HSC Public Health Agency

Health Intelligence briefing

Minority Ethnic (ME)[1] Groups

- The 2001 Census estimated that 0.75% of the NI population (12,569) was of non-white ethnic origin. Between 2004 and 2009, NI experienced large in-migration. There is not one overall population estimate, rather several sources are drawn upon:
    - 80,000 individuals born outside UK/ROI lived in NI in 2010 (LFS);
    - 3.3% of primary and 1.7% of post-primary pupils have English as an additional language (NI school census 2010/11);
    - 17% of babies born in 2010 had one or both parents born outside the UK, with 12% having one or both parents born outside UK/ROI.
- ME groups are non-homogenous, reflecting a highly diverse range of cultures and languages. The Chinese, Indian and Pakistani communities are the largest and longer established ethnic groups. New migrants have been mainly adults of working age from Eastern Europe, particularly Poland and Lithuania, but also from Portugal and the Philippines. Areas with the largest density of ME population are Dungannon, Craigavon, Belfast, Armagh, and Newry and Mourne.
- Different migrant groups, depending on country of origin, bring different challenges in relation to issues of health protection (Tb, Hep B, Hep C, HIV), vulnerability to non-communicable diseases, experience of health care (immunisation, prevention, screening, treatment), cultural beliefs about health/illness and acceptability of treatments. Experiences from country of origin (eg conflict, war, torture) have lasting impact.
- Many migrants experience discrimination and are disadvantaged in relation to the wider determinants of health such as employment, poverty, housing, education, etc.

[1] In this HIB the terms 'ethnic minority' and 'migrant' are used interchangeably.

Contents

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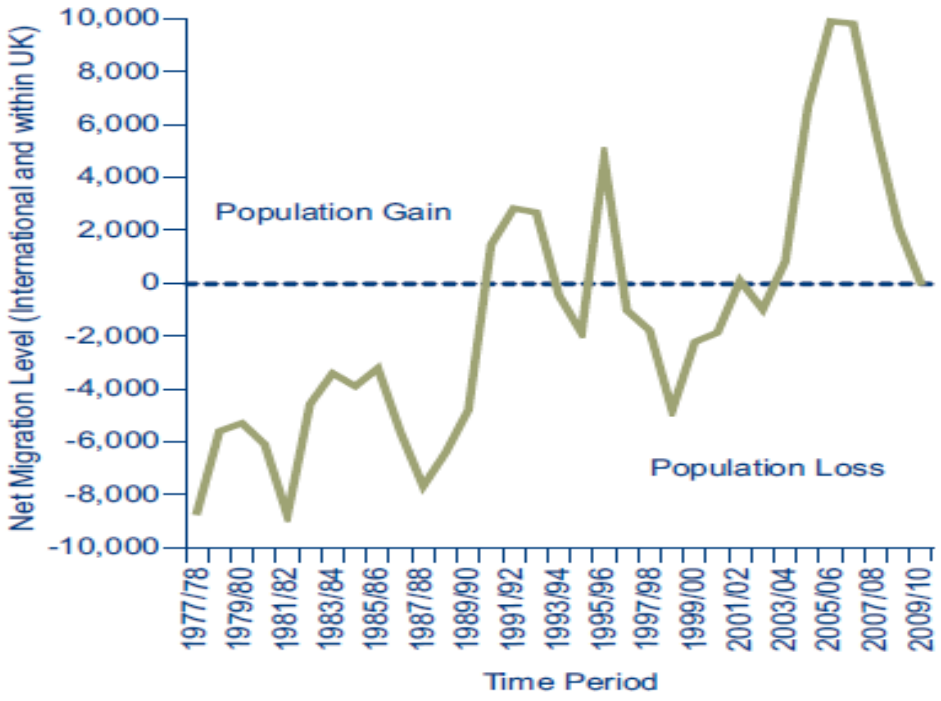
1. Population estimates

Less than 1% of the population in NI was of non-white ethnic origin according to the 2001 Census. The largest ethnic groups were the Chinese, Indian and Pakistani communities.

Since 2004, there was significant population growth in NI; however, in the year to mid-2010 the net migration has dropped to zero net population gain. Figure 1 shows the net migration over the last four decades. The following political decisions and economic situation contributed to the migration and, thus, increase in population (BHDU, 2011):

- 2004: EU expansion when eight Central and Eastern European countries joined (referred to as accession A8 countries)[2]
- 2007: further EU expansion with Bulgaria and Romania joining (referred to as A2 countries; restrictions on movement and employment)
- Non-EU nationals seeking work, particularly in HSC sector and food industry
- 1999 Immigration and Asylum Act disperses asylum seekers and refugees to other regions in UK

Figure 1. Estimated level of net migration (1977/78 – 2009/10) (NISRA, 2011a)



Until the 2011 Census is published, there is **no one data source that provides an overall estimate** of the ME population. Instead, several data sources are used to monitor migration since the 2001 Census and each has its own limitations.

The report *"Migration statistics for Northern Ireland (2009)"* (NISRA, 2010) summarises the data from these various sources up to June 2010. It provides links to further detailed tables. Population statistics (in tables, maps, diagrams) are taken from this report unless otherwise referenced.

[2] A8 countries include: Poland, Lithuania, Slovakia, Latvia, Estonia, Hungary, Slovenia, Czech Republic

1.1. Census 2001

The 2001 Census recorded 12,569 people from a ME background in NI (0.75% of the population, excluding Irish Travellers). Table 1 shows the different ME groups living in NI and by HSSB area, with the Eastern HSSB having the highest proportion (Belfast 1.6%).

Table 1. ME groups from 2001 Census

	NI	**Eastern**	**Northern**	**Western**	**Southern**
Chinese	*4,145*	2,426	982	276	461
Mixed	*3,319*	1600	772	523	424
Indians	*1,567*	681	403	328	155
Pakistani	*666*	293	163	49	161
Bangladeshi	*252*	189	29	16	18
Other Asian	*194*	138	31	14	11
Black African	*494*	291	95	67	41
Black Caribbean	*255*	140	43	44	28
Other Black	*387*	156	56	126	49
Other ethnic group	*1,290*	767	232	150	141
Total ME population	*12,569*	6,681	2,806	1,593	1,489
Total population	*1,685,267*	665,968	426,965	281,215	311,119
ME groups per total population*	*0.75%*	1%	0.66%	0.57%	0.48%

Note: * not including Irish Travellers
Source:
http://www.nisra.gov.uk/Census/2001%20Census%20Results/Key%20Statistics/KeyStatisticstoOutputAreaLevel.html

