>
<td>88 (1 RCT)</td>
<td>⊕⊕⊕ LOW*</td>
<td></td>
</tr>
<tr>
<td>Number of exacerbations over 52 weeks follow-up: 12 months</td>
<td>Mean number of exacerbations over 52 weeks (exacerbation rate) in the intervention group was 0.18 MD higher (0.25 lower to 0.62 higher)</td>
<td>-</td>
<td>110 (2 RCTs)</td>
<td>⊕⊕⊕ LOW*</td>
<td></td>
</tr>
<tr>
<td>Severe exacerbations requiring hospitalisation over the study period follow-up: 6-12 months</td>
<td>RR 0.48 (0.24 to 0.95)</td>
<td>-</td>
<td>305 (2 RCTs)</td>
<td>⊕⊕⊕ LOW*</td>
<td></td>
</tr>
</tbody>
</table>
The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: rate ratio; OR: Odds ratio

This table was created using the GRADE Pro software (GRADEpro GDT 2015)

GRADE Working Group grades of evidence

High quality: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate quality: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low quality: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low quality: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

* Only one study with small number of participants was included in this analysis. This RCT was unblinded (downgrades for risk of bias and imprecision) (Valery 2010)

* One study by Valery 2010 carried 85.4% of the weight of the results, which may have introduced bias. This RCT was also unblinded (downgrades for risk of bias and imprecision).

* One study carried 75.1% of the analysis weight (Canino 2008). Both studies (Canino 2008; Valery 2010) were unblinded which may have introduced bias (downgrades for risk of bias and inconsistency).
BACKGROUND

Description of the condition

Asthma education is regarded as an important management step in national asthma guidelines (National Asthma Council Australia 2015; BTS 2016). Asthma education, defined as provision of information on asthma, encompasses various formats which include face-to-face encounters, group sessions, outreach, home visits, provision of asthma action plans, recognition of loss of asthma control and self-management skills (BTS 2016). The effects on asthma-related outcomes of many of these various forms of education have been addressed in other Cochrane reviews (Powell 2002; Wolf 2002; Gibson 2002a; Gibson 2002b; Tapp 2007; Toelle 2011). Racial and socio-economic factors can influence both asthma severity and rates of recurrent acute presentations to emergency health facilities (Coul tas 1994; de Oliveira 1999; Sin 2002; Haselkorn 2008). The reasons for this are unclear, however contributing factors are arguably likely to include broad service delivery issues rather than a reflection of intrinsic asthma severity (Enarson 1999; Chang 2002). Other cultural influences and barriers on the management of asthma include symptom perception, low literacy levels, and understanding of disease and self-management (Enarson 1999; Poureslami 2012; Stewart 2013; Harrington 2015).

Description of the intervention

An appropriate model of care is important to successfully deliver services to improve outcomes for people with asthma (Partridge 2000; Chang 2002; Mitchell 2016). The model of care should arguably be culturally appropriate (Enarson 1999; Poureslami 2012; Press 2012) and modified to fit within the local context. As outlined by the World Health Organization’s model of health care for chronic diseases in low-income settings, “health care should facilitate an ongoing relationship between provider and patient and help patients to make full use of their own and their community’s resources for health” (Swartz 2002). This is further supported by the implementation of chronic care models in low- to middle-income countries to facilitate chronic disease care (Beaglehole 2008) and asthma guidelines (National Asthma Council Australia 2015; BTS 2016). Not surprisingly, in the health literature, the model of care for chronic diseases in Indigenous people includes the involvement of Indigenous healthcare workers (IHWs) (Hamdorf 1996; Chino 2006; Abbott 2007). Amongst other factors, involvement of IHWs in a supportive service delivery system would theoretically facilitate provider-patient relationships and could potentially reduce prejudices and inequities that exist in some areas of healthcare systems (Eades 2000; Schmidt 2016). The involvement of IHWs specifically as an inclusion factor has been addressed in another Cochrane review (Chang 2010).

How the intervention might work

For a variety of reasons (e.g. availability) not all culture-specific asthma programmes involve intervention by IHWs (Anderson 2004). Also, many minority groups are non-Indigenous to their country of residence (e.g. Latino groups in the United States of America). People from these groups have also been shown to have poorer asthma outcomes (Anderson 2004; La Roche 2006; Alicea-Alvarez 2014). Furthermore, there is a growing body of literature highlighting the need to tailor asthma education programmes specifically for ethnic and cultural groups to improve asthma outcomes (Poureslami 2012; Press 2012; Douglas 2013; Stewart 2013; Alicea-Alvarez 2014; Speck 2014; National Asthma Council Australia 2015; BTS 2016). It is therefore not surprising that publications such as the Australian National Strategic Improvement Framework for Asthma makes special reference to disadvantaged/ minority groups (NHPAC 2006). However, culture-specific programmes are likely more expensive than generic programmes as they involve specifically designed programmes to fit within the local context. It is therefore important that the efficacy of culture-specific education programmes for asthma is systematically examined.

There is no universally accepted definition of a culture appropriate program; however it usually refers to adapting the program to the culture-values, language, and/or using educators that come from the same culture, inclusion of beliefs and practices, culturally appropriate role models, involvement of local community health workers to support clinical teams, to that of the recipients (BTS 2016). Such adaptation impacts on the understanding and/or how well it is received and thus more likely to be effective (compared to non adapted programs).

Why it is important to do this review

Arguably, the most important asthma education outcome is to improve self-management, so as to prevent morbidity and death from acute exacerbations. Other outcomes include reduction of day to day morbidity from asthma symptoms (e.g. improved asthma control scores and quality of life measures) and objective measurements of asthma severity (e.g. lung function data) (National Asthma Council Australia 2015; BTS 2016). This systematic review update examines whether culture-specific asthma education programmes improve asthma-related outcomes in children and adults from minority groups who have asthma. This review update will provide much needed evidence to guide asthma specific clinical practice guidelines and health policy.

OBJECTIVES

To determine whether culture-specific asthma education programmes in comparison to generic asthma education programmes...
or usual care, improve asthma-related outcomes in children and adults diagnosed with asthma who belong to minority groups.

**METHODS**

**Criteria for considering studies for this review**

**Types of studies**

We included randomised controlled trials (RCTs) with parallel group design, comparing specifically developed culture-orientated asthma education programmes in comparison to generic asthma education programmes or usual care for children and adults who belong to minority groups.

**Types of participants**

**Inclusion criteria:** Children (≤ 18 years) and adults from minority groups with physician diagnosed asthma. Minority was defined by study authors according to their respective country’s definition.

**Exclusion criteria:** Eosinophilic bronchitis, asthma related to an underlying lung disease such as bronchiectasis and chronic obstructive airway disease, or diagnostic categories such as ‘cough variant asthma’ and ‘wheezy bronchitis’ where controversy exists.

**Types of interventions**

We included RCTs involving comparisons of specifically developed culture-orientated asthma programmes with their local generic asthma education programmes or usual care. We considered studies that involved the use of other education and other interventions for inclusion if all participants had equal access to such interventions. An education programme is defined as a programme which transfers information about asthma in any form, including but not limited to, adapting the program to the culture-values, language, and/or using educators who come from the same culture, inclusion of beliefs and practices, culturally appropriate role models, involvement of local community health workers to support clinical teams etc,

**Types of outcome measures**

Attempts were made to obtain data on at least one of the following outcome measures. All analyses were planned separately for adults and children.

**Primary outcomes**

Asthma exacerbations during follow-up defined as:

1. Number of participants who had one or more exacerbation over the study period
2. Number of exacerbations over 52 weeks (exacerbation rate)
3. Severe exacerbations requiring oral corticosteroids over the study period
4. Severe exacerbations requiring hospitalisation over the study period

**Secondary outcomes**

1. Objective measurements of asthma control (FEV1, peak flow, airway hyper-responsiveness)
2. Asthma Control Score (score ≤ 19 = uncontrolled asthma)
3. Asthma quality of life (QoL) score
4. Other asthma symptom scores (e.g. diary cards)
5. Adherence outcomes
6. Asthma knowledge factors
7. Economic data

**Search methods for identification of studies**

**Electronic searches**

Studies were identified from the following sources.

2. The Cochrane Central Register of Controlled Trials (CENTRAL), the Cochrane Library, 2016, Issue 6.
3. MEDLINE (1950 to June 2016). Topic search strategy combined with the RCT search filter as outlined in the Airways Group module.
4. Embase (1980 to June 2016). Topic search strategy combined with the RCT search filter as outlined in the Airways Group module.
5. Clinical trials registries: ClinicalTrials.gov and the WHO trials portal (all years to June 2016).

Conference abstracts and grey literature were searched for through the CENTRAL database. We did not impose any restrictions on language of publication. Full search strategies are listed in Appendix 1.

**Searching other resources**

In addition to the electronic search, we checked reference lists of relevant publications for additional studies.

**Data collection and analysis**

**Selection of studies**
Retrieval of studies: Using article titles, abstracts, or descriptors, two review authors (EJB and ABC in original and 2009 reviews; GBM and ABC in search from 2009 to 2016) independently reviewed literature searches to identify potentially relevant studies for full review. They conducted searches of bibliographies and texts to identify additional studies. From the full-text articles, the two review authors independently assessed studies for inclusion on the basis of specific criteria.

**Data extraction and management**

We had no disagreements but had planned to resolve disagreements through discussion with another review author (PSM). We extracted data using a standardised data collection form and entered the data in Review Manager 5.3 (Review Manager (RevMan)), in accordance with recommendations provided in the *Cochrane Handbook for Systematic Review of Interventions* (Higgins 2011). When required, we sought further information from study authors. We recorded the selection process in the PRISMA flow diagram (Figure 1).

**Assessment of risk of bias in included studies**

Two review authors (GBM and ABC) independently assessed risk of bias for each study using the criteria outlined in the *Cochrane Handbook for Systematic Review of Interventions* (Higgins 2011). It was planned that disagreements would be resolved by discussion or by third party adjudication. We assessed risk of bias according to the following domains.
1. Allocation sequence generation (selection bias)
2. Concealment of allocation (selection bias)
3. Blinding of participants (performance bias)
4. Outcome assessment (detection bias)
5. Incomplete outcome data (attrition bias)
6. Selective outcome reporting (reporting bias)

We graded each potential source of bias as low, unclear or high and provided a justification for our judgement in the "Risk of bias" tables (Figure 2).
Figure 2. Risk of bias summary: review authors' judgements about each risk of bias item for each included study.

<table>
<thead>
<tr>
<th></th>
<th>Random sequence generation (selection bias)</th>
<th>Allocation concealment (selection bias)</th>
<th>Blinding of participants and personnel (performance bias)</th>
<th>Blinding of outcome assessment (detection bias)</th>
<th>Incomplete outcome data (attrition bias)</th>
<th>Selective reporting (reporting bias)</th>
<th>Other bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blixen 2001</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>+</td>
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<tr>
<td>Canino 2008</td>
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<td>-</td>
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<td>Grover 2016</td>
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<tr>
<td>Valery 2010</td>
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<td>?</td>
<td>?</td>
<td>+</td>
</tr>
</tbody>
</table>
**Measures of treatment effect**

We analysed dichotomous data as odds ratios (OR) and continuous data as mean difference (MD) and planned to use standardised mean difference (SMD) if necessary. We then entered data presented as a scale with a consistent direction of effect. We undertook meta-analyses only where it was meaningful. This took into account differences in study populations, inclusion/exclusion criteria, interventions, outcome assessment, and estimated effect size. We described skewed data which was reported as medians and interquartile ranges (IQR) in the text.

**Unit of analysis issues**

For dichotomous data, we reported the proportion of participants contributing to each outcome in comparison with the total number randomised. For rate ratios of common events whereby one participant may have more than one event, generic inverse variance (GIV) was used. The rate ratios were taken from the published papers and the standard errors calculated from confidence intervals or P values published in the papers. Cross-over trials are not appropriate for this intervention and therefore were not planned for inclusion in any meta-analysis performed.

**Dealing with missing data**

We planned to contact investigators or study sponsors to verify key study characteristics and to provide missing numerical outcome data when necessary. Three study authors (Canino 2008; Poureslami 2012; Valery 2010) were contacted for further information, with responses from all three (Canino 2008; Poureslami 2012; Valery 2010).

**Assessment of heterogeneity**

It was proposed that any heterogeneity between the study results would be described and tested to see if it reached statistical significance using a Chi². The 95% confidence interval (CI), estimated using a random-effects model, would be included whenever there are concerns about statistical heterogeneity. Heterogeneity is considered significant when the P value is less than 0.10 (Higgins 2011).

**Assessment of reporting biases**

If reporting bias was suspected (see 'Selective reporting (reporting bias)' in the 'Risk of bias in included studies' table), we planned to contact the study authors to ask them to provide missing outcome data. We planned that if missing data were not provided, and if this was thought to introduce serious bias, the impact of including such studies in the overall assessment would be explored through a sensitivity analysis.

**Data synthesis**

The results from studies that met the inclusion criteria and which reported any of the outcomes of interest (as defined above) were included in the subsequent meta-analyses. The summary weighted rate ratio and 95% CI (fixed-effect model) was calculated (Review Manager (RevMan) using generic inverse ratio (GIV), whereby one participant may have more than one event. The risk ratios were taken from the published papers and the standard errors were calculated from CIs or P values in the published papers. The outcome indices would be assumed to be normally distributed continuous variables so the MD in outcomes could be estimated. If studies had reported outcomes using different measurement scales, we planned to estimate the SMD.

**'Summary of findings' (SoF) tables**

We created 'Summary of findings' tables, using the primary outcomes (where able) (Summary of findings for the main comparison; Summary of findings 2).

**Subgroup analysis and investigation of heterogeneity**

We planned to carry out the following a priori subgroup analysis.