1.2. Labour Force Survey (LFS)

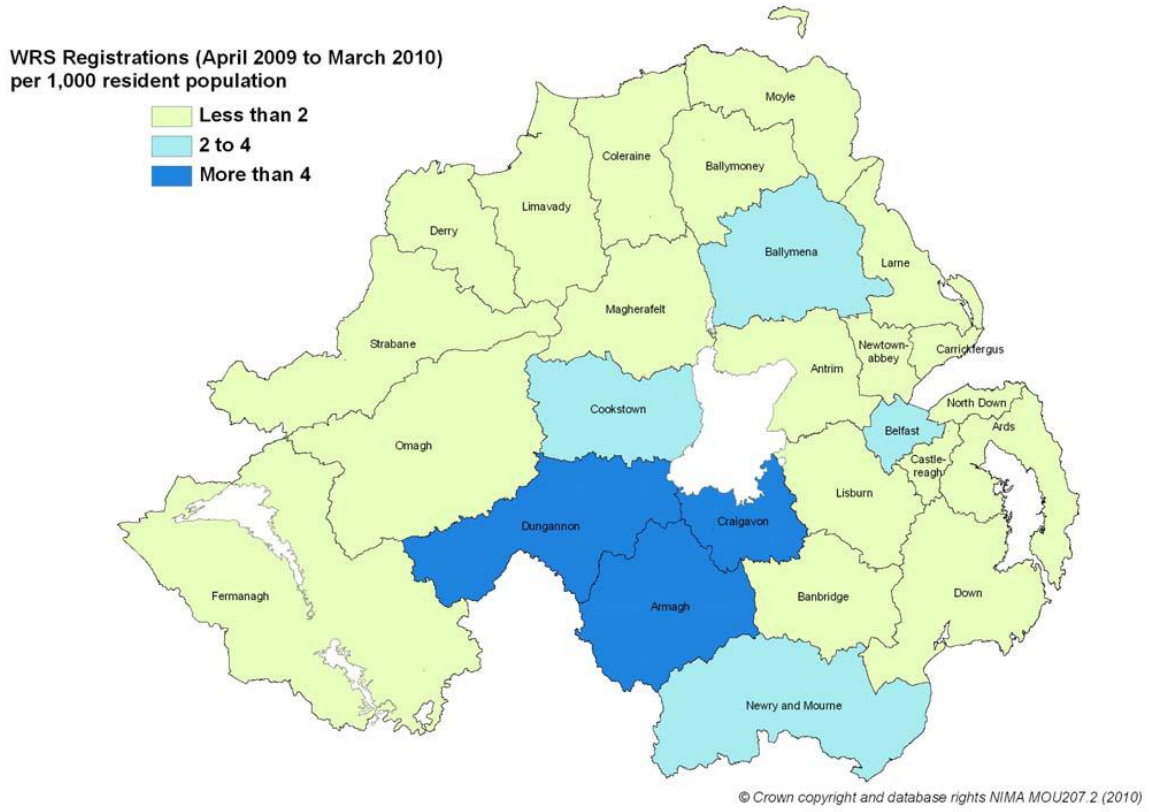
Estimates based on the LFS suggest that there were 80,000 individuals born outside the UK and Ireland living in NI in 2010 (April-June) (NISRA, 2010). The estimate has continually increased since 1997. The age structure of foreign born nationals seems to be younger than that of the total NI population: 77% compared to 59% aged 16-59, respectively (estimated for 2009). Although the LFS samples households to estimate populations, it omits communal establishments which may result in an under-estimation of the foreign born population.

1.3. UK Border Agency Worker Registration Schemes (WRS)

Members of the A8 countries had to register with the WRS if they wanted to work in the UK. This requirement ceased from May 2011 (scheme ended in April 2011). WRS registration figures (see Figure A1, Appendix) show that after an initial increase in registrations, following the recession, a decline was observed. Between May 2004 and March 2010, 39,505 registrations with the WRS were recorded (NISRA, 2010). The majority of people registered with the WRS were from Poland (56%), followed by Lithuanian (19%), Slovak (14%), Latvian (5%) and Czech (4%) nationals.

WRS statistics are only available by area of employer. Map 1 shows the number of WRS registrations by 1000 population. The **Craigavon, Dungannon, and Armagh LGDs** had the highest number of registrations.

Map 1. NI WRS registrations by local authority of employer per 1,000 resident population (April 2009 – March 2010)



1.4. UK Border Agency scheme for A2 nationals

A2 citizens have some restrictions, with an initial right of residency in the UK for three months. Only those who are students, self-employed or self-sufficient have the right to remain indefinitely. Between April 2008 and March 2010, 288 applications for Accession Worker cards were approved in NI (247 Bulgarian, 41 Romanian; 82% decrease in approvals from 2008/9 to 2009/10 from 210 to 37). A further 780 registration certificate applications were approved between April 2008 and March 2010 (368 Bulgarian, 412 Romanian).

1.5. Work permits: Home Office Tier 2 (skilled workers with job offer) and 5 (temporary workers and youth mobility):

During the financial year 2009/10, 290 applications were received for main applicants, with additional 270 dependents. Again, statistics are only available by employer area, showing that most workers were employed in the **Derry, Belfast, and Newtownabbey LGDs**. Indian, Philippine and Chinese nationals made up 75% of NI 2009/10 applications.

1.6. National Insurance Number (NINo) registrations

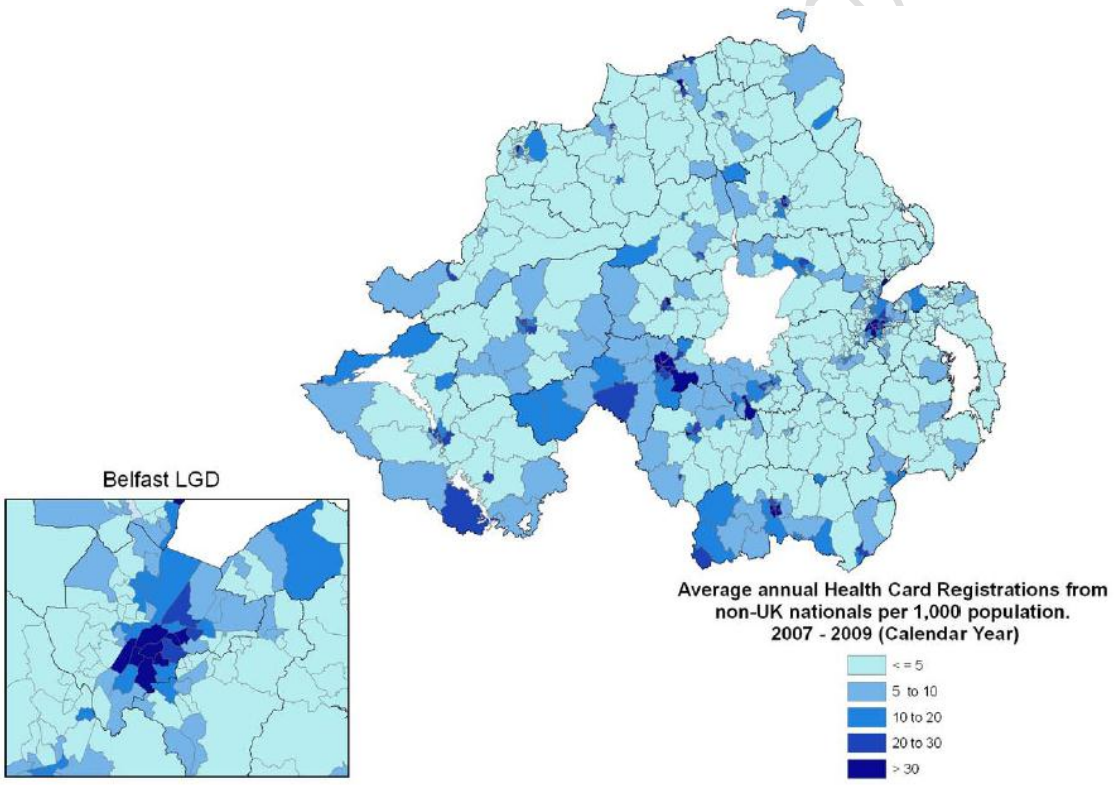
NINos are required for employment purposes or to claim benefits and tax credits. Registrations increased from 2003/4 onwards (4,492), with a peak in 2006/7 (19,680) before falling in 2009/10 (7,500). A8 members account for the majority (>60%) of NINo registrations to non-UK nationals, with over 1,600 registrations by Polish nationals in 2009/10.

LGD areas with highest rate of registration (per 1,000 resident population) were **Dungannon** (11.5), **Belfast** (7.8), **Armagh** (7.5), **Craigavon** (6.4), **Newry and Mourne** (5.9), **Fermanagh** (5.6), and **Ballymena** (5.4).

1.7. New health card registrations

Health card registrations are only possible for those planning to stay for three months or longer. In 2009, 12,700 people from outside the UK registered with a family doctor, which is a decrease from previous years (Figure A2, Appendix). Since 2005, most registrations were by migrants from Poland, Lithuania, India, Latvia and Slovakia. Areas with the highest number of registrations include the **Belfast, Craigavon, Dungannon, and Newry and Mourne LGDs**. The main reason for migration was work (50%; A8 nationals: 74%), followed by family reasons (27%) and education (12%).

Map 2. Average annual health card registration from non-UK nationals, by electoral ward per 1000 population (2007-2009)



1.8. Annual school census

In October of each school year, the Department of Education undertakes a school census. Information is gathered on pupils who have English as an additional language (EAL; now referred to as newcomer pupils). Since 2006, the number of children with EAL who commenced school during the previous academic year is also included.

According to the 2009 school census, Polish was the most common first language (1,700 PS pupils, 800 PPS pupils). The majority of EAL pupils had an A8 language, with the most common non-A8 language being Portuguese, Filipino (primary only), and Cantonese (post-primary only) (see also NICEM, 2009). **Dungannon LGD** had the highest proportion at both primary (10%) and post-primary (6%) level.

Table 2. Newcomers and pupils who came to live in NI during previous year – 2010/11

	Total number of pupils	Newcomer pupils (with English as an additional language)		Pupils who arrived in previous year	
	N	n	%	n	%
Primary					
All	*163,451*	*5,393*	*3.3*	*1,507*	*0.9*
Belfast	24,171	1,052	4.4	296	1.2
Western	28,999	657	2.3	204	0.7
North Eastern	36,973	906	2.5	302	0.8
South Eastern	34,564	668	1.9	262	1.1
Southern	38,744	2,110	5.4	443	0.9
Post-primary					
All	*147,902*	*2,450*	*1.7*	*518*	*0.4*
Belfast	29,818	492	1.7	130	0.4
Western	26,459	265	1.0	70	0.3
North Eastern	32,514	413	1.3	82	0.3
South Eastern	25,699	278	1.1	118	0.5
Southern	33,412	1,002	3.0	118	0.4

Source: NI school census; personal communication with DENI
Note: primary includes nursery, reception and year 1-7 classes

DENI also gathers information on pupils' ethnicity via 15 categories and defines minority ethnic pupils as 'non-white'. However, this categorises pupils from some of the largest ethnic minority groups (eg Polish, Lithuanian, and Portuguese) as white. Also, there is no Filipino category (Rooney & Fitzpatrick, 2011).

1.9. Births to mothers and fathers born outside the UK

Table 3 shows the number of births overall and by country of birth of mother and father (please note, on some birth registrations the father is absent). Births to women from A8 countries have risen particularly dramatically (from 12 in 2001 to 1,235 in 2010). Births to women from all other countries (not UK/ROI) roughly doubled over the period 2001 to 2010 (from 649 to 1,262). Births to fathers mirror the pattern for mothers.

Table 3. Births by country of birth of mother and country of birth of father

Year	*All*	NI	Other UK	ROI	A8	Other country	
Mother - country of birth							
2009	*24,910*	20,539	1,364	689	1,113	1,205	
2010	*25,315*	20,805	1,323	714	1,235	1,238	
Father - country of birth							***No father***
2010	*25,315*	19,281	1,374	645	1,070	1,262	1,683

Source: NISRA (2011a); http://www.nisra.gov.uk/demography/default.asp98.htm

Across the period 2001-2010, the percentage of live births to non-UK born mothers has risen steadily across all parts of NI. The rate more than doubled in Belfast and the Southern HSCT area and is above the NI average. Two areas reported very high rates: in **Dungannon**, over one in four births (28.1%) and **Fermanagh** about one in five births (19.6%) were to non-UK born mothers (please note, figures include ROI-born mothers).

Table 4. Percentage of live-births to non-UK born mothers 2001-2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
All	*6.4*	*6.5*	*7.3*	*8.3*	*8.2*	*9.4*	*10.9*	*12.2*	*12.1*	*12.6*
BHSCT	6.5	7.3	10.3	12.2	10.5	10.9	13.3	14.2	14.4	15.0
NHSCT	4.5	5.0	5.1	5.6	5.6	7.0	8.3	9.7	9.2	9.5
SEHSCT	5.5	5.5	5.4	6.7	6.9	7.7	7.3	8.7	9.2	9.1
SHSCT	7.2	7.3	7.4	8.7	9.0	11.7	14.9	16.7	16.1	16.9
WHSCT	9.1	8.1	9.0	9.3	9.8	10.1	11.0	11.7	11.3	12.1

Source: NISRA (2011a); http://www.nisra.gov.uk/demography/default.asp98.htm

Table 5 shows the breakdown of the total births registered in NI: 17% of babies born in 2010 had one or both parents born outside the UK, while 12% of babies had one or both parents born outside UK/ROI.