1. Different settings (rural versus non-rural: as defined by study authors)

**Sensitivity analysis**

Sensitivity analyses were planned to assess the impact of the potentially important factors on the overall outcomes.

1. Study quality (adequate allocation concealment and blinding)
2. Study size
3. Variation in the inclusion criteria
4. Differences in outcome measures
5. Analysis using random-effects model
6. Analysis by “treatment received”

**RESULTS**

**Description of studies**

See Characteristics of included studies, Characteristics of excluded studies and Characteristics of ongoing studies.
Results of the search
From the previous versions of this review (2007 and 2009), the Cochrane Airways Group Specialised Register (CAGR) identified 228 potentially relevant titles (29 abstracts with four studies satisfying the inclusion criteria for the review) (Figure 1). An additional 170 articles were identified from the updated search (up to June 2016), with a further four titles identified from reference lists. After duplicates were removed, 96 titles were considered for the review. After assessing abstracts, 20 studies were retrieved for full review; 15 studies were excluded, with three additional studies (Valery 2010; Poureslami 2012; Grover 2016) fulfilling the eligibility criteria for this update (Figure 1). Two other studies remain ongoing at the time of the review (Janevic 2012; Patel 2014) (see Characteristics of ongoing studies’). Another two studies are awaiting classification (Buist 2001; Butz 2004) (see ‘Characteristics of studies awaiting classification’). An update search run in June 2017 returned three potentially relevant trials which have been added to Studies awaiting classification (Feldman 2016; Griffiths 2016; Patel 2016) and have not been fully incorporated into the review.

Included studies
For this review update seven studies were included (see ‘Characteristics of included studies’). A total of 837 participants with asthma from an ethnic minority group were included in this review. Two studies were multi-centre (Moudgil 2000; Valery 2010) and five were single-centre studies (Blixen 2001; La Roche 2006; Canino 2008; Poureslami 2012; Grover 2016). Two studies (Blixen 2001; Poureslami 2012) examined adults and four studies examined children (La Roche 2006; Canino 2008; Valery 2010; Grover 2016). The study by (Moudgil 2000) included both adults and children, however specific results for adults and children were not presented in the published paper. The study by (Poureslami 2012), reported outcomes from four treatment groups. For our analysis, we chose to report data from group three (intervention) and group four (control) as we believe group three was the true intervention (participants viewed both the community and knowledge video). The study duration varied ranging from six to 12 months. Exacerbations were defined differently in each study. Culture-specific programs and controls were defined differently for each study and are further described in (Table 1).

Participants
The seven studies used different inclusion and exclusion criteria for participation. All participants had ‘doctor diagnosed asthma’, but the definition varied across the studies.

Paediatric studies
La Roche 2006 enrolled families (of African-American or Hispanic descent) with children aged one to 13 years with physician diagnosed asthma. Canino 2008 enrolled poor (defined by utilisation of the Peurto Rico Health Insurance Administration Agency Plan which required that the family be close to the poverty level) Peurto Rican families, with a child aged five to 12 years who had utilised health services for asthma within the previous 12 months. Valery 2010 enrolled Australian Indigenous children (Aboriginal or Torres Strait Islander) aged one to 17 years from Thursday Island and Horn Island with doctor diagnosed asthma. The study by Grover 2016 enrolled Indian children aged seven to 12 years with asthma, who had at least two asthma-related visits to hospital in the previous 12 months.

Adult studies
Moudgil 2000 enrolled participants (adults and children) with asthma aged 11 to 59 years from participating General Practices (GP) in the United Kingdom (UK). Specific data for children could not be obtained. Of the 689 participants, only 344 were from of an ethnic minority (i.e. Indian Sub-Continent (ISC)). The remainder (n = 345) were of White European descent. We included this study in the review but only examined data relevant to the ISC participants as published outcomes were stratified by ethnic descent as well as intervention group allocation. Blixen 2001 enrolled African-American adults, aged 18 to 50 years who had been hospitalised for at least one night with a primary diagnosis of asthma. Poureslami 2012 enrolled adults aged > 21 years with physician diagnosed asthma who had immigrated to Canada within the last 20 years, lived in the Greater Vancouver Area, and spoke Mandarin, Cantonese or Punjabi.

Outcomes

Paediatric studies
Three studies (La Roche 2006; Canino 2008; Valery 2010) used asthma exacerbations as their primary outcome. The study by Grover 2016 used paediatric asthma caregiver quality of life (QoL) as their primary outcome. For other primary outcomes, Canino 2008 was the only study to report the use of oral corticosteroids over the study period. Two studies (Canino 2008; Valery 2010) reported on severe asthma exacerbations requiring hospitalisation. Secondary outcomes varied between studies. Two studies (Canino 2008; Valery 2010) used the change in Juniper Asthma QoL (Juniper 1992; Juniper 1993). Valery 2010 also reported on adherence outcomes using parents’ descriptions of asthma action plan (AAP). Asthma knowledge factors were assessed differently between studies. La Roche 2006 used the individualism-collectivism scale to measure asthma behavioural assessment for both career/parent and children; where Canino 2008 used change in carers knowledge on triggers and treatment. Grover 2016 used modified scores for asthma knowledge, asthma control and medication adherence.
Excluded studies
The main reason that studies were excluded from the review related to non culture-specific interventions in minority groups, or non-randomised controlled studies (see 'Characteristics of excluded studies' table).

Risk of bias in included studies
Risk of bias for included studies are summarised in Figure 2.

Allocation
Valery 2010 was the sole study assessed at low risk for both selection bias domains, as the authors adequately described the method of randomisation using computer-generated block randomisation sequencing with concealed allocation. Moudgil 2000 and Canino 2008 reported that randomisation was computer generated and randomly allocated, however did not describe the method of concealment allocation (unclear risk). The three remaining studies (Blixen 2001; La Roche 2006; Poureslami 2012) were assessed as an unclear risk; Blixen 2001 and Poureslami 2012 did not describe the method of randomisation or method of concealment allocation. La Roche 2006 reported that randomisation was computer generated, yet did not describe method or how the allocation method was maintained. The study by Grover 2016 reported that randomisation was generated randomly, however it was considered high risk, as the authors reported that allocation concealment was not implemented. There was an imbalance of allocation of treatment groups at baseline.

Blinding
One study (Poureslami 2012) was assessed as low risk for both blinding domains. The authors adequately described how outcome measures were assessed where blinding was not feasible. Two studies (Canino 2008; Grover 2016) were assessed as a high risk for both domains, as they did not describe how blinding was maintained for participants, study personal and did not describe if outcome assessors were blinded. The study by Valery 2010 was assessed as high risk for performance bias as participants and study personal were unblinded and unclear risk for detection bias, as it was not clear whether outcome assessors were blinded. The study by Blixen 2001 was assessed as high risk for performance bias, as participants were unblinded, but low risk for detection bias as outcome assessors were blinded to groups. The remaining two studies (Moudgil 2000; La Roche 2006) were assessed as an unclear risk as study authors did not describe how blinding was maintained or if outcome assessors were blinded to treatment allocation.

Incomplete outcome data
Three studies (La Roche 2006; Canino 2008; Grover 2016) were assessed as low risk, as > 90% of participants were followed up. Three studies (Moudgil 2000; Poureslami 2012; Valery 2010) were assessed as an unclear risk. In the Moudgil 2000 study, clinical data were only available in 86% of participants and 76% for asthma QoL at the 12-month follow-up. Poureslami 2012 did not describe if any participants withdrew or were lost to follow-up. The Valery 2010 study described that authors did not follow-up five children due to costs of travel. The study by Blixen 2001 was assessed as high risk as only 46% of participants were able to be contacted for the six-month follow-up.

Selective reporting
Six studies (Moudgil 2000; Blixen 2001; La Roche 2006; Canino 2008; Valery 2010; Grover 2016) were assessed as low risk. They adequately described method of analysis (e.g. intention-to-treat or by per protocol analysis). Poureslami 2012 was assessed as an unclear risk, as they did not report complete baseline data (some variables presented as grouped data), thus it was difficult to determine differences between the four groups.

Other potential sources of bias
Sources of bias were determined by the review authors and reported in each ‘Risk of bias’ table.

Effects of interventions
See: Summary of findings for the main comparison Summary of findings (paediatric studies); Summary of findings 2 Summary of Findings (adult studies)
See ‘Summary of findings’ tables for the main comparisons (Summary of findings for the main comparison; Summary of findings 2).
Three paediatric (La Roche 2006; Canino 2008; Valery 2010) and two adult (Moudgil 2000; Blixen 2001) studies used asthma...
exacerbations as their primary outcome. The study by Grover 2016 did not report any primary outcome data. Primary and secondary outcome data are reported below in accordance to the adult or paediatric studies.

**Paediatric studies (Comparison 1)**

**Primary outcome**

Asthma exacerbations during follow-up defined as:

Three studies (La Roche 2006; Canino 2008; Valery 2010) reported exacerbation data, however we were only able to obtain data for one study (Valery 2010), thus meta-analysis was not possible. The study by Valery 2010 reported exacerbation data over a 12-month period in 88 children. There was no significant difference between groups for this outcome (odds ratio (OR) 1.55, 95% confidence interval (CI) 0.66 to 3.66) (Analysis 1.1; Figure 3).

![Figure 3. Forest plot of comparison: 1 Paediatric studies, outcome: 1.1 Number of participants who had one or more exacerbation over the study period.](image)

**Number of exacerbations over 52 weeks (exacerbation rate)**

Combined data from two studies in 110 children (La Roche 2006; Valery 2010) did not show significant differences of the number of exacerbations over 52 weeks between groups (mean difference (MD) 0.18, 95% CI -0.25 to 0.62) (Analysis 1.2; Figure 4). Canino 2008 presented data on emergency department (ED) presentations post intervention (in the following six-month period), but these data could not be combined in the meta-analysis.

![Figure 4. Forest plot of comparison: 1 Paediatric studies, outcome: 1.2 Mean number of exacerbations over 52 weeks (exacerbation rate).](image)

**Severe exacerbations requiring oral corticosteroids over the study period**

Canino 2008 reported this outcome over the 12-month study period.
period. The number of events per group include 33 in the culture-specific group compared to 30 in the controls. We were, however unable to obtain further data from the study authors.

Severe exacerbations requiring hospitalisations

Combined data from two studies in 305 children (Canino 2008; Valery 2010) showed significantly improved outcomes in the culture-specific group compared to the control group (Rate Ratio 0.48, 95% CI 0.24 to 0.95) (Analysis 1.3; Figure 5). It is important to note that Canino 2008 reported on hospitalisations for asthma in the six-month period, whilst Valery 2010 study reported on hospitalisations for asthma in the 12-month period.

Figure 5. Forest plot of comparison: 1 Paediatric studies, outcome: 1.3 Severe exacerbations requiring hospitalisation over the study period.

Secondary outcomes

Objective measurements of asthma control (FEV1, peak flow, airway hyper-responsiveness)

No studies reported this outcome.

Asthma Control Score

One study (Canino 2008) reported this outcome over the 12-month study period, with the outcome being the proportion of children (n=62) with good asthma control based on the score. They reported an OR 3.35, (95% CI 1.45 to 7.73), significantly favouring the group receiving the culture-specific intervention compared to the control group (Analysis 1.4; Figure 6).

Figure 6. Forest plot of comparison: 1 Paediatric studies, outcome: 1.4 Improved asthma control.

Asthma Control Questionnaire

One study (Grover 2016) reported this outcome in 40 children over the six-month study period. They used a validated modified Hindi/English version of the asthma control questionnaire and reported a significant improvement in the intervention group com-
pared to controls (Analysis 1.5).

Change in parent proxy asthma QoL score

Three studies (Canino 2008; Valery 2010; Grover 2016) reported this outcome. Data from Valery 2010 could not be combined. The follow-up period varied for each study: six months in Grover 2016 and 12 months in Canino 2008 and Valery 2010. Additional data were obtained directly from the study authors (Valery 2010; Grover 2016). The study by Valery 2010 measured the change in parent QoL at 12 months (88 parents), but there was no significant difference between the groups (MD -0.04; 95% CI -0.25 to 0.17). The studies by Canino 2008 and Grover 2016 reported an improvement favouring the culturally-specific group, but these were not significant. Canino 2008 in 109 parents (MD 3.15; 95% CI -0.13 to 6.43) and Grover 2016 in 16 parents (MD 0.70; 95% CI 0.26 to 1.14). The study by Grover 2016 was a feasibility study and of low quality and thus the certainty of this outcome is poor. The clinically minimum important difference (MID) in the QoL scores differ in accordance to the type of QoLs. The most common asthma QoL used in studies is that of Juniper where the MID is 0.5 points (Juniper 1996).

Other asthma symptoms scores (e.g. diary cards)

No studies reported this outcome.

Adherence outcomes

Parent description of Asthma Action Plan (AAP)

Two studies reported on use of AAP (Valery 2010; Grover 2016) but data were only available in the Valery 2010 study. Valery 2010 measured the change in 88 parents’ description of AAP when the child was well. The outcome significantly favoured the group who received the culture-specific program (OR 2.82, 95% CI 1.17 to 6.83) (Figure 7). The study by Grover 2016 reported that none of the participants in either treatment group had a written AAP at baseline. All children in the intervention group were subsequently provided an AAP after baseline and education session. By six months, all participants in the intervention group reported they were confident in using their AAP. Children in the control group were provided a blank template in their information pack at baseline, however no additional data were provided if they were completed or used.

Self-reported medication adherence (using brief medication questionnaire)

A single study (Grover 2016), measured adherence to medications in 40 participants using a validated medication adherence questionnaire (see Characteristics of included studies tables). Study authors reported an improvement in score from baseline in the culture-specific group compared to the controls.