Table 5. Breakdown of total births registered in NI in 2010 (N=25,315)

	Number of births	% of total births registered
Both parents born in UK	19,434	77%
Mother born in UK – father not registered	1,563	6%
One parent born in UK	2,472	10%
Neither parent born in UK	1,846	7%
Both parents born in UK/ROI	20,655	82%
Mother born in UK/ROI – father not registered	1,593	6%
One parent born in UK/ROI	1,319	5%
Neither parent born in UK/ROI	1,738	7%

Source: NISRA (2011a); http://www.nisra.gov.uk/demography/default.asp98.htm

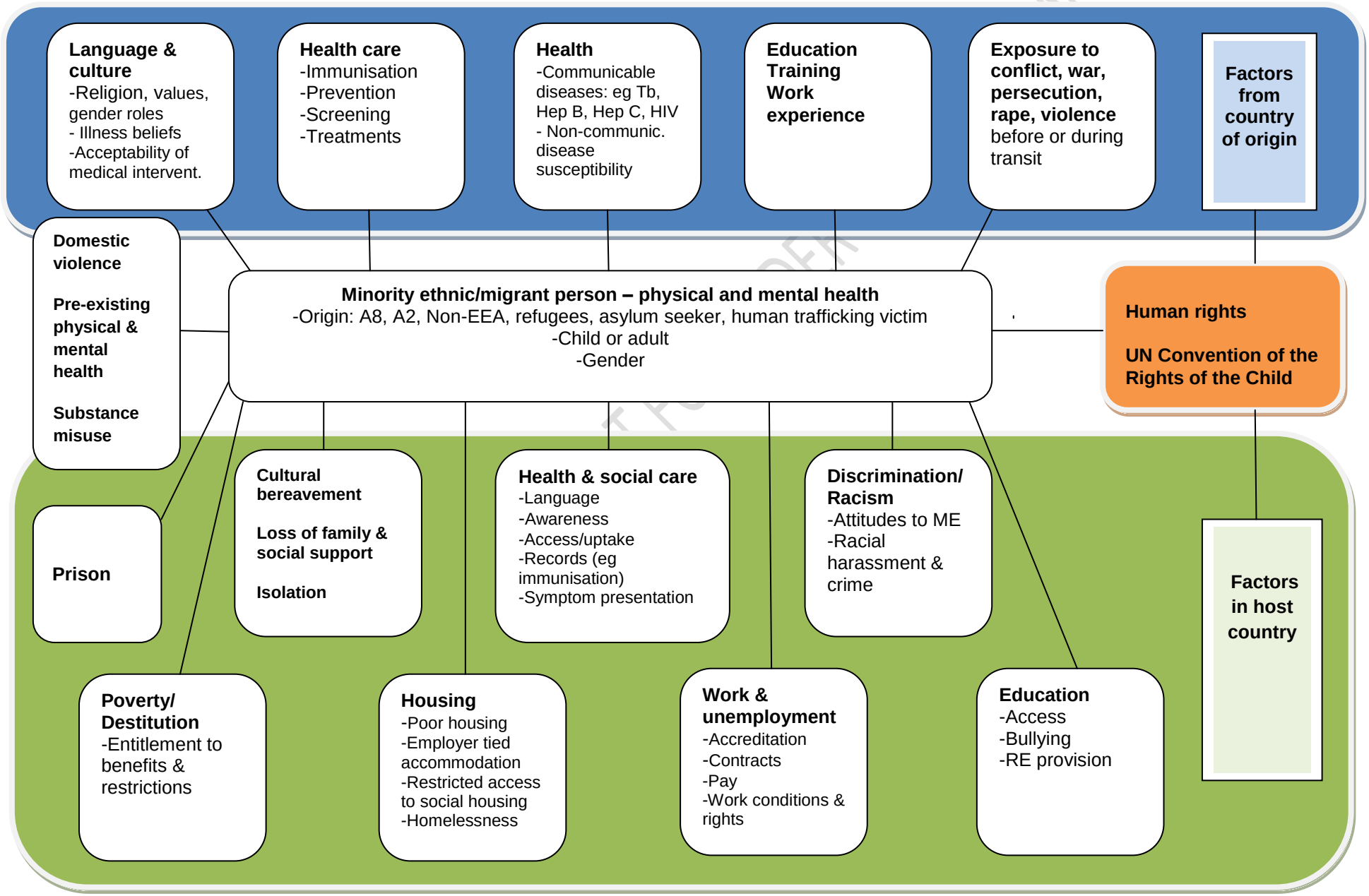
2. Influences on the health of ME groups

The report *Barriers to health: migrant health and wellbeing in Belfast*, prepared by the Belfast Health Development Unit (BHDU, 2011), provides a general summary on the health status and needs of ME groups and the wider determinants of health such as legislation around immigration and work, entitlement to social security benefits and health and social care, work, housing, education, etc. Many other reports highlighted further issues or addressed them in greater detail; they are referred to in the relevant sections.

Figure 2 provides an overview of the multitude of factors that impact on the health of ME groups and which need to be taken into consideration when planning health and social care provision. Please note that these factors do not operate in isolation but are interconnected (which is not shown for reasons of clarity of the presentation). ***In particular, the experiences/conditions from individuals' countries of origin remain to affect their life in the new host country.***

The following subsections address these factors with varying degree of detail and refer to further available NI evidence. It is difficult to report prevalence figures for most areas due to a lack of recording of ME status. Thus, caution needs to be applied regarding provided figures as they depend on the context in which they were collected.

Figure 2. Influences on health of ME individuals: overview of factors from country of origin and host country



2.1. General health

"Migrants arriving from less developed regions of the world may have had less access to preventative care, health promotion programmes and diagnostic or therapeutic interventions for disease." (BHDU, 2011, p. 33). Thus, disease presentation may be at more advanced stages. Yet, many migrants show better health parameters than the host population in relation to life-style related, non-infectious diseases. Over time, however, this difference may disappear (ie through cultural adaptation, diet, and behavioural change).

For example, almost half (49%) of migrants in the WHSCT area reported no long standing health problem, with 12% reporting back problems and 11% allergies (Jarman, 2009).

Certain ethnic groups seem to experience higher rates of certain non-communicable diseases than others.