Asthma knowledge factors

One study La Roche 2006 reported this outcome in 22 parents. They used a behavioural assessment score. There was an improvement in mean asthma knowledge scores favouring the culture-specific intervention, but the confidence interval includes no between-group difference (MD 1.90, 95% CI -0.04 to 3.84) (Analysis 1.10).

Parent asthma knowledge scores

Only one study La Roche 2006 reported this outcome in 22 parents. The outcome significantly favoured the group who received
the culture-specific programme; MD 3.30, (95% CI 1.04 to 5.56) (Analysis 1.10).

Asthma knowledge (change in parent knowledge on triggers and treatment)
The Canino 2008 study presented change from baseline for 218 parents asthma knowledge on asthma triggers and treatment. This outcome favoured the group receiving the culture-specific program (MD 0.94, 95% CI 0.31 to 1.57) (Analysis 1.10).

Change in asthma knowledge
The study by Grover 2016, used a customised knowledge questionnaire and reported that participants in the intervention group had significantly higher knowledge at the six-month follow-up compared to those in the control group.

Economic data
The La Roche 2006 study estimated that the economic savings made by using the culturally specific education programme, based on the reduction of ED presentations was $4675. The estimated total cost of the culturally specific programme for asthma education was $2295.

Adult studies (Comparison 2)

Primary outcome

Asthma exacerbations during follow-up defined as:

Number of participants who had one or more exacerbations over the study period
Two studies (Moudgil 2000; Blixen 2001) reported exacerbations but numerical data were only provided by one paper (Moudgil 2000), therefore meta-analysis was not possible. Blixen 2001 stated that there was no statistically significant differences between groups in asthma-related healthcare resource (defined as hospitalisations, ED visits and physician visits) but no figures were given. In the Moudgil 2000 study, we used the outcome of GP consultations for asthma exacerbations in 294 participants. There was no significant differences between groups (OR 0.80; 95% CI 0.50 to 1.26) (Figure 8).

Figure 8. Forest plot of comparison: 2 Adult studies, outcome: 2.1 Asthma exacerbations during follow-up.

Number of exacerbations over 52 weeks (exacerbation rate)
Two studies reported exacerbations over 52 weeks. Moudgil 2000 reported the number of events in each group (e.g. culture-specific n = 218 compared to controls n = 212), however we were unable to obtain or calculate the standard error. Blixen 2001 stated that there was no statistically significant differences between groups but no figures were given. Thus meta-analysis was not possible for this outcome.

Severe exacerbations requiring oral corticosteroids over the study period
One study (Moudgil 2000) reported data for this outcome. There was no significant difference between groups for those participants.
Severe exacerbations requiring hospitalisations

Two studies (Moudgil 2000; Blixen 2001) reported this outcome, but numerical data could only be obtained from one study (Moudgil 2000). Blixen 2001 stated that there was no statistically significant differences between groups. There was no significant difference between the groups for number of participants (n=294) who were hospitalised for asthma (OR 0.83; 95% CI 0.31 to 2.22) (Figure 8).

Secondary outcomes

Objective measurements of asthma control (FEV1, peak flow, airway hyper-responsiveness)

One study (Moudgil 2000) reported there was no statistically significant differences between groups for lung function, however numerical data were not provided, therefore meta-analysis was not possible. We were unable to obtain any further details from study authors.

Asthma Control Score

No studies reported this outcome.

Change in asthma QoL score

Two studies reported this outcome (Moudgil 2000; Blixen 2001). An improved asthma QoL score (the change in score Analysis 2.2) was seen in those who received the culture-specific education programme when compared to controls (MD 0.26, 95% CI 0.17 to 0.36) (Figure 9). For this outcome, the study authors (Moudgil 2000) report that 280 participants completed the end of study QoL, but the specific numbers for each group was not reported and we assumed that n = 140 was for each group. We could not obtain any further data from the primary author.

Figure 9. Forest plot of comparison: 2 Adult studies, outcome: 2.2 Change in AQLQ.

Other asthma symptoms scores (e.g. diary cards)

No studies reported this outcome.

Adherence outcomes

No studies reported this outcome.

Knowledge of asthma symptoms

One study (Poureslami 2012) reported improvement in knowledge of asthma symptoms in 42 participants. There was no significant difference between groups (Analysis 2.3).

Proper use of inhaler

One study (Poureslami 2012) reported outcome data on improvement of the proper use of inhaler technique in 42 participants. There was no significant differences between groups (Analysis 2.3).

Economic data
No studies reported this outcome.

**Subgroup analysis**

**Different settings (rural versus non-rural)**

We did not perform a separate subgroup analysis, as there was only one study in each subgroup (*Analysis 1.2*). The study by La Roche 2006 was conducted in an urban setting in Boston, USA, whereas the study by Valery 2010 was conducted in two Indigenous communities in remote Australia.

**Sensitivity analysis**

There were insufficient data to undertake any sensitivity analysis.
### Additional Summary of Findings

**Culture-specific asthma education program compared to generic asthma education (or usual care) for asthma in adults**

**Participant or population:** Adults from minority groups with doctor diagnosed asthma  
**Setting:** Any  
**Intervention:** Culture-specific asthma education program  
**Comparison:** Generic asthma education program (or usual care)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Anticipated absolute effects* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>N of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk with generic or usual care</td>
<td>Risk with Culture-specific asthma education program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants who had one or more exacerbation of the study period follow-up: 12 months</td>
<td>559 per 1,000 (388 to 615)</td>
<td>504 per 1000</td>
<td>OR 0.80 (0.50 to 1.26)</td>
<td>294 (1 RCT)</td>
<td>⊕⊕⊕⊕ ⊕⃝⃝⃝ VERYLLOW*</td>
</tr>
<tr>
<td>Number of participants requiring oral corticosteroids over the study period follow-up: 12 months</td>
<td>203 per 1,000 (123 to 306)</td>
<td>198 per 1000</td>
<td>OR 0.97 (0.55 to 1.73)</td>
<td>294 (1 RCT)</td>
<td>⊕⊕⊕⊕ ⊕⃝⃝⃝ VERYLLOW*</td>
</tr>
<tr>
<td>Severe exacerbations requiring hospitalisation over the study period follow-up: 12 months</td>
<td>63 per 1,000 (20 to 130)</td>
<td>53 per 1000</td>
<td>OR 0.83 (0.31 to 2.22)</td>
<td>294 (1 RCT)</td>
<td>⊕⊕⊕⊕ ⊕⃝⃝⃝ VERYLLOW*</td>
</tr>
</tbody>
</table>

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; OR: Odds ratio
This table was created using the GRADE Pro software (GRADEpro GDT 2015)

GRADE Working Group grades of evidence
High quality: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate quality: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low quality: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low quality: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

* The sole study (Moudgil 2000) was of very low quality. There were many uncertainties in this study particularly with regard to outcomes reported (e.g. participants from the age of 11 were included, however the data presented combine adult data, thus outcomes are not shown separately for the paediatric population), allocation concealment, performance/detection bias, reporting bias and imprecision (3 downgrades for these items).
**DISCUSSION**

**Summary of main results**

In this updated review, an additional three studies and 220 participants were added, with a total of seven randomised controlled trials (RCTs) with 837 participants with asthma from ethnic minority groups. Two were multi-centre and five single-centre with study durations ranging from six to 12 months. There were two adult-based studies and four paediatric-based studies, while one study included both adult and children. This updated review improves the evidence from the previous review supporting the use of culture-specific asthma education programmes for adults and children from minority groups with asthma. The benefit of culture-specific asthma education programmes (compared to generic or usual education programme) was stronger in children than in adults. In children, significant differences between groups were found for reducing hospitalisations and improving the outcomes of asthma control, asthma knowledge and adherence. In adults, asthma-related QoL was the only outcome where there was statistical significance between groups (although clinically the evidence was weak). In both children and adults, there was no difference between groups for the outcome of all exacerbations. A single study examined economic cost and described a significant benefit in cost saving when culture-specific asthma education programmes were used.

**Overall completeness and applicability of evidence**

This systematic review is substantially limited by few studies and by a lack of available data preventing combining outcomes for meta-analysis. Statistical difference between the groups were not found in all outcomes, although this may be related to insufficient sample size (discussed below). While the studies shared some common themes, there were also differences among the studies; notably, the type of interventions used, ethnic groups being investigated and outcomes measured. Furthermore, several studies did not report follow-up data for clinical outcomes; Blixen 2001 did not report hospitalisations, emergency department (ED) visits etc, and Moudgil 2000 did not report objective measurements e.g. peak flow. Also, La Roche 2006 and colleagues’ study was small, leading to baseline imbalances in the asthma knowledge scores. It was also unclear whether there were any participants lost to follow-up in the Poureilami 2012 study. The study by Grover 2016 was a small feasibility RCT which had some baseline imbalances at randomisation.

The absence of a significant difference between groups for all types of asthma exacerbations may be related to a type 1 error (inadequate sample size). Therefore, while both this review and the review from Tapp 2007 found no improvement in adult ED presentations or exacerbations over the study period, the type of educational intervention used can affect self-reported asthma-related QoL of participants. In this instance, we could theorise that the use of a culture-specific programme enables participants (adults) to more fully engage in the education being provided and in turn have a positive effect on QoL scores. These results however should be interpreted with caution due to the small number of included studies that measured asthma QoL (two studies) and the relatively small sample size (n = 308) in those studies (Moudgil 2000; Blixen 2001). Similar to previous updates, we were unable to include results from Canino 2008, which also included an asthma QoL outcome. In children however, a reduction with severe asthma exacerbations requiring hospitalisations was seen (Figure 5).

For the purpose of this review, it was assumed that ‘usual care’ for asthma presentations would include the provision of generic asthma education, in accordance with recommendations such as the 1997 National Asthma Education and Prevention Program Guidelines (Edmond 1998). Therefore, while the studies by Blixen 2001 and Moudgil 2000 do not specify the nature of the education that control group participants received, it has been assumed that through the provision of ‘usual care’, participants would have received some form of education during the clinical encounter. Ideally, this review would have included RCTs in both adults and children with larger sample sizes and have presented more data regarding asthma exacerbation outcomes (e.g. hospitalisations, ED visits, use of rescue oral corticosteroids). This review is limited by the relatively small number of studies and sample sizes, and by the high rate of attrition of participants (clinical outcomes were measured for 329 participants from an original total sample size of 396). It should be noted that three of the studies (Blixen 2001; La Roche 2006; Grover 2016) were pilot/feasibility studies. There were significant differences in several outcomes, however where outcomes did not reach statistical significance, the direction of results tended to favour the culture-specific programmes. It has been recognized by Swartz and Dick that in models of care for chronic diseases, the focus must be on the person in his or her own context (Swartz 2002). Certainly this ideal has been met with the intervention in the study by La Roche and colleagues, with one focus of the intervention being to locate the signs and symptoms of asthma within the cultural context of the participant and family (La Roche 2006). La Roche and colleagues also trialled their culturally specific intervention against a generic education programme (La Roche 2006), whereas the control groups in the two other included studies (Moudgil 2000; Blixen 2001) received ‘usual care’ (standard asthma education) and participants were asked to continue with their usual follow-up routine. The interventions used by Blixen 2001 and Moudgil 2000 could be argued to be culturally modified, rather than culturally specific, with both studies using interventions that have been used in populations understood to be white participants, and modified through the use of language, images and other additions. However, the decision was made to include these two studies as it was felt that the modifications and delivery of the intervention were specific to the
ethnic groups to which the participants belonged. It should also be noted that while all the studies trialled interventions in minority groups, only two studies (Valery 2010; Grover 2016) involved a population who were Indigenous to the study setting.

Quality of the evidence

The ‘Summary of findings’ tables report the available evidence for our primary outcomes related to asthma exacerbations and our justification for the quality of evidence (Summary of findings for the main comparison; Summary of findings 2). Overall, the quality of evidence of the studies was very low to low, due to methodological differences, lack of objective measurements, reporting and imprecision of data.

Potential biases in the review process

One of the authors of this review is the senior author on the Valery 2010 paper. Additional data were obtained by direct contact with A/Prof Valery and data extraction was performed by another review author using data from another Cochrane review (Chang 2010).

Agreements and disagreements with other studies or reviews

This review’s findings are in agreement with the review examining the efficacy of involvement of an Indigenous healthcare worker (IHW) in comparison to absence of an IHW in asthma education programs in improving asthma-related outcomes in Indigenous children and adults with asthma (Chang 2010). Other systematic reviews on culture-specific interventions have like-wise found that culture-adapted programs were more efficacious than generic programs such as interventions that target smoking cessation, diet, and/or physical activity (Nierkens 2013). However, for health promotion interventions, other systematic reviews have also called for more evidence as there is yet insufficient evidence on the clinical effectiveness or cost-effectiveness of these adapted approaches although it has been shown that culturally adapting interventions increases salience, acceptability and uptake (Liu 2012; Davidson 2014).

The results of another Cochrane review in adults found that asthma education interventions in the ED, while effective at reducing hospital admission, did not significantly reduce subsequent ED visits (Tapp 2007). The review by Tapp and colleagues also found no significant difference in QoL scores between treatment and control groups (Tapp 2007), whereas the review presented here found a significant improvement in asthma QoL scores for adult participants, although the difference between groups was lower then the minimum important difference for the QoL tool.

Authors’ conclusions

Implications for practice

The evidence presented in this review suggests that culture-specific education programmes for adults and children from minority groups may be effective in improving asthma-related outcomes, but our confidence is limited by the small number of randomised controlled trials (RCTs) identified and difficulties encountered in performing meta-analysis. However, the benefits seen are in keeping with the wider body of evidence and current guidance and it is therefore justified that asthma education programmes for children and adults from minority groups should be culture-specific and considered for health service and policy (where able) to reduce ongoing disparities and poorer health outcomes faced by disadvantaged and minority groups.

Implications for research

Given the diversity of settings and complexities of health outcomes of people with asthma from minority groups, evidence from seven RCTs suggests that culture-specific education programmes are effective in improving some but not all asthma-related health outcomes.

Further high-quality parallel RCTs are needed to further assess the role of culturally specific education programmes for people with asthma from minority groups. Trials should include both adults and children (including families), and should compare the culture-specific programmes with generic education programmes (as opposed to usual care). Collection of clinical outcomes of asthma exacerbations and severity, as well as other asthma-related outcomes including QoL, knowledge, self-management behaviours, adherence outcomes and economic impact should be included in future trials to gain a better perspective on the efficacy of culture-specific programmes for people with asthma from minority groups. Trials involving minority groups indigenous to their country of residence should also be conducted. The type and extend of ‘culture-specific’ approaches should also be explicit. Given that there was only one study that reported economic data, economic data for the intervention are also required.

Acknowledgements

We also thank Elizabeth Stovold for performing the original and updated searchers and for obtaining the relevant papers. We further thank Dr Martin La Roche, Dr Fitzgerald, Dr Poureaslami, Dr Canino, Dr Grover and A/Prof Patricia Valery for responding to our queries about their study. We are grateful to the Airways Group for their on-going support.

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We are very grateful to Dr Chris Cates for advice and help with extracting data and analysis.

REFERENCES

References to studies included in this review

Blixen 2001 [published data only]

Canino 2008 [published data only]

Grover 2016 [published data only]

La Roche 2006 [published and unpublished data]

Moudgil 2000 [published data only]

Possamai 2012 [published data only]

Valery 2010 [published data only]

References to studies excluded from this review

Alicea-Alvarez 2014 [published data only]

Anderson 2004 [published data only]

Apter 2003 [published data only]

Baren 2001 [published data only]

Bruss 2011 [published data only]

Butz 2006 [published data only]
Culture-specific programs for children and adults from minority groups who have asthma (Review)

Choy 1999 (published data only)

Clark 2004 (published data only)

Crowder 2012 (published data only)

DePue 2007 (published data only)

Evans 1997 (published data only)

Evans 1999 (published data only)

Fisher 2009 (published data only)

Ford 1997 (published data only)

Griffiths 2005 (published data only)

Gundelman 2004 (published data only)

Kay 2006 (published data only)

Kelso 1995 (published data only)

Mc Manus 2010 (published data only)

Mitchell 1986 (published data only)

Mosnaim 2013 (published data only)

Nelson 2011 (published data only)

Partridge 2000 (published data only)

Perez 1999 (published data only)

Persky 2007 (published data only)

Pilcher 2014 (published data only)

Poureslami 2011 (published data only)

Velsor-Friedrich 2004  *(published data only)*

Velsor-Friedrich 2005  *(published data only)*

Wise 2010  *(published data only)*

Zar 2012  *(published data only)*

Zorc 2009  *(published data only)*

References to studies awaiting assessment

Buist 2001  *(unpublished data only)*

Butz 2004  *(unpublished data only)*

Feldman 2016  *(published data only)*

Griffiths 2016  *(published data only)*

Patel 2016  *(published data only)*

References to ongoing studies

Janivic 2012  *(unpublished data only)*

Patel 2014  *(unpublished data only)*
Study protocol for improving asthma outcomes through cross-cultural communication training for physicians: a randomised trial of physician training. Ongoing study December 2010.

Additional references

Abbott 2007

Beaglehole 2008

BTS 2016

Chang 2002

Chang 2010
Chino 2006

Coultas 1994

Davidson 2014

de Oliveira 1999

Douglas 2013

Eades 2000

Edmond 1998

Enarson 1999

Gibson 2002a

Gibson 2002b

GRADEpro GDT 2015

Hamdorf 1996

Harrington 2015

Haselkorn 2008

Higgins 2011

Juniper 1992

Juniper 1993

Juniper 1996

Liu 2012

Mitchell 2016

National Asthma Council Australia 2015

NHPAC 2006
Nierkens 2013

Powell 2002

Review Manager (RevMan) [Computer program]

Schmidt 2016

Sin 2002

Speck 2014

Stewart 2013

Swartz 2002

Tapp 2007

Toelle 2011

Wolf 2002

References to other published versions of this review

Bailey 2007
Bailey EJ, Chang AB. Culture-specific programs for children and adults from minority groups who have asthma. *Cochrane Database of Systematic Reviews* 2007, Issue 3. [DOI: 10.1002/14651858.CD006580]

Bailey 2008

Bailey 2009a

Bailey 2009b

* Indicates the major publication for the study
## Characteristics of included studies  
*ordered by study ID*

### Blixen 2001

<table>
<thead>
<tr>
<th>Methods</th>
<th>An open, prospective, randomised controlled study evaluating the use of an asthma education program specifically targeted for African Americans compared with no education (control group)</th>
</tr>
</thead>
</table>
| Participants | **Inclusion criteria:** African-American adults aged between 18 to 50 years hospitalised overnight at a single hospital with a primary diagnosis of asthma  
**Exclusion criteria:** No information described  
Participants were identified and approached whilst hospitalised with an asthma episode. Verbal consent was obtained from those who wished to participate. A face-to-face baseline interview was arranged (whilst still hospitalised). Following baseline interview, participants were randomly assigned to either the intervention or control group. Telephone interviews were conducted at 3 and 6 months consisting of the same questions asked at baseline plus additional information about any asthma events since the last interview  
**Number approached:** n = 40  
**Number declined:** n = 12  
**Number consented and randomised:** n = 28 (n = 14 intervention group and n = 14 control group)  
**Baseline:** Intervention group n = 14, Control group n = 14  
**3 month follow-up:** Intervention group n = 10, Control group n = 11  
**6 month follow-up:** Intervention group n = 7, Control group n = 6 |
| Interventions | **Recruitment dates:** July to November 1997  
**Sample size:** n = 30 (15 per arm)  
**Intervention group:** received three one-hour individual asthma self-management educational sessions with a nurse educator while hospitalised with a primary diagnosis of asthma  
The aim of the sessions was to teach patients the rationale and skills required to manage asthma as a chronic inflammatory process rather than an episodic crisis-driven process. During these educational sessions, participants received a number of resources as outlined 1. Workbook (Learn Asthma Control in Seven Days) which was modified to be culturally appropriate to African Americans. This included a discussion on handling the stressors common to many African Americans. The goals of the educational intervention were to;  
- optimise anti-inflammatory therapy by improving inhalation technique with metered dose inhalers (MDI’s); and  
- have patients learn to monitor changes in airway obstruction through use of peak flow meters  
To achieve these goals a video on MDI technique and peak flow monitoring was shown during the educational sessions. The video featured a well-known African-American asthma researcher (Dr Marvella Ford). Participants rehearsed the demonstration until appropriate technique was mastered, and which included:  
1. illustrations of African Americans performing asthma management techniques  
2. references to famous African Americans who have asthma and who could serve as role models  
3. the addition of a discussion on handling the stresses common to many African Americans |
Americans (such as looking for work)
4. substitution of lay language for medical terms wherever possible
5. addition of ideas for communicating with healthcare providers, such as taking a
   tape recorder to doctors visits and recording what the doctor says
6. the addition of toll-free telephone numbers for asthma organisations and local
telephone numbers for the American Lung Association

2. Participants were shown a video on MDI-technique and peak flow monitoring. The
   video, “Managing Your Asthma: Understanding Proper Inhale and Peak Flow Tech-
   nique” was produced by Glaxo-Wellcome and featured an African-American asthma
   specialist showing African-American patients how to use MDIs and Peak flow meters.
Participants then rehearsed the demonstration until the technique was mastered. Partic-
ipants were given the video, a peak flowmeter and a spacer for an MDI to take home
Written materials to reinforce the concepts and self-management techniques introduced
in the educational sessions were mailed to the intervention group participants at 3 and
6 months

Control group: were asked to continue with their usual care and follow-up, which
represented the ‘generic’ asthma programme

### Outcomes

**Outcome measures**
1. Symptom frequency (frequency of wheeze, shortness of breath and coughing in 2
   weeks prior to hospitalisation) self-reported by participants, coded into categories of:
   i) mild intermittent (symptoms twice a week or less)
   ii) mild persistent (symptoms more than twice a week but less than once a day)
   iii) moderate persistent (daily symptoms)
   iv) severe persistent (continual symptoms)
2. Asthma self management behaviours (participants recorded which medications
   they use, frequency of following physician instructions regarding these medications,
   use of a rescue plan for asthma, the use of a peak flow meter and whether they have a
   physician they see regularly for asthma).
3. Overall health status (participants asked to rate their health as excellent, very
good, good, fair, or poor, using one question from Medical Outcomes Study 36-Item
   Short-Form-Health Survey).
4. Asthma QoL evaluating 4 domains: activity limitation, symptoms, emotional
   functioning and environmental stimuli.
5. Depression (participants asked to complete the Center for Epidemiological
   Studies Depression Scale)
6. Health Care Resource Use (survey addressing asthma-related inpatient hospital
   admissions and length of stay, number of office or clinic based physician visits,
   emergency department presentations for asthma and telephone contacts to nursing or
   medical personnel in 3 months prior to each interview).

Outcome assessments were performed by telephone interview at three and six months
post intervention

### Notes

Lost to follow-up at final assessment: n = 15

**Funding:** The Nursing Research Program-Clinical Applications Research-GlaxoWell-
come and The Agency for Health Care Policy and Research

### Risk of bias
### Blixen 2001 (Continued)

<table>
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<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
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<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Method of randomisation was not described by authors</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Study authors did not describe method of allocation concealment and how this was maintained</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>High risk</td>
<td>Blinding of participants was not possible after randomisation, given the nature of the intervention compared to the control group</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Low risk</td>
<td>The randomisation status of participants at 3 and 6 months interviews were concealed by using a different trained interviewer who did not participate in the education program and was not aware of randomisation status</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>High risk</td>
<td>Attrition was high, with only 13/28 (46%) participants able to be contacted for the 6-month post discharge follow-up interview due to disconnected phone or moving without a forwarding address</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>Descriptive data reported. Intention-to-treat analysis not used</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Education intervention aimed to optimise anti-inflammatory therapy by improving metered dose inhalation and peak flow - data not reported in paper</td>
</tr>
</tbody>
</table>

### Canino 2008

**Methods**

Single-blinded randomised controlled trial comparing intervention “Take Control, Empower Yourself and Achieve Management of Asthma” (CALMA) program with control (usual care group)

All study participants completed a one hour in-home baseline interview and similar post-interview 4 months after randomisation

Randomisation by computer algorithm based on mixed block design

**Participants**

Participants were identified and screened for eligibility before invitation to participate

**Inclusion criteria:**

1. families with a child aged between 5 and 12 years with poor asthma control, as defined by any of the following in the past 4 weeks:
i) use of any asthma medication more than once a week
ii) experiencing asthma symptoms such as wheezing, tightness of chest, problems coughing, or waking up at night because of asthma either daily or continuously
iii) using the emergency department 2 or more times during the last 4 weeks; and
iv) using oral steroids or having been hospitalised in the last year

**Exclusion criteria:**
1. currently participating in another asthma study
2. being the sibling of a selected child
3. no appropriate address for follow-up

All study participants completed a one-hour in-home baseline interview and similar post-interview 4 months after randomisation

Randomisation by computer algorithm based on mixed block design

**Number screened:** $n = 332$

**Number eligible:** $n = 256$

**Number randomised:** $n = 221$ (Intervention group $n = 110$ and Control group $n = 111$)

1 participant from control group and 2 participants from CALMA (intervention) group were lost to follow-up. All analyses were based on intention-to-treat

### Interventions

**Recruitment dates:** April 2006 to October 2006

**Sample size:** Not stated

**Intervention group:** CALMA is the abbreviation of the Spanish for “Take Control, Empower Yourself and Achieve Asthma Management”. The intervention was developed for reducing asthma morbidity in poor Puerto Rican children (aged 5 to 12 years) with asthma

Children and families enrolled in the intervention group received 8 asthma education modules, delivered over the course of 2 home visits with telephone contact for follow-up and reinforcement of recommended plans and assignments. The modules aimed to help the patient/family with the following goals

1. Understanding the chronic nature of asthma
2. Identifying and overcoming barriers to care and to appropriate medication use
3. Better understanding and use of the types of medications
4. Appropriately use the healthcare system and keep follow-up appointments
5. Enhance the use of action plans
6. Improve identification of asthma triggers and environmental avoidance techniques
7. Encourage identification of onset of symptoms and early management
8. Assume an active role in the communication with the provider
9. Identify the stressors that may affect the psychological well being of the parent and learn when and where to look for psychological and family therapy help, and
10. Provide a culturally competent environment in which the family feels understood and free to share cultural beliefs and practices.

The modules were culturally adapted with inclusions such as common practices and myths that Puerto Rican parents have about asthma, proper use of home remedies, culturally congruent pictures, and common asthma triggers in the island, such as Sahara dust and eruptions from Caribbean volcanoes. Educational material was developed relating to coping with marital and family stress resulting from the consequences of the child’s asthma, increasing parental empowerment to deal with the Puerto Rican health system and educating parents how to teach their child and others how to manage asthma.
Control group: received five flyers of educational materials that contained information about:
1. a description of control and rescue medications, when to use them and their benefit
2. information about what asthma is
3. common allergens and triggers and how to prevent episodes
4. how to take care of asthma equipment
5. common foods that may be allergenic.