Table 6. Ethnic variation in rates of non-communicable diseases

Illness	**Higher among**
Diabetes (5.4% in general population)	• Asians from Indian subcontinent (12.4%) • Afro-Caribbean people (8.4%)
Cardiovascular disease	• Asians from Indian subcontinent • Afro-Caribbean people
Hypertension	• Afro-Caribbean people
Helicobacter pylori infection - gastritis, peptic ulcer	• People from African countries
Cancer	• Polish and other Eastern Europeans
Vitamin D deficiency - osteopenia or osteoporosis	• Women with covered dress code
Iron deficiency, B12 and folate deficiency anaemia and micronutrient deficiencies	• People from less well developed countries
Haemolytic anaemia (thalassaemia anaemia or sickle cell disease)	• People from certain European countries and African countries
Death rates from liver and prostate cancer	• Afro-Caribbean and African people in the UK
Death rate from oral cancer	• Asian people in UK
	Lower among
Cancer prevalence	• Indian, Caribbean, and African migrants

Source: BHDU (2011), O'Rawe (2004)

2.2. Health protection

Most migrants do not present a greater risk for infectious diseases than the indigenous population. Yet, some individuals come from countries with a high prevalence of tuberculosis, Hepatitis B and C and HIV which requires appropriate screening and treatment to limit transmission (BDHU, 2011).[3]

[3] Please also see the latest UK-wide report from the Health Protection Agency (2011): http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131998682

Table 7. Health protection issues for NI

Tuberculosis (Tb) (2009 prevalence)[4]	• 8,286 cases in UK (16 per 100,000) • Non-UK born: 5,703 cases (88.8 per 100,000 compared to UK born: 4 per 100,000) – 69% of all UK cases
Hepatitis B (BHDU, 2011)	• Endemic regions: South East Asia, Africa, Middle and Far East, Southern and Eastern Europe • Prevalence of less than 1% in UK and Ireland, • NI: increase in total number of cases between 1992-2008 • Hep B vaccination not routine child immunisation
Hepatitis C (BHDU, 2011)	• Low prevalence: NI 3/5 of England's prevalence • Confined to certain at risk groups • No ethnic identifier in surveillance system
HIV (2010 prevalence)[5]	• Lowest prevalence of UK regions • 79 new incidences (+20% to 2009) • 474 treated cases (+12% to 2009): 75% white, 18% Black African, 7% other ethnic • Main routes of infection: MSM, sex between men and women

2.3. Mental health

Mental health is an important issue for many ME groups. Asylum seekers and refugees experience poorer mental health than the native population (Centre for Social Justice, 2011). Experiences in NI interact with cultural beliefs, pre-existing mental health problems, and traumatic experiences in the country of origin and/or during transit. Table 8 summarises findings on prevalence and influencing factors.[6]

In the UK and Ireland, individuals from BME groups face systemic problems regarding mental health: they are more likely to be wrongly diagnosed (cultural differences in illness presentation), prescribed medication, and being placed in institutionalised care (Centre for Social Justice, 2011; see also Jarman, 2009 for a summary).

ME children are affected by similar factors as adults as well as by their parents' mental health problems, thus they show more mental health problems than indigenous children. Problems are again worse for asylum seeking/refugee children (Geraghty et al., 2010).

A school based survey (Years, 5, 6, and 8) in the Southern area, using a quality of life measure, showed no difference in mental and social health among European migrant and Asian children from white settled children. Psychological wellbeing varied between different groups: self-worth was lower among both ME groups but locus of control was lower only among European migrant children (Biggart et al., 2009).[7]

[4] http://www.hpa.nhs.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1294740307825
[5] http://www.publichealth.hscni.net/sites/default/files/HIV_and_STI_Report_12_2011.pdf
[6] Some of these findings are also highlighted in the report in 2006: http://www.hse.ie/eng/services/Publications/services/SocialInclusion/MentalHealthNeedsofminorityethnicgroups.pdf
[7] The study also included Traveller children who consistently showed the worst experience. However, these findings are excluded here.

Table 8. Prevalence of mental health problems and influencing factors

Prevalence/Factors	Potential issues for service*
Prevalence	
• Migrants in WHSCT area (Jarman, 2009) o Stress in the last 12 months: 32% o Depression: 18% o Anxiety: 18% o Employer reported incidences of self-harm and suicide	• Requests for employer support to support their other employees and the family of the deceased
• 1% of suicide cases among mentally ill (5% of those with schizophrenia; University of Manchester, 2011)	
• Polish community: higher risk of depression and suicide and increased use of addiction services for both alcohol and drug addiction (Polish Association Northern Ireland, 2009 cited in BHDU, 2011)	• Counselling services provided by Polish Association
• Asylum seekers and refugees: Psychological distress in form of anxiety and post-traumatic stress	
• Migrant children (particularly asylum seekers, refugees) - higher incidence of mental health problems: mental illness (eg depression, PTSD) and behavioural problems (eg bed wetting, nightmares) (Geraghty et al., 2010)	• Effect of parental mental health on children
Country of origin factors	
• Cultural beliefs about mental illness (eg weakness of character) – often seen as a taboo	• Presentation with different symptoms: more somatic complaints • Later presentation (ie in crisis)
• Pre-existing mental health problems	
• Experience of war, conflict, persecution, torture, rape, violence, and injury (in country of origin and/or during transit) – experience of loss and trauma	• Need for treating PTSD
Factors in NI/UK	
• Asylum seeking process and life in detention centres (eg uncertainty of legal status, fear of deportation)	
• Cultural bereavement	
• Lack of social support (extended family, friends) among migrants – isolation o Worry over family left in country of origin	• Longer term settled ME groups draw on extended network of friends and family
• Strains of adapting to life in NI: obtaining work, (fear of) unemployment, work stress, financial strains and limited access to benefits	• Recession increasing risk of unemployment and thus mental health problems
• Discrimination and racial harassment/crime	

Source: BHDU (2011), Centre for Social Justice (2011), Jarman, 2009
*as reported in the sources

2.4. Experience of health care in NI

The majority of migrants are registered with a GP but there is variation by English proficiency and professional level (Table 9). Working hours also impede registration and GP consultation (Bell et al., 2009a). However, some migrants are not entitled to register with a GP.

Table 9. Registrations with GP by different NI-based surveys

Source	Main finding	Variations
Bell et al. (2004) N=176 migrant workers	85% registered with GP	• 100% academics, 93% nurses, 73% factory workers • 92% fluent English speakers, 68% not speaking English
	71% contact with health centre	
	59% contact with hospital	
Bell et al. (2009a) N=319 migrant workers	82% registered with GP	
Jarman (2009) WHSCT N=139	84% registered with GP	• Single men less likely to register
	35% registered with dentist 60% not registered	

The 2009/10 GP patient survey (Ipsos MORI, 2010) reported that, overall, non-white patients where less positive about their experience of the GP surgery than white patients (various indicators are summarised in Table A3 in the Appendix).

In the WHSCT area, over half (57%) of respondents were satisfied with the health service, with 1 in 10 being dissatisfied. Migrants were more positive about the care they received in hospital than at their GP surgery (Jarman, 2009). In relation to the UK's GP-as-gatekeeper system, those from countries with direct access to medical specialists were unconvinced by GPs competence and frustrated by the referral process (Bell et al., 2009a).

Table 10. Minority ethnic people's perceptions of health service

Positives about health service	Negatives about health service
• Free health care • Efficiency of medical staff • Standard of treatment better in hospital than at GP • Free contraceptive services	• Absence of a family doctor • Receiving medication without seeing doctor • Long waiting and referral times • Dental treatment expensive and of poor standard - cheaper access in home country • GPs as gatekeeper

Source: Bell et al. (2009a); Jarman (2009)

There were gaps in knowledge of how to access services; it was best known how to access family planning/contraception (48%), information on pregnancy/childbirth (40%), and cervical screening/smears (39%). Access to parent support (24%, breast screening (26%), and health visitor (27%) were least well known (Jarman, 2009).

Some ME people experienced negative encounters in terms of racist behaviour from other patients while waiting at GP surgery, from surgery staff or other NHS staff. A small number were refused treatment or GP registration, the latter due to GP's reluctance to take on migrant workers above a perceived 'quota' (see Jarman, 2009 for summary; O'Rawe, 2004).

In a NI survey of migrant workers, 44% of respondents felt treated the same by public services as NI nationals, with 20% feeling they did not receive the same treatment and 35% being unsure (Bell et al., 2009a). If needing advice on or having problems with services, migrants go to friends, family and the Citizen Advice Bureau (Bell et al., 2009a; Jarman, 2009).

Aside of language and discrimination, further cultural issues need to be considered when providing care for ME communities. These focus on issues of faith/religion, medications (containing animal derivatives such as porcine), medical interventions (eg circumcision, blood transfusion, transplantations, and post-mortems), dietary requirements (halal, kosher), but also on values such as autonomy/dependency (ie who makes decisions) (see Jarman, 2009 for summary). Some guidance on ethnic-religious minority communities is available: http://www.diversiton.com/downloads/checkUp.pdf.

2.5. Language as a barrier

Little or no knowledge of English is considered to be the most significant barrier to accessing health and social care but also to service delivery. This can lead to an overreliance on friends, family, and minority ethnic support organisations to provide information on services. The HSC is obliged to provide an interpreting service; this is offered 24 hours, face-to-face and in 33 registered languages. The demand has increased dramatically from 1,850 requests in 2004/5 to 51,734 in 2010/11, with over 50% of requests made in the SHSCT (July-September 2011).[8] The most requested languages were Polish (over 50%), Lithuanian, Chinese (Cantonese, Mandarin), and Portuguese (BHDU, 2011). However, many migrants find it difficult to communicate to health professionals via an interpreter, particularly around mental health issues (NICEM, 2011). In a similar vein, calls were made for developing capacity within the ME community to have bilingual staff as "the language barrier is not easily overcome in the sensitive area of support work, through the use of interpreters" (McAliskey et al., 2005).

English proficiency varies by age, gender, country of origin, education, and social class. Indian and African communities tend to have better levels of English proficiency. Women in the home are disadvantaged in learning English which is further compounded by fewer minority ethnic women accessing employment (NICEM, 2007). ***Migrant men's better proficiency in English can have implications for a woman's health particularly when her husband interprets for her. This becomes particularly problematic in cases of domestic violence and abuse, and in gynaecological, obstetric and sexual health settings (Jarman, 2009; NICEM, 2011).***

In some cases children interpret for their parents and may therefore miss school. Although children acting as interpreters raises issues of confidentiality and appropriateness, many migrants do not see it as unethical (Jarman, 2009).

[8] http://www.publichealth.hscni.net/sites/default/files/Orla%20Barron%20-%20Interpreting.pdf

2.6. Specific issues: women, children and groups with complex needs

Some groups of the ME community are faced by further issues which present challenges for the health and social care provided for them. Table 11 provides an overview of such issues for women, children, Roma, asylum seekers and refugees, and irregular migrants.

Table 11. Health and social care issues relating to women, children, and groups with complex needs

Women	• Women more seriously affected by migration than men: lower social status than men in many cultures, fewer in employment, lack of social and family supports – lonely and isolated, dependent on male family members for decision-making • Lacking awareness and uptake of antenatal care • Lack of support network of other female family members during pregnancy, after birth and when looking after young children: increased isolation, higher rate of postnatal depression • Domestic violence more prevalent; financially dependent on husbands where they have no recourse to public founds • Preference for female doctors due to cultural modesty rules
Children	• Possibly no neonatal screening in country of origin • Higher accident rate due to poor accommodation (overcrowded, cramped) • Immunisation: o Routine appointments only sent for children who are permanently registered with GP – impact on uptake o Childhood immunisation schedule may vary by country of origin o Lack of immunisation history and/or incomplete courses • Child protection
Roma	• Come from a range of Central and Eastern European countries, with most Roma arriving in NI being from Romania • Socially and economically deprived minority in home countries • High illiteracy levels • Difficulties registering for health care and NINo • Marginalised, vulnerable, and poor – lack of access to services and language barrier, hard to reach with existing services
Asylum seekers and refugees	• Asylum process lasting from several months to several years - if granted asylum, person must move out of accommodation within 28 days • Pre-existing disease, traumatic experience in country of origin (torture, rape, etc) and/or during transit • Asylum: poor housing with multiple occupancy and little income; isolation and little social support, psychological problems and substance misuse • Refugees: cultural bereavement and isolation; impact of asylum process on physical and mental health; adaptation to new country and obtaining work; loss of family/friends in country of origin
Irregular migrants	• Arrived via human trafficking or people smuggling • Trafficked from: Baltic states, Eastern and Central Europe, Central Asia, Bangladesh, Jamaica, Sri Lanka, African countries (eg Cameroon, Nigeria, South Africa, Sudan) • Health risks of trafficking: psychological trauma, injuries from violence, STIs, HIV/AIDS, other adverse reproductive health outcomes, substance misuse • No recourse to public funds • Unable to register with GP

Source: BHDU (2011); Jarman (2009), NICEM (2007)

3. Wider determinants of health

3.1. Isolation

Those who recently moved to NI often leave behind their immediate or extended family as well as friends. Social isolation can lead to the experience of loneliness and depression as well as to excessive alcohol consumption. About 1 in 5 migrants in the WHSCT area who reported stress, anxiety, or depression said that missing their family had caused their mental health problem (Jarman, 2009).