Outcomes

Primary outcome
1. Number of symptom free days in the past month and past 2 weeks at follow-up

Secondary outcome
1. Childhood Asthma Control Test
2. Medication use in the last 12 months as per retrospective daily self-report
3. Pediatric Asthma QoL (caregivers QoL measured with Junipers Pediatric Asthma QoL scale)
4. Caregivers Asthma Knowledge Scale
5. Family Empowerment Scale
Assessments were performed at baseline and 4 months post randomisation

Notes

Lost to follow-up at final assessment: n = 3
Funding: National Centre for Minority Health and Health Disparities and the National Institutes of Health

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
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</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Study authors state randomisation was done based on a mixed block randomisation scheme</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Randomisation by computerised algorithm based on mixed block randomisation scheme. No information provided on how allocation concealment was maintained</td>
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<tr>
<td>Blinding of participants and personnel (performance bias)</td>
<td>High risk</td>
<td>Complete blinding was not possible after randomisation, given the nature of the intervention compared to the control group</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Low risk</td>
<td>Complete outcome data were measured in &gt; 95% of participants</td>
</tr>
</tbody>
</table>
### Grover 2016

**Methods**

A single-centre randomised controlled trial aiming to develop, implement and evaluate the efficacy of a culturally contextualised asthma education program for Indian parents and children with asthma.

**Participants**

**Inclusion criteria:** Indian children aged between 7 and 12 years; family spoke either English/Hindi; child diagnosed with asthma and child had at least 2 asthma-related visits to the hospital in the 12 months prior to study

**Exclusion criteria:** Not stated

**Clinical asthma:** Child needed to be diagnosed with asthma, however not defined as to who made diagnosis

**Recruitment strategy:** Eligible participants were recruited and invited by their physician or by medical record review when attending asthma outpatient clinic in a Chest Diseases Hospital in New Dehli

**Number approached:** Not stated

**Number refused:** Not stated

**Number randomised (parent-child pairs):** n = 24 (intervention group; n = 16 control group (usual care))

**Interventions**

**Education program development:** The overarching aim was to develop, implement and evaluate the efficacy of a culturally adapted asthma education program to parents and children with asthma. The asthma education program was designed based on key principles of health education and pedagogy and was split into three key components:

1. **Power point presentation** (covering asthma symptoms, triggers, medication, adherence, medication-related beliefs, inhaler techniques, written asthma action plans and setting health goals)

2. **A child workbook** (covering same topics as the power point presentation but with graphics, child friendly language and space for the child to write in)

3. **Related activities interspersed at appropriate spots during power point presentation**

The asthma education content was underpinned by international asthma guidelines (Global initiative for Asthma - GINA)

**Participant recruitment dates:** July to December 2012

**Sample size:** n = 20 per arm (total n = 40)

Parents and children were invited to participate in the RCT when attending asthma outpatient visit. It was not clear if the intervention was done at the time of the outpatient visit or arranged for another time convenient to families. While not reported, it was assumed that the intervention was individualised with parent-carer pairs

Both the intervention and control group completed data collection at the baseline visit. This included asthma caregiver quality of life questionnaire, paediatric asthma control, asthma knowledge, asthma control, medication adherence, inhaler use competence and asthma action plan ownership

**Intervention group:** This was delivered by two allied health professionals (pharmacists)
and asthma educators (researchers x 2) and included:
1. Delivery of the asthma education intervention (1 hour)
2. Working through power point/child workbook
3. Collaborative goal setting
4. All parent-child pairs sent to physician for asthma action plan

Further data collection was done at 3 months (phone call) and at 6 months (face to face follow-up) to collect primary and secondary outcome data

**Control group:** After baseline data were collected (identical to intervention group), parents and children were given a standard information pack for asthma in line with GINA guidelines. They were assessed at 6 months (face-to-face follow-up) to collect primary and secondary outcome data

**Outcomes**

**Primary outcome**
1. Paediatric asthma caregiver quality of life

**Secondary outcomes**
1. Asthma knowledge (customised questionnaire - score ranging from 0 to 34. A high score indicated increased knowledge)
2. Asthma control (Juniper questionnaire - score is a mean of 7 items. 0 = poorly controlled, 7 = well controlled)
3. Medication adherence (validated beliefs questionnaire - 9 items. Score ranged between 0 (not hard at all) and 2 (very hard))
4. Inhaler technique

Outcomes were assessed at baseline, 3 and 6 months

**Notes**

It was not clear how many people were screened or if written informed consent was provided

Study reached sample size, however baseline imbalance between groups (n = 24 intervention group and n = 16 control group). Analysis of baseline characteristics was not clinically significant

**Funding:** Nil

**Risk of bias**

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<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Authors describe participants were recruited from asthma outpatient clinic and through note reviews. Generated using Microsoft Excel, using number sequence generation</td>
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<tr>
<td>Allocation concealment (selection bias)</td>
<td>High risk</td>
<td>Authors acknowledge in discussions that allocation concealment was not implemented</td>
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<td>High risk</td>
<td>It was not clear when the intervention took place with the parent-child at the time of outpatient visit, or arranged for another time convenient for the family. It was not</td>
</tr>
</tbody>
</table>
### Grover 2016 (Continued)

| Blinding of outcome assessment (detection bias) | High risk | Outcome assessors were not blinded to treatment groups |
| All outcomes | | |

| Incomplete outcome data (attrition bias) | Low risk | Authors report all participants remained in study until end of study at 6 months |
| All outcomes | | |

| Selective reporting (reporting bias) | Low risk | Authors report primary and secondary outcomes |
| | | |

| Other bias | Low risk | Nil |
| | | |

### La Roche 2006

#### Methods

Randomised single-blind, parallel comparison of 2 types of interventions: Multifamily asthma group treatment (MFAGT) vs. Standard Psycho-educational Asthma Intervention (SPAI) in children with asthma

These two interventions were also compared to controls (no additional education program provided) that were randomly selected from a pool of patients with asthma

#### Participants

Families with children with asthma were enrolled from Martha Eliot Health Centre, an inner-city community health centre which is part of the Boston's children Hospital

**Inclusion criteria:** African-American or Hispanic descent, aged 7-13 years with physician diagnosed asthma

**Exclusion criteria:** Nil described

**Number families screened:** n = 46

**Number families randomised:** n = 24

**Number families completed study:** n = 22

16 (73%) were Hispanic and 6 (27%) were African American. Mean age of children randomised was 10.2 years. 13 (59%) were male and 9 (41%) were female

The control group had 11 families and were matched to the intervention group by ethnicity, age and sex. All children were from low socio-economic background. Participants competed 2 assessments (see outcome measures); one at enrolment and the second at one year following enrolment

**Lost to follow-up:** n = 2 participants at final assessment

#### Interventions

**Recruitment dates:** Not stated

**Sample size:** Not stated

**Intervention group:** MFAGT is based on allocentric self-orientation and socio-economic context of ethnic minorities. Program delivery included a Hispanic and African-American educator/psychologist. MFAGT also emphasised relational and collaborative asthma management among children, families, primary physician, and mental health specialist (as opposed to learning in isolation from others)

Families in the intervention group received three one-hour education sessions (on separate days) each covering one module of the education programme

The content of each module consisted of:
1. Identifying and monitoring asthma symptoms and learning to effectively use medical/contextual resources (peak flow, medications) to control symptoms.
2. Identifying and preventing asthma triggers
3. Preventing and coping with an asthma attack (e.g. asthma action plans)

**Control group:** SPAI has the same 3 education modules above but followed a structured teaching approach without locating asthma symptoms within the socio-economic or cultural context. This asthma education/management strategy did not include contingency plans that emphasised cultural resources and reflected a generic approach to asthma education.

Therefore, participants in the MFAGT arm of the study received the ‘culturally specific’ programme, whereas the SPAI participants served as a control group receiving the generic asthma education programme.

**Outcomes**

**Primary outcome**
1. Number of asthma-related Emergency Department visits

**Secondary outcome**
1. Individualism-Collectivism scale
2. Asthma Behavioural Assessment which consists of Asthma Knowledge (AK) and Asthma skills (AS) in both parents and children. AK scores ranged from 0 to 12 and AS ranged from 17 to 85

Outcomes were assessed 12 months post intervention.

**Notes**

The paper provided data that compared MFAGT to SPAI and to controls. However, as the control group was not randomised, control group data were not included in the analysis.

**Funding:** Office of Sponsored Projects of the Children’s Hospital Boston and Harvard Medical School, Center of Excellence in Minority Health and Health Disparities.

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
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<td>Randomisation by computer, allocation method not described</td>
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<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Study authors do not provide information on how allocation concealment was maintained</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>Unclear risk</td>
<td>Study authors do not describe how blinding was maintained throughout study</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Unclear risk</td>
<td>Study authors do not describe if outcome assessment was completed by study personnel who were blinded to treatment allocation. While treatment (exacerbations outcome) was given by health professionals unrelated to trial, for the outcome of asthma</td>
</tr>
</tbody>
</table>
La Roche 2006  (Continued)

knowledge, risk is high as this was a single blind study

Incomplete outcome data (attrition bias)
All outcomes
Low risk
All completed the trial, however two families did not complete 2nd evaluation (these families were omitted from analysis)

Selective reporting (reporting bias)
Low risk
Paper provided data that compared MFAGT to SPAI and to controls. However, as the control group was not randomised, control group data was not included in analysis. Intention-to-treat analysis not used

Other bias
Unclear risk
Authors do not provide data for control children - not included in analysis

Moudgil 2000

Methods
Open, prospective, randomised, controlled, parallel group study examining individually-based asthma education and structured follow-up for people with asthma

Participants
Potential participants were identified through registration and diagnostic records inner city general practices in the Birmingham area. All eligible patients were requested to attend their general practice for review by the researcher. Participants were randomised to either the intervention or control group prior to initial appointments being sent

Inclusion criteria: All white European (WE) or Indian sub-continent (ISC) participants with asthma, from 12 participating general practices in the Birmingham area, aged 11 to 59 years

Exclusion criteria: Minority groups (e.g. Afro-Caribbean and some mixed race) and a small number of Bangladeshi and/or only Bengali speaking patients who did not speak English, Punjabi, Urdu or Hindu

Number identified: n = 1217
Number randomised: n = 689 (Intervention group: n = 343 and Control group: n = 346)

Interventions

Study dates: August 1995 to 1996
Sample size: n = 331 in each arm

Intervention group participants: received individual asthma education session of 40 minutes duration with an asthma educator fluent in each participants own dialect (e.g. English, Punjabi, Hindi or Urdu). Emphasis during the session was on:

1. Advising GP regarding any necessary changes of treatment;
2. Optimising treatment including drug delivery technique and compliance;
3. Improving knowledge about disease severity and medication.

Participants were given peak flow meters free of charge and a booklet to record measurements during the 12-month intervention period, along with an individually-tailored asthma management plan and educational literature (in the appropriate dialect) describing aspects of asthma and asthma management. Plans were based on existing BTS guide-
Educational literature in the relevant ethnic dialect, describing aspects of asthma and its management, including triggers, medication, delivery devices etc were distributed to all participants in the intervention group (literature provided by Allen & Hanburys). Educational intervention was reinforced at 4 and 8 months, although it is not stated how this was done.

Control group participants: attended their GP at the start and end of the study for outcome assessment and were asked to continue their usual asthma follow-up and care for asthma (e.g. generic asthma programme).

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Number of asthma-related hospital admissions</td>
</tr>
<tr>
<td></td>
<td>2. Number of asthma-related presentations to the ED</td>
</tr>
<tr>
<td></td>
<td>3. Number of asthma-related home visits from GP</td>
</tr>
<tr>
<td></td>
<td>4. Number of asthma-related visits (during regular hours) to GP</td>
</tr>
<tr>
<td></td>
<td>5. Prescriptions of oral steroids</td>
</tr>
<tr>
<td></td>
<td>6. Prescriptions of antibiotic</td>
</tr>
<tr>
<td></td>
<td>7. Asthma QoL (Juniper - 32 questions about asthma events in the last 2 weeks and scores responses on 7-point scale (1 = severe limitation or most of the time; 7 = no limitation or none of the time))</td>
</tr>
</tbody>
</table>

Outcomes were performed 12 months post intervention.

Notes

Although the study included participants from the age of 11, data presented combines adult data, thus outcomes are not shown separately for the paediatric population. Study measured clinical outcomes for 294 (of 344) participants, and Asthma QoL outcomes for 280 (of 344) participants.

Domains for activity limitation, symptoms, emotional function and exposure to environmental stimuli. Some terms did not translate directly into the different dialects used and the terms used were agreed by two bilingual persons after a translation-back translation process.

Funding: West Midlands Regional Health Authority and North Birmingham Health Authority.

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Randomisation was computer-generated and randomly allocated</td>
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<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Participants were reviewed at local GP clinics by researcher. Study authors did not describe how allocation was concealed</td>
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<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>Unclear risk</td>
<td>Unclear if outcome assessor was blinded to intervention groups</td>
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### Moudgil 2000 (Continued)

<table>
<thead>
<tr>
<th>Bias</th>
<th>Risk</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Blinding of outcome assessment (detection bias)</td>
<td>Unclear risk</td>
<td>Study authors did not describe if outcomes assessor was blinded to intervention groups</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Unclear risk</td>
<td>Clinical data was available for (86%) and 76% for Asthma QoL</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>Intention-to-treat analysis not used. Per protocol analysis</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Objective measurement of airflow obstruction (e.g. peak flow) recorded for 12 months - nil data reported in paper</td>
</tr>
</tbody>
</table>

### Poureslami 2012

#### Methods

A randomised controlled trial to determine the effectiveness of different formats of culturally relevant asthma education on self-management in Punjabi and Chinese asthma patients in Canada

#### Participants

**Inclusion criteria:** Adults with a physician diagnosis of asthma, used asthma medications daily, > 21 years, immigrated to Canada within the last 20 years, lives in the Greater Vancouver Area, and spoke Mandarin, Cantonese or Punjabi

**Exclusion criteria:** Not stated

**Number physician confirmed asthmatics:** n = 167

**Number participated in development of educational intervention:** n = 35

**Number participated in focus group session:** n = 40

**Number randomised in the educational intervention:** n = 92 (n = 4 groups)

1. Group 1: Physician-led knowledge video n = 22
2. Group 2: Patient-generated community video n = 21
3. Group 3: Knowledge and Community video n = 20
4. Group 4: Pictorial pamphlet n = 22

#### Interventions

The overarching purpose of this study was to conduct a community-based research project to develop culturally and linguistically appropriate educational intervention to improve self-management of asthma among immigrants to Canada. 167 asthmatic adults were recruited at a University Pulmonary medical clinic in Vancouver using a convenience sampling method. This study was subsequently split into three parts

- **Part 1:** Development of educational resources (two educational videos on knowledge and community views and educational pamphlet) (n = 35 participants)
- **Part 2:** Randomised controlled trial (n = 92 participants)
- **Part 3:** Focus group session (n = 40 participants)

**Participants recruitment dates for RCT:** Not stated

**Sample size:** n = 92

**Intervention group:** Education interventions took place in a convenient place for participants (usually in their home or clinic). Participants were interviewed using bilingual and bicultural experienced moderators who were blinded to study groups and study hypothesis. Participants in the intervention group consisted of three groups
1. Group 1: Physician-led knowledge video
2. Group 2: Patient-generated community video
3. Group 3: Knowledge and Community video

Participants undertook a pre-test assessment, followed by a 1-month education intervention based on their group allocation. This was followed by a 3-month follow-up post-test assessment. Immediately after receiving the education intervention, participants were asked a series of standardised qualitative questions. 6 months after the post-test assessment, participants were called to assess their self-management using a shorter version of the study questionnaire.

**Control group**: Education interventions took place in a convenient place for participants (usually in their home or clinic). Participants were interviewed using bilingual and bicultural experienced moderators who were blinded to study groups and study hypothesis.

Control participants (group) four received a pictorial pamphlet for asthma. They followed the same process as the intervention group with respect to pre and post assessments.

| Outcomes | 1. Knowledge of asthma symptoms  
2. Knowledge of asthma triggers  
3. Self-reported medication adherence  
4. Proper use of inhaler medication (self-reported) |
<table>
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<tbody>
<tr>
<td></td>
<td>Outcomes were assessed at baseline, 3 and 6 months</td>
</tr>
</tbody>
</table>

| Notes | It was not clear if any participants were lost to follow-up. We assumed all participants were included in the final analysis (n = 92) |

**Funding**: Canadian Institutes of Health Research and The Centre for Lung Health at the University of British Columbia, Vancouver

<table>
<thead>
<tr>
<th>Risk of bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
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<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Authors describe participants were recruited from a convenience sample; however randomisation process not described</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Study authors did not describe how allocation was concealed</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>Low risk</td>
<td>Education intervention and assessments were done individually at participants home or in clinic. Personnel conducting assessments were blinded to study groups</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Low risk</td>
<td>Personnel conducting assessments were blinded to study groups</td>
</tr>
</tbody>
</table>
Incomplete outcome data (attrition bias) | Unclear risk | Authors do not describe if any participants withdrew or were lost to follow-up. Baseline characteristics were reported as one group

Selective reporting (reporting bias) | Unclear risk | Authors do not report descriptive data. Intention-to-treat analysis not used

Other bias | Unclear risk | Unclear whether the original 167 asthmatics participated in more than one step of the development phase (e.g., development of asthma education or focus group)

**Valery 2010**

Methods

A multi-centre randomised controlled trial to assess the outcomes of an education intervention for childhood asthma conducted by Australian Indigenous Health Care Workers (ICHWs)

Participants

**Inclusion criteria:** Indigenous children (Aboriginal or Torres Strait Islander) aged < 18 years from Thursday Island and Horn Island with a provisional diagnosis of asthma or had been referred by Indigenous healthcare workers for assessment with respiratory specialist were eligible

**Exclusion criteria:** Not stated

**Clinical asthma** was defined as repeated episodes of wheeze with dyspnoea that responded to bronchodilators (in children aged 3-6 years, 2 or more episodes of wheezy illness associated with cough and shortness of breath and documented amelioration of symptoms and clinical signs after administration of a bronchodilator)

**Severity of asthma** was classified as persistent, frequent episodic, or infrequent episodic, based on the clinical pattern in the last 12 months

**Number screened for asthma:** n = 484

**Number with physician confirmed asthma:** n = 117

**Number refused:** n = 4

**Number randomised:** Total n = 113 (Intervention group: n = 42 and Control group: n = 71)

Interventions

Prior to the RCT, 67 ICHWs were trained in 7 separate 3-day asthma education workshops on Thursday Island during 2005 and 2008. ICHWs also attended respiratory specialist clinics where asthma management knowledge and skills were reinforced. Existing paediatric asthma and respiratory education resources were adapted to support Torres Strait culture, including child-friendly and age-specific asthma booklets

**Participant recruitment dates:** April 2005 to March 2007

**Sample Size:** n = 54 children per arm

After children (n = 484) were screened by the respiratory physician, those with a confirmed diagnosis of asthma (n = 117) received an education session delivered by trained ICHWs, using existing paediatric asthma and respiratory education resources which were adapted to support Torres Strait culture. Training included using a child-friendly age-specific asthma booklet at enrolment (prior to randomisation)
Eligibility for the RCT was subsequently confirmed and consented children (n = 113) were then randomised to the intervention or control group.

**Intervention group:** Children received additional education sessions delivered by ICHWs at 1, 3 and 6 months after the baseline visit (randomisation). Children were also clinically assessed by the ICHWs at baseline, 1, 3, 6 and 12 months to collect primary and secondary outcome data.

**Control group:** Control group children did not receive any further education sessions. Children were clinically assessed by ICHWs at the baseline visit (randomisation) and again 12 months later.

### Outcomes

**Primary outcome:**
- Number of unscheduled visits to hospital or a doctor due to asthma exacerbation in 12 months after follow-up

**Secondary outcomes:**
- QoL
- Functional severity index for asthma
- Asthma knowledge and use of AAP
- School days missed because of wheezing

Data for primary outcome were collected 12 months prior and 12 months post intervention.

Data for secondary outcomes were collected as baseline (randomisation) 1, 3, 6 and 12 months.

### Notes

**Lost to follow-up at final assessment:** n = 19. A further five children who were infrequent episodic asthmatics were excluded as study investigators could not justify the cost of transport from a remote island for the clinical assessment at 12 months.

**Funding:** National Health and Medical Research Council, Rural Health Support, Education and Training grant, Telstra Foundation and Royal Children's Hospital Foundation.

### Risk of bias

<table>
<thead>
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<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>Allocation to intervention groups was revealed after enrolment</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>High risk</td>
<td>Study was unblinded</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Unclear risk</td>
<td>Unblinded study, but staff collecting data from medical records were blinded to intervention study allocation</td>
</tr>
</tbody>
</table>
Incomplete outcome data (attrition bias)
All outcomes
Five participants who had infrequent data were excluded from the 12 month follow-up, as investigators decided it was not cost-effective to fly participants in for this review.

Selective reporting (reporting bias)
Low risk
Progress of all randomly assignment participants was clearly described. Participants analysed using a per protocol analysis (n = 88)

Other bias
Unclear risk
Nil

AAP: asthma action plan
RCT: randomised controlled trial:
QoL; quality of life

Characteristics of excluded studies [ordered by study ID]

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicea-Alvarez 2014</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Anderson 2004</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Apter 2003</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Baren 2001</td>
<td>Excluded as the intervention was not culture-specific.</td>
</tr>
<tr>
<td>Bruzzese 2011</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Burz 2006</td>
<td>Excluded as the intervention was not culture-specific.</td>
</tr>
<tr>
<td>Choy 1999</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Clark 2004</td>
<td>Excluded as the intervention was not culture-specific.</td>
</tr>
<tr>
<td>Crowder 2012</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>DePue 2007</td>
<td>Non RCT and intervention was not culture-specific.</td>
</tr>
<tr>
<td>Evans 1997</td>
<td>Non RCT and participants were staff of the clinics rather than asthma patients. Intervention was not culture-specific</td>
</tr>
<tr>
<td>Study</td>
<td>Reason for Exclusion</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Evans 1999</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Fisher 2009</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Ford 1997</td>
<td>Excluded as this re-analysis was not an RCT.</td>
</tr>
<tr>
<td>Griffiths 2005</td>
<td>Excluded as asthma management was nested within an RCT for chronic diseases.</td>
</tr>
<tr>
<td>Gundelman 2004</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Kay 2006</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Kelso 1995</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Mc Manus 2010</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Mitchell 1986</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Mosnaim 2013</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Nelson 2011</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Partridge 2000</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Perez 1999</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Persky 2007</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Pilcher 2014</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Poureslami 2011</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Press 2012</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Sperber 1995</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Sullivan 2002</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Tatis 2005</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Velsor-Friedrich 2004</td>
<td>Excluded as study was not an RCT.</td>
</tr>
<tr>
<td>Velsor-Friedrich 2005</td>
<td>Excluded as intervention was not culture-specific.</td>
</tr>
<tr>
<td>Wise 2010</td>
<td>Excluded as intervention was not culture-specific and was not an RCT.</td>
</tr>
</tbody>
</table>
Zar 2012  Excluded as study was not an RCT.
Zorc 2009  Excluded as intervention was not culture-specific.

RCT: randomised controlled trial

**Characteristics of studies awaiting assessment [ordered by study ID]**

**Buist 2001**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>White, Asian (Hawaii), Hispanic and African-American persons with asthma</td>
</tr>
<tr>
<td>Interventions</td>
<td>Does not use a culturally specific education intervention</td>
</tr>
<tr>
<td>Outcomes</td>
<td>No data available</td>
</tr>
<tr>
<td>Notes</td>
<td>Start date in January 2001. Unable to establish if study is ongoing. Information from author in 2007 (Buist AS - Principal Investigator; <a href="mailto:buists@ohsu.edu">buists@ohsu.edu</a>)</td>
</tr>
</tbody>
</table>

**Butz 2004**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>African American (93%)</td>
</tr>
<tr>
<td>Interventions</td>
<td>Includes teaching children communication skills in order to communicate asthma health issues to their primary care provider. Parents completed a one-page cue card when talking with the child's physician, which included child's symptom frequency, number of emergency department visits or hospitalisations in the last 12 months, current medications and worries, health beliefs or expectations about their child's asthma</td>
</tr>
<tr>
<td>Outcomes</td>
<td>No data available</td>
</tr>
<tr>
<td>Notes</td>
<td>Study completed in July 2008, however no further data available on Clinical.Trials.Gov (last checked 25th January 2017)</td>
</tr>
</tbody>
</table>

**Feldman 2016**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Randomised controlled trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Latino persons 18 years or older with asthma and panic disorder (PD)</td>
</tr>
</tbody>
</table>
### Feldman 2016 (Continued)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Cognitive behavior psychophysiological therapy (CBPT) culturally adapted for Latino people compared with music and relaxation therapy (MRT) for 8 weekly sessions to reduce PD severity, improve asthma control and inhaled corticosteroid adherence by 3 months</th>
</tr>
</thead>
</table>
| Outcomes      | **Primary outcome:**  
|               | 1. Reduce PD severity  
|               | **Secondary outcomes:**  
|               | 1. Improvements in asthma control  
|               | 2. Improvements in inhaled corticosteroid adherence  
|               | Data for primary and secondary outcomes were collected at baseline and again at 3 months. Attrition was high (40%). Both groups showed improvements in PD severity, asthma control and several other anxiety and asthma outcome measures from baseline to 3 months. CBPT was more effective over MRT for improved adherence to inhaled corticosteroids |
| Notes         | Trial registered with ClinicalTrials.gov (NCT01583296) |

### Griffiths 2016

<table>
<thead>
<tr>
<th>Methods</th>
<th>Cluster randomised controlled trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>South Asians with asthma aged 3 year or older</td>
</tr>
</tbody>
</table>
| Interventions | Culturally adapted Physician Asthma Care Education (PACE) programme and the Chronic Disease Self Management Programme (CDSMP), compared to usual practice. Participants in the intervention group received education on key messages about asthma with asthma specialist nurses using the PACE and CDSMP program, including self management plans and a follow up appointment either their general practitioner or practice nurses. Participants in the control group received standardised structured education from an asthma specialist  
|               | Participants were interviewed in both groups by researchers (blinded to randomisation status) at baseline, 3 and 12 months. Medical records were reviewed at baseline and then again at 12 months |
| Outcomes      | **Primary outcomes:**  
|               | 1. Time to first unscheduled contact with an asthma exacerbation  
|               | 2. Proportion of participants without unscheduled care  
|               | **Secondary outcomes**  
|               | 1. Time to first asthma review in primary care  
|               | 2. Asthma-specific and generic health related quality of life, using AQ20, North of England and EQ5D scales  
|               | 3. Prescribing assessed from patient records and interviews  
|               | Data for primary and secondary outcomes were collected at baseline, 3 and 12 months. The intervention group did not have any effect on time to first unscheduled attendance for asthma, yet did improve follow-up in primary care, self-efficacy and quality of life |
| Notes         | Unclear if trial was registered |
### Patel 2016

<table>
<thead>
<tr>
<th>Methods</th>
<th>Randomised controlled trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>African American women with persistent asthma</td>
</tr>
<tr>
<td>Interventions</td>
<td>To evaluate a telephone-based self-regulation intervention that emphasised African women's management of asthma compared to usual care in a series of six sessions</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Behavioral factors, symptoms and asthma control, asthma-related quality of life, and health care use were collected at baseline and 2 years later</td>
</tr>
<tr>
<td>Notes</td>
<td>Trial registered with ClinicalTrials.gov (NCT01117805)</td>
</tr>
</tbody>
</table>