Poor levels of English seem to increase the experience of isolation. Women in particular are at risk as they are less likely to work and more likely to stay at home and be responsible for childcare. Having children in school provides opportunities to socialise, with women with pre-school children in rural areas feeling particularly isolated (Jarman, 2009)

3.2. Racism, racial harassment, and discrimination

An increase of racial incidents and racial hate crime of on average 10-15% has been recorded in the last 10 years (NICEM, 2011, p.35).

Table 12. Racist incidents, crimes and detection with a hate motivation summary 2009/10 and 2010/11

	Total number of incidents	Total number of crimes	Total number of crimes detected	Detection rate	
				Overall (%)	Change
2009/10	1,038	712	115	16.2	-2.8%
2010/11	842	531	71	13.4	

Source: PSNI as reported in NICEM (2011)

Almost half (46%) of migrant workers in the NI health sector had experienced racist harassment at work in both the private and public sector, with work colleagues being the most likely source. Three quarters of those experiencing racist harassment did not make an official complaint (Hamilton & Betts, 2006 cited in Jarman, 2009).

The NI Life and Times survey (NILT)[9] measured attitudes/prejudice towards ME groups. Some of the findings of the 2009 survey include:

- Almost 1 in 3 people were prejudiced against people from minority ethnic communities (very prejudiced 2%, a little prejudiced 30%);[10]
- Of those reporting prejudice, 18% stated their opinion had become more positive, 24% more negative, while 58% said it stayed about the same;[11]
- The ethnic group receiving the most prejudice were the Polish (30%), Romanian (20%), and Irish Travellers (16%); ethnic groups with least prejudice were (lowest three): Bulgarian 0%, Filipino 1%, Chinese 2%;[12]

[9] http://www.ark.ac.uk/nilt/results/mineth.html
[10] http://www.ofmdfmni.gov.uk/index/equality/equalityresearch/research-publications/gr-pubs.htm
[11] http://www.ark.ac.uk/nilt/2009/Minority_Ethnic_People/PREJCHGD.html
[12] http://www.ark.ac.uk/nilt/2009/Minority_Ethnic_People/RACPRG3.html

- Almost 1 in 4 agreed with “in relation to colour and ethnicity I prefer to stick with people of my own kind” (strongly agree 6%, agree 18%), while almost half disagreed (strongly disagree 16%, disagree 31%) and 29% neither agreed nor disagreed;[13]
- Although the vast majority of respondents would accept someone from another ethnic group as a resident in their local area or as a colleague, fewer respondents would accept them as a close friend or a relative by marriage.

Table 13. Attitudes to people from ethnic minorities

Would you accept someone from other ethnic groups as ...	Yes %	No %	Don’t know %
... a resident in your local area?	90	10	0
... a colleague?	90	9	1
... a close friend?	82	16	1
... a relative by marriage?	79	19	2

Source: NI Life and Times Survey 2009[14]

3.3. Employment

Work was one of the key reasons for coming to NI for many migrants. One survey of migrants showed that 32% came to find work, 21% to take up prearranged work, 16% to improve their English, and 15% to join their partner/spouse (Bell et al., 2009a). Different surveys show different levels of employment and unemployment (Table 14). A survey of Polish migrant workers suggested an unemployment rate (20%) three times that of the general population (6.7%). Yet, uptake of Job Seekers Allowance is low (Bell et al., 2009a: 3%; NICEM, 20011: 5%).

Table 14. Prevalence of migrant employment and unemployment in NI

Source	N	Employed	Unemployed
DEL survey 2008, (Bell et al., 2009a)	319	77% (87% men, 72% women)	9% (4% males, 12% females)
Polish migrant workers (McVeigh & McAfee, 2009)	412	80%	20%

Migrants from A8 and other EU countries were more likely to earn national minimum wage or less than those from outside the EU (Bell et al., 2009b). There was uncertainty about recognition of employment experiences and education qualifications in NI and many worked at lower levels than would be expected from their education (particularly Eastern Europeans; Bell et al., 2009b; McVeigh & McAfee, 2009).

Some migrant workers experience problems with payment, holiday pay, sickness and maternity entitlements, and salaries not reflecting their professional experience as well as forced labour (Allamby et al., 2011; Bell et al., 2009a; NICEM, 2011). Almost 1 in 3 felt discriminated against in the work place (32%) or when seeking work (28%; Bell et al., 2009a). National minimum wage does not apply to agency workers whose contracts were created by agencies outside UK jurisdictions and for some migrants employment conditions are below UK standard, thus violating equality and employment law, health and safety legislation (NICEM, 2011).

[13] http://www.ark.ac.uk/nilt/2009/Minority_Ethnic_People/RACOWNKD.html
[14] http://www.ark.ac.uk/nilt/results/mineth.html

Migrant workers with children find childcare expensive and may not be able to afford it to care for their children after school (Biggart et al., 2009). Care over the summer school holidays is seen as particularly problematic as being "either too expensive, or alternatively operated with too limited hours to cater for the needs of working parents" (p.57). Some rely on grandparents in their home countries or bring them over to NI over the school holiday period.

3.4. Poverty and destitution

The higher unemployment rate, "unsafe working conditions, employment contracts tied to accommodation, barriers in accessing health and welfare and insecure immigration status all contribute to migrants occupying a position more vulnerable and pertinent to destitution than the general population." (NICEM, 2011, p.9).

The different migrant groups are entitled to/restricted in accessing certain benefits which is shown in Table A4 (Appendix; see also BHDU, 2011). Length of employment and national insurance payments are essential in accessing benefits. Full refugee status provides entitlements as accessible by all UK citizens. Asylum seekers without financial resources are entitled to NASS[15] which provides free accommodation (wherever they are placed) and cash support. However, this weekly cash support is 30% less than income support received by the population, ie 30% less than what is deemed to be the minimum necessary to live. Women of insecure immigration status trying to escape domestic violence are at particularly high risk of destitution as they have no recourse to public funds (NICEM, 2011).

3.5. Housing

Migrants often share private rental accommodation either between individuals or families to afford high rents. Overcrowding and poor quality housing is common. Those in accommodation tied to employment contracts do not complain due to fear of losing their job (Bell et al., 2004; BHDU, 2011; Steed, 2010; see also Bell et al., 2009a).