### Characteristics of ongoing studies [ordered by study ID]

#### Janevic 2012

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>Study protocol for women of color and asthma control: A randomised controlled trial of an asthma-management intervention for African-American women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Randomised controlled trial</td>
</tr>
</tbody>
</table>
| Participants         | Inclusion Criteria: African-American women > 18 years with asthma who have access to a telephone or cell phone, not pregnant and willing to be involved in the study  
Exclusion Criteria: Patients with chronic respiratory conditions, including cystic fibrosis and chronic obstructive pulmonary disease (COPD) |
| Interventions       | African-American women comparing a five-session asthma-management intervention (over telephone by trained health care educator) compared with usual care |
| Outcomes            | No data available |
| Starting date       | May 2010 |
| Contact information | Mary R Janevic - Investigator mjanevic@umich.edu |
| Notes               | Last clinical trials registry update - June 2016 (recruitment completed) |

#### Patel 2014

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>Study protocol for improving asthma outcomes through cross-cultural communication training for physicians: a randomised trial of physician training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Parallel randomised controlled trial</td>
</tr>
<tr>
<td>Participants</td>
<td>Inclusion criteria: Primary healthcare physicians who treat African-American and Latino/Hispanic children with asthma</td>
</tr>
</tbody>
</table>
### Patel 2014 (Continued)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Three-arm randomised controlled trial to compare effectiveness of Physician Asthma Care Education (PACE) with cross-cultural communication training on health outcomes of African-American and Latino/Hispanic children with asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>No data available</td>
</tr>
<tr>
<td>Starting date</td>
<td>December 2010</td>
</tr>
</tbody>
</table>
| Contact information | Minal R Patel - Principal Investigator  
  minalrp@umich.edu                                                                                                                                                      |
| Notes         | Last clinical trials registry update - May 2016 (recruitment completed)                                                                 |
## Data and Analyses

### Comparison 1. Paediatric studies

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Number of participants who had one or more exacerbation over the study period</td>
<td>1</td>
<td>88</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>1.55 [0.66, 3.66]</td>
</tr>
<tr>
<td>2 Mean number of exacerbations over 52 weeks (exacerbation rate)</td>
<td>2</td>
<td>110</td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>0.18 [-0.25, 0.62]</td>
</tr>
<tr>
<td>3 Severe exacerbations requiring hospitalisation over the study period</td>
<td>2</td>
<td>305</td>
<td>Rate Ratio (Fixed, 95% CI)</td>
<td>0.48 [0.24, 0.95]</td>
</tr>
<tr>
<td>4 Improved asthma control</td>
<td>1</td>
<td></td>
<td>Odds Ratio (Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>5 Asthma control questionnaire</td>
<td>1</td>
<td></td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>6 Improvement in carer’s asthma QoL scores (parent/carer PACQLQ)</td>
<td>1</td>
<td>88</td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>-0.04 [-0.25, 0.17]</td>
</tr>
<tr>
<td>7 Change in Carers’ Asthma QoL (PACQLQ)</td>
<td>2</td>
<td></td>
<td>Mean Difference (Fixed, 95% CI)</td>
<td>Subtotals only</td>
</tr>
<tr>
<td>8 Parent description of AAP when child is well</td>
<td>1</td>
<td>88</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>2.82 [1.17, 6.83]</td>
</tr>
<tr>
<td>9 Self-reported medication adherence (brief medication questionnaire)</td>
<td>1</td>
<td></td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>10 Asthma Knowledge Factors</td>
<td>2</td>
<td></td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>10.1 Parent/carer Asthma Knowledge (behavioural assessment - score 0-12)</td>
<td>1</td>
<td></td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
</tr>
<tr>
<td>10.2 Child Asthma Knowledge (behavioural assessment - score 0-12)</td>
<td>1</td>
<td></td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
</tr>
<tr>
<td>10.3 Parent/carer Asthma knowledge (triggers and treatment)</td>
<td>1</td>
<td></td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
</tr>
</tbody>
</table>
### Comparison 2. Adult studies

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Asthma exacerbations during follow-up</td>
<td>1</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>Totals not selected</td>
<td></td>
</tr>
<tr>
<td>1.1 Number of participants who had one or more exacerbation over the study period</td>
<td>1</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
<td></td>
</tr>
<tr>
<td>1.2 Number of participants requiring oral corticosteroids over the study period</td>
<td>1</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
<td></td>
</tr>
<tr>
<td>1.3 Severe exacerbations requiring hospitalisation over the study period</td>
<td>1</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
<td></td>
</tr>
<tr>
<td>2 Change in AQLQ</td>
<td>2</td>
<td>Mean Difference (Fixed, 95% CI)</td>
<td>0.26 [0.17, 0.36]</td>
<td></td>
</tr>
<tr>
<td>3 Asthma Knowledge Factors</td>
<td>1</td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>Totals not selected</td>
<td></td>
</tr>
<tr>
<td>3.1 Proper use of inhaler technique</td>
<td>1</td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
<td></td>
</tr>
<tr>
<td>3.2 Knowledge of asthma symptoms</td>
<td>1</td>
<td>Mean Difference (IV, Fixed, 95% CI)</td>
<td>0.0 [0.0, 0.0]</td>
<td></td>
</tr>
</tbody>
</table>

### Analysis 1.1. Comparison 1 Paediatric studies, Outcome 1 Number of participants who had one or more exacerbation over the study period.

**Review:** Culture-specific programs for children and adults from minority groups who have asthma

**Comparison:** Paediatric studies

**Outcome:** Number of participants who had one or more exacerbation over the study period

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H,Fixed,95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H,Fixed,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valery 2010</td>
<td>19/35</td>
<td>23/53</td>
<td>1.55 [0.66, 3.66]</td>
<td>100.0 %</td>
<td>1.55 [0.66, 3.66]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>35</strong></td>
<td><strong>53</strong></td>
<td><strong>100.0 %</strong></td>
<td></td>
<td><strong>1.55 [0.66, 3.66]</strong></td>
</tr>
</tbody>
</table>

Total events: 19 (Culture-specific), 23 (Control)
Heterogeneity: not applicable
Test for overall effect: Z = 1.00 (P = 0.32)
Test for subgroup differences: Not applicable

---

Culture-specific programs for children and adults from minority groups who have asthma (Review)

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Analysis 1.2. Comparison 1 Paediatric studies, Outcome 2 Mean number of exacerbations over 52 weeks (exacerbation rate).

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: Paediatric studies

Outcome: Mean number of exacerbations over 52 weeks (exacerbation rate)

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Mean Difference</th>
<th>Weight</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV,Fixed,95% CI</td>
</tr>
<tr>
<td>La Roche 2006</td>
<td>11</td>
<td>0.7 (0.9)</td>
<td>11</td>
<td>1.2 (1.7)</td>
<td>-0.50 [-1.64, 0.64]</td>
</tr>
<tr>
<td>Valery 2010</td>
<td>35</td>
<td>1 (1.19)</td>
<td>53</td>
<td>0.7 (0.95)</td>
<td>0.30 [-0.17, 0.77]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>46</strong></td>
<td><strong>64</strong></td>
<td></td>
<td></td>
<td><strong>100.0 %</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Chi² = 1.62, df = 1 (P = 0.20); I² = 38%
Test for overall effect: Z = 0.83 (P = 0.41)
Test for subgroup differences: Not applicable

---

Analysis 1.3. Comparison 1 Paediatric studies, Outcome 3 Severe exacerbations requiring hospitalisation over the study period.

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: Paediatric studies

Outcome: Severe exacerbations requiring hospitalisation over the study period

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific</th>
<th>Control</th>
<th>log [Rate Ratio]</th>
<th>Rate Ratio</th>
<th>Weight</th>
<th>Rate Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>(SE)</td>
<td>IV,Fixed,95% CI</td>
<td>IV,Fixed,95% CI</td>
<td>IV,Fixed,95% CI</td>
</tr>
<tr>
<td>Canino 2008</td>
<td>108</td>
<td>109</td>
<td>-1.127 (0.4074)</td>
<td></td>
<td>75.1 %</td>
<td>0.32 [ 0.15, 0.72 ]</td>
</tr>
<tr>
<td>Valery 2010</td>
<td>35</td>
<td>53</td>
<td>0.4148 (0.7071)</td>
<td></td>
<td>24.9 %</td>
<td>1.51 [ 0.38, 6.05 ]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>143</strong></td>
<td><strong>162</strong></td>
<td></td>
<td></td>
<td><strong>100.0 %</strong></td>
<td><strong>0.48 [ 0.24, 0.95 ]</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Chi² = 3.57, df = 1 (P = 0.06); I² = 72%
Test for overall effect: Z = 2.10 (P = 0.035)
Test for subgroup differences: Not applicable
Analysis 1.4. Comparison 1 Paediatric studies, Outcome 4 Improved asthma control.

Review: Culture-specific programs for children and adults from minority groups who have asthma

Comparison: 1 Paediatric studies

Outcome: 4 Improved asthma control

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-Specific</th>
<th>Control</th>
<th>log [Odds Ratio]</th>
<th>Odds Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canino 2008</td>
<td>68</td>
<td>62</td>
<td>1.208 (0.427)</td>
<td>3.35</td>
<td>1.45, 7.73</td>
</tr>
</tbody>
</table>

Analysis 1.5. Comparison 1 Paediatric studies, Outcome 5 Asthma control questionnaire.

Review: Culture-specific programs for children and adults from minority groups who have asthma

Comparison: 1 Paediatric studies

Outcome: 5 Asthma control questionnaire

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-Specific</th>
<th>Control</th>
<th>Mean Difference</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grover 2016</td>
<td>24</td>
<td>0.08 (0.41)</td>
<td>-1.11</td>
<td>-2.31, 0.09</td>
</tr>
</tbody>
</table>
Analysis 1.6. Comparison 1 Paediatric studies, Outcome 6 Improvement in carer’s asthma QoL scores (parent/carer PACQLQ).

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: 1 Paediatric studies

Outcome: 6 Improvement in carer’s asthma QoL scores (parent/carer PACQLQ)

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-Specific</th>
<th>Control</th>
<th>Mean Difference</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
</tr>
<tr>
<td>Valery 2010</td>
<td>35</td>
<td>0.49 (0.55)</td>
<td>53</td>
<td>0.53 (0.39)</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>35</td>
<td>53</td>
<td></td>
<td>100.0 %</td>
</tr>
</tbody>
</table>

Heterogeneity: not applicable
Test for overall effect: Z = 0.37 (P = 0.71)
Test for subgroup differences: Not applicable

Analysis 1.7. Comparison 1 Paediatric studies, Outcome 7 Change in Carers’ Asthma QoL (PACQLQ).

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: 1 Paediatric studies

Outcome: 7 Change in Carers’ Asthma QoL (PACQLQ)

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Mean Difference (SE)</th>
<th>Mean Difference</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td></td>
<td>IV,Fixed,95% CI</td>
<td>IV,Fixed,95% CI</td>
</tr>
<tr>
<td>Canino 2008</td>
<td>108</td>
<td>109</td>
<td>3.15 (1.675)</td>
<td></td>
<td>3.15 [-0.13, 6.43]</td>
</tr>
<tr>
<td>Grover 2016</td>
<td>24</td>
<td>16</td>
<td>0.7 (0.2255)</td>
<td></td>
<td>0.70 [0.26, 1.14]</td>
</tr>
</tbody>
</table>

Test for subgroup differences: Not applicable
Analysis 1.8. Comparison 1 Paediatric studies, Outcome 8 Parent description of AAP when child is well.

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: 1 Paediatric studies

Outcome: 8 Parent description of AAP when child is well

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Fixed,95% CI</td>
<td>M-H,Fixed,95% CI</td>
</tr>
<tr>
<td>Valery 2010</td>
<td>20/35</td>
<td>17/53</td>
<td>100.0 %</td>
<td>2.82 [ 1.17, 6.83 ]</td>
<td>2.82 [ 1.17, 6.83 ]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>35</strong></td>
<td><strong>53</strong></td>
<td><strong>100.0 %</strong></td>
<td><strong>2.82 [ 1.17, 6.83 ]</strong></td>
<td><strong>2.82 [ 1.17, 6.83 ]</strong></td>
</tr>
</tbody>
</table>

Total events: 20 (Culture-specific), 17 (Control)
Heterogeneity: not applicable
Test for overall effect: Z = 2.30 (P = 0.021)
Test for subgroup differences: Not applicable

Analysis 1.9. Comparison 1 Paediatric studies, Outcome 9 Self-reported medication adherence (brief medication questionnaire).

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: 1 Paediatric studies

Outcome: 9 Self-reported medication adherence (brief medication questionnaire)

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean(SD)</td>
<td>Mean(SD)</td>
</tr>
<tr>
<td></td>
<td>IV,Fixed,95% CI</td>
<td>IV,Fixed,95% CI</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Grover 2016</td>
<td>24 0.26 (0.44)</td>
<td>16 1.4 (0.63)</td>
</tr>
<tr>
<td></td>
<td>-1.14 [ -1.50, -0.78 ]</td>
<td></td>
</tr>
</tbody>
</table>

Test for overall effect: Not applicable
Test for subgroup differences: Not applicable
Analysis 1.10. Comparison 1 Paediatric studies, Outcome 10 Asthma Knowledge Factors.

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: 1 Paediatric studies

Outcome: 10 Asthma Knowledge Factors

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific</th>
<th>Control</th>
<th>Mean Difference</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
</tr>
<tr>
<td>1 Parent/carer Asthma Knowledge (behavioural assessment - score 0-12)</td>
<td>11</td>
<td>13.6 (2.6)</td>
<td>11</td>
<td>11.7 (2)</td>
</tr>
<tr>
<td>2 Child Asthma Knowledge (behavioural assessment - score 0-12)</td>
<td>11</td>
<td>13.3 (2.1)</td>
<td>11</td>
<td>10 (3.2)</td>
</tr>
<tr>
<td>3 Parent/carer Asthma knowledge (triggers and treatment)</td>
<td>108</td>
<td>12.64 (2.31)</td>
<td>110</td>
<td>11.7 (2.4)</td>
</tr>
</tbody>
</table>

Analysis 2.1. Comparison 2 Adult studies, Outcome 1 Asthma exacerbations during follow-up.

Review: Culture-specific programs for children and adults from minority groups who have asthma.

Comparison: 2 Adult studies

Outcome: 1 Asthma exacerbations during follow-up

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Fixed,95% CI</td>
<td>M-H,Fixed,95% CI</td>
</tr>
<tr>
<td>1 Number of participants who had one or more exacerbation over the study period</td>
<td>76/151</td>
<td>80/143</td>
<td>0.80 [0.50, 1.26]</td>
<td></td>
</tr>
<tr>
<td>2 Number of participants requiring oral corticosteroids over the study period</td>
<td>30/151</td>
<td>29/143</td>
<td>0.97 [0.55, 1.73]</td>
<td></td>
</tr>
<tr>
<td>3 Severe exacerbations requiring hospitalisation over the study period</td>
<td>8/151</td>
<td>9/143</td>
<td>0.83 [0.31, 2.22]</td>
<td></td>
</tr>
</tbody>
</table>
Analysis 2.2. Comparison 2 Adult studies, Outcome 2 Change in AQLQ.

Review: Culture-specific programs for children and adults from minority groups who have asthma

Comparison: 2 Adult studies

Outcome: 2 Change in AQLQ

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Mean Difference (SE)</th>
<th>Mean Difference (IV,Fixed,95% CI)</th>
<th>Weight</th>
<th>Mean Difference (IV,Fixed,95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blixen 2001 (1)</td>
<td>0.33 (0.2)</td>
<td></td>
<td>6.1 %</td>
<td>0.33 [-0.06, 0.72 ]</td>
</tr>
<tr>
<td>Moudgil 2000 (2)</td>
<td>0.26 (0.051)</td>
<td></td>
<td>93.9 %</td>
<td>0.26 [ 0.16, 0.36 ]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td></td>
<td></td>
<td>100.0 %</td>
<td>0.26 [ 0.17, 0.36 ]</td>
</tr>
</tbody>
</table>

Heterogeneity: \( \chi^2 = 0.12, df = 1 \) \( \chi^2 = 0.73 \); \( P = 0.00 \%

Test for overall effect: \( Z = 5.35 \) \( P < 0.00001 \)

Test for subgroup differences: Not applicable

(1) 13 participants

(2) 280 participants
Analysis 2.3. Comparison 2 Adult studies, Outcome 3 Asthma Knowledge Factors.

Review: Culture-specific programs for children and adults from minority groups who have asthma

Comparison: 2 Adult studies

Outcome: 3 Asthma Knowledge Factors

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Culture-specific</th>
<th>Control</th>
<th>Mean Difference</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
</tr>
<tr>
<td>1 Proper use of inhaler technique</td>
<td>Poureslami 2012</td>
<td>20</td>
<td>6.8 (1.6)</td>
<td>22</td>
</tr>
<tr>
<td>2 Knowledge of asthma symptoms</td>
<td>Poureslami 2012</td>
<td>20</td>
<td>8.4 (1.5)</td>
<td>22</td>
</tr>
</tbody>
</table>

ADDITIONAL TABLES

Table 1. Summary description of culture-specific programs vs control programs Study ID

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Setting</th>
<th>Definition of minority</th>
<th>Participants</th>
<th>Description of Culture-specific intervention</th>
<th>Description of control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>La Roche 2006</td>
<td>Community Health Centre</td>
<td>African-American and Hispanic people living in the USA</td>
<td>African-American or Hispanic descent, children aged 7-13 years (n = 22)</td>
<td>Multi-family asthma group treatment (MFAGT) was based on allocentric self-orientation and socio-economic context of ethnic minorities. Program delivery included a Hispanic and African-American educator/psychologist emphasising relational and collaborative asthma management among</td>
<td>Standard Psycho-educational Asthma Intervention (SPAI). SPAI has the same 3 education modules as intervention group but followed a structured teaching approach without locating asthma symptoms within the socioeconomic or cultural context</td>
</tr>
</tbody>
</table>
Table 1. Summary description of culture-specific programs vs control programs

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Intervention</th>
<th>Study Population</th>
<th>Study Design</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canino 2008</td>
<td>Home visits</td>
<td>Socially disadvantaged (low-income and poor) Puerto Rican families living in the USA. They were identified from the national health plan insurance claims database.</td>
<td>Eight asthma education modules, delivered at 2 home visits with telephone contact for follow-up and reinforcement of recommended plans and assignments. Modules were culturally adapted with inclusions such as common practices and myths that Puerto Rican parents have about asthma, home remedies, culturally congruent pictures, and common asthma triggers.</td>
<td>Participants given 5 flyers that contained information on asthma (e.g. what is asthma, control and rescue medications, common allergens (including food) and triggers, how to take care of asthma equipment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor Puerto Rican children aged 5 to 12 years (n = 221)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participants received three one-hour education sessions (separate days) covering three modules:

1. Identify and monitor asthma symptoms; effectively use medications/resources (e.g. peak flow, medications) to control symptoms.
2. Identifying and preventing asthma triggers.
3. Preventing and coping with an asthma attack (e.g. asthma action plans).
Table 1. Summary description of culture-specific programs vs control programs  

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Location</th>
<th>Description</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valery 2010</td>
<td>Community Health Centre</td>
<td>First nations people of Australia who make up a minority of the whole Australian population. They are generally a socially disadvantaged group in a high-income country</td>
<td>Aboriginal or Torres Strait Islander children aged &lt; 18 years (n = 113)</td>
<td>Three additional education sessions delivered by trained Indigenous Health Care Workers, using existing paediatric asthma and respiratory education resources which were adapted to support Torres Strait culture at baseline, 1, 3 and 6 months</td>
</tr>
<tr>
<td>Grover 2016</td>
<td>Hospital (chest clinic)</td>
<td>Indian residents whose first language was not English living in India</td>
<td>Indian children aged between 7 and 12 years (n = 40)</td>
<td>Culturally adapted asthma education program to Indian parents and children with asthma (underpinned by GINA guidelines) using age appropriate, graphically appealing and culturally relevant educational materials. The education program was designed based on key principles of health education and pedagogy and intervention delivered by 2 pharmacists. Asthma education was delivered over 1 hr with child/family, workbooks, goal setting and setting asthma action plan with physician</td>
</tr>
</tbody>
</table>

Adult studies
<table>
<thead>
<tr>
<th>Study ID</th>
<th>Setting</th>
<th>Participants Description</th>
<th>Intervention</th>
<th>Usual care and follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moudgil 2000</td>
<td>General practitioners</td>
<td>A sub group of Indian sub-continent people living in the UK whose first language was not English</td>
<td>White European (WE) or Indian sub-continent (ISC) participants aged between 11 to 59 years (n = 689)</td>
<td>Usual care and follow-up; 'generic' asthma programme.</td>
</tr>
<tr>
<td>Blixen 2001</td>
<td>Hospital</td>
<td>African-American people living in the USA. They are generally a socially disadvantaged group in a high-income country</td>
<td>African-American adults aged between 18 to 50 years (n = 28)</td>
<td>Usual care and follow-up; 'generic' asthma programme.</td>
</tr>
<tr>
<td>Poureslami 2012</td>
<td>Usually home or pulmonary clinic</td>
<td>Immigrants to Canada whose first language was not English (e.g. non-Indigenous to Canada)</td>
<td>Migrants in greater Vancouver Area, who spoke Mandarin, Cantonese or Punjabi with asthma aged &gt; 21 years (n = 92)</td>
<td>Received a pictorial pamphlet on asthma.</td>
</tr>
</tbody>
</table>
Table 1. Summary description of culture-specific programs vs control programs

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>knowledge video</td>
</tr>
<tr>
<td></td>
<td>2. Patient-generated community video</td>
</tr>
<tr>
<td></td>
<td>3. Knowledge and community video</td>
</tr>
</tbody>
</table>

## APPENDICES

### Appendix 1. Search strategies

**Cochrane Airways Register of trials**

#1 AST:MISC1
#2 MeSH DESCRIPTOR Asthma Explode All
#3 asthma*:ti,ab
#4 #1 or #2 or #3
#5 MeSH DESCRIPTOR Oceanic Ancestry Group
#6 aboriginal* or aborigine*
#7 indigenous*
#8 MeSH DESCRIPTOR Minority Groups
#9 MeSH DESCRIPTOR Culture Explode All
#10 MeSH DESCRIPTOR Ethnology
#11 culture* NEAR3 (specific* OR appropriate* or tailored*)
#12 cultural*
#13 MeSH DESCRIPTOR Cultural Diversity
#14 MeSH DESCRIPTOR Cultural Deprivation
#15 MeSH DESCRIPTOR Cultural Characteristics
#16 MeSH DESCRIPTOR Anthropology, Cultural Explode All
#17 #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16
#18 MeSH DESCRIPTOR Self Care
#19 MeSH DESCRIPTOR Self Administration
#20 MeSH DESCRIPTOR Self Medication
#21 MeSH DESCRIPTOR Self Efficacy
#22 self* NEXT manage*
#23 MeSH DESCRIPTOR Patient Acceptance of Health Care Explode All
#24 MeSH DESCRIPTOR Patient Education as Topic
#25 MeSH DESCRIPTOR Patient Care Planning Explode All
#26 MeSH DESCRIPTOR Patient-Centered Care
#27 MeSH DESCRIPTOR Health Services, Indigenous
#28 indigenous* NEAR3 health*
#29 aboriginal* NEAR3 health*
#30 (educat*) or (program*) or (learn*) or (specific*)
#31 #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30
#32 #4 AND #17 AND #31
Culture-specific programs for children and adults from minority groups who have asthma (Review)
30. placebo$.ti,ab.
31. random$.ti,ab.
32. ((control$ or prospectiv$) adj3 (trial$ or method$ or stud$)).tw.
33. (crossover$ or cross-over$).ti,ab.
34. or/21-33
35. exp animals/ or exp invertebrate/ or animal experiment/ or animal model/ or animal tissue/ or animal cell/ or nonhuman/
36. human/ or normal human/ or human cell/
37. 35 and 36
38. 35 not 37
39. 34 not 38

**WHAT'S NEW**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
</table>
| 10 June 2016   | New citation required but conclusions have not changed | Author group changed and review updated to current Cochrane format  
Primary and secondary outcomes modified for clarification, and to reflect current asthma-related outcomes  
Subgroup analysis - adults versus children and types of education have been removed. Adults and children are now analysed separately  
New studies included (Valery 2010; Poureslami 2012; Grover 2016) including an additional 220 participants.  
New 'Risk of bias' tool used.  
SoF table included. |
| 10 June 2016   | New search has been performed         | Literature search updated to June 2016. An update literature search in July 2017 was not fully incorporated and three studies were added to studies awaiting classification |

**HISTORY**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 December 2008</td>
<td>New citation required but conclusions have not changed</td>
<td>Author list changed</td>
</tr>
<tr>
<td>17 October 2008</td>
<td>New citation required but conclusions have not changed</td>
<td>One new author added to the byline of the review. The conclusions of the review have not been substantively amended by the addition of the study by Canino et al</td>
</tr>
<tr>
<td>30 August 2008</td>
<td>New search has been performed</td>
<td>Literature searches re-run; One new study added (Canino 2008)</td>
</tr>
</tbody>
</table>
17 June 2008  |  Amended  |  Converted to new review format.
11 December 2007  |  New citation required and conclusions have changed  |  Substantive amendment

**CONTRIBUTIONS OF AUTHORS**

Previous version: ABC and EJB wrote protocol, selected studies, extracted data and drafted the review (2009). Other previous authors (NB, PM, SK) reviewed the manuscript.

Current review: GBM and ABC selected relevant papers from searches, extracted and analysed data and updated the review. PSM and NB contributed to writing the review.

**DECLARATIONS OF INTEREST**

GBM: none known.
PSM: none known.
NB: none known.
ABC: was an author in one of the included studies.

**SOURCES OF SUPPORT**

**Internal sources**
- Australian Cochrane Airways Scholarship, Other.
  Gabrielle McCallum received a scholarship to complete review

**External sources**
- National Health and Medical Research Council, Australia.
- Australian Cochrane Airways Group Network Scholarship, Australia.

**DIFFERENCES BETWEEN PROTOCOL AND REVIEW**

The primary and secondary outcomes in this version were altered for clarity (compared to the previous version of the review) and to reflect current asthma-related outcomes. In the previous review (Bailey 2009b), we used a hierarchy of assessment which made it confusing. In this version, our primary and secondary outcomes are in line with other Cochrane reviews on asthma with exacerbation being the primary outcome and secondary outcomes reflecting other components of asthma morbidity (lung function, QoL, etc).
INDEX TERMS

Medical Subject Headings (MeSH)

*Minority Groups; Asthma [ethnology; *therapy]; Culturally Competent Care [*organization & administration]; Disease Progression; Patient Education as Topic [*methods]; Randomized Controlled Trials as Topic

MeSH check words

Adolescent; Adult; Child; Child, Preschool; Humans; Infant; Middle Aged; Young Adult