Table 15. Type of accommodation by migrant worker survey

Type of accommodation	Bell et al. (2004) N=176	Bell et al. (2009a) N=313	NI population N=2,474
Owner occupied	18%	7%	69%
NIHE	6%	3%	14%
Private rented	54%	77%	17%
Housing association		5%	
Employer owned	22%	3%	
Stayed with family/friends		5%	

Source: NI population: Continuous Household Survey 2008/9[16]

Social housing and housing benefit are only accessible if the individuals are registered with the WRS or have been continuously working for 12 months. NIHE has published a mapping of housing need among ME groups (Steed, 2010). In the year to 31st July 2009, **Dungannon** District Office (209) received the greatest number of applications for social housing, followed by **North Belfast** (155) and **Portadown** (140).

[15] National Asylum Support Services
[16] http://www.csu.nisra.gov.uk/accomten/Accommodation_by_tenure_Trend.htm

In this period, NIHE also received 455 applications from migrant workers who applied as homeless. Dungannon, Portadown, and North Belfast also had the highest number of such applications from 2007 to 2009. Polish migrants make up the largest proportion in all these applications, followed by Portuguese and Lithuanians (2009: 44%, 16%, and 8%, respectively).

"In Northern Ireland, homelessness assistance is not available to non-UK nationals, yet by legislation, being rendered vulnerable and potentially destitute is a human rights concern" (BHDU, 2011; p.40).

3.6. Education

A recent report published by NICEM (Rooney & Fitzpatrick, 2011) examines equality issues at post-primary level. They summarise that "on average non-whites are performing better at the top end of the spectrum of academic attainment and worse at the lower end" (p.13).

Table 16. Academic achievement among white and non-white pupils in 2009/10

	White	Non-white	Non-white - specifically
Achieved 3 or more A-levels	50.7%	55.6%	• Indian/Sri Lankan: 68.9% • Chinese/Hong Kong: 67.5%
Left school with no GCSEs	2.0%	5.1%	• Other: 18.2% • Black: 9.0%

Source: DENI (Rooney & Fitzpatrick, 2011)

Further issues raised in the report relate to access to grammar schools, racist bullying, language, RE provision, and school dinners. The key points are summarised in Table A5 in the Appendix (see also NICEM, 2009 for education related disadvantage and discrimination).

While about 88% of ethnic minority pupils found it easy or very easy to make friends with pupils from the majority Catholic/Protestant communities, over half reported having experienced bullying in secondary school because of their ethnicity (Rooney & Fitzpatrick, 2011). One report showed that ethnic minority youth were 8 times more likely to have been racially bullied (NCB NI & ARK YLT, 2010; p.55). Table 17 lists prevalence of bullying from various sources and also provides some comparison figures from general population surveys. The most common form of bullying is name calling (75%) followed by exclusion from social activities (25%) (verbal threats: 25%; Rooney & Fitzpatrick, 2011); this is similar to the general population (NISRA 2011b).

A survey in the Southern area, distinguishing between different ME groups and white children, found no differences in the overall rate of bullying among ME and white settled children (Biggart et al., 2009). ME children reported lower levels of many forms of bullying (except for racist name calling) than white settled children, yet European migrant children experienced the highest rate of exclusion (from social activity; see Table A6, Appendix). This is also reflected in European migrant children's significantly lower participation in extra-curricular activities although all minority children participated less in clubs than white settled children. Issues of accessing sport and leisure activities (not knowing where, not feeling welcome, culturally inappropriate facilities) for both children and adults have also been raised elsewhere (NICEM, 2007).

Table 17. Experience of bullying: findings from different NI-based surveys

Surveys		**Experience of bullying**	
... of ethnic minority groups			
NCB NI (NCB NI & ARK YLT, 2010) N=452 16 year olds (7 PPS; majority and ME pupils; ME include Travellers)	Recorded ME pupils	Been victim of racist bullying or harassment in their school	42%
		Witnessed racist bullying or harassment in their school	68%
	Self-identified as belonging to minority group	Been victim of racist bullying or harassment in their school	15%
		Witnessed racist bullying or harassment in their school	48%
NICEM (Rooney & Fitzpatrick, 2011)	N=91 post-primary pupils	Bullied because of their ethnic background	53.7%
... of the general population			
Kids Life and Times 2011[17]	N>4,000 P7 pupils	In last 2 months: been physically bullied	18%
		In last 2 months: been bullied in other way	33%
		In last 2 months: been bullied via mobile or internet	12%
Young Life and Times 2008[18]	N>900 16 year olds	Ever been bullied	37%
		In last 2 months: been bullied	31%
		Been victim of racist bullying or harassment	3%
Summary of 3 DENI commissioned surveys (2000, 2006, 2011) (NISRA, 2011b)	Around 1,000 Year 6 pupils (60 PS)	Experience of being bullied	40%
	>1,200 Year 9 pupils (60 PPS)	Experience of being bullied	30%
2011 DENI survey (NISRA, 2011b)	N=904 Year 6 pupils (60 PS)	Been bullied with mean names or comments about my race or colour	14.0%
	N=1,297 Year 9 Pupils (60 PPS)	Been bullied with mean names or comments about my race or colour	7.6%
... Southern area survey			
Year 5, 6 and 8 pupils (Biggart et al., 2009)	*N=501 white settled*	Been bullied in last 2 months	45%
	N=108 European migrant	Been bullied in last 2 months	45%
	N=52 Asian	Been bullied in last 2 months	36%

[17] http://www.ark.ac.uk/klt/2011/Bullying/
[18] http://www.ark.ac.uk/ylt/results/ylteduc2.html

3.7. Prison

Foreign born nationals are overrepresented in prison (8.9% in January 2011 vs 0.6% in the general population). The 131 prisoners came from 28 countries, with Lithuanians (37), Chinese (19), and Polish (17) being the most numerous. The most common offenses were drug-related (n=26) (NI Assembly, 2011).

A NI Assembly paper (2011) summarises problems and experiences of foreign prisoners based on several studies. These issues are interrelated and impact upon each other. Mental health is a particular problem for foreigners who are more likely to be diagnosed with psychiatric illness then the general population (Centre for Social Justice, 2011) and for prisoners in general (NEPHO, 2005). These two factors combine to an increased vulnerability/risk among foreign prisoners and in worst case result in suicide.

Table 18. Problems faced by prisoners from minority ethnic background

• Language barriers • Isolation • Mental health brought about by separation, trauma and loss, eg if coming from area in conflict • Immigration issues • Cultural differences	• Lack of access to information and legal support • Lack of respect and racism • Lack of preparation for release • Bureaucratic limbo (awaiting deportation after serving sentence) • Fear of return to home country

4. Conclusion

The information in this brief comes from a variety of sources. There is no single source on ME groups and further evidence continuously emerges. The 2011 Census will provide up-to-date population figures. In addition, an ongoing process to amend HSC systems to collect standardised demographic data on ethnicity will fill current gaps in knowledge around the uptake of services.

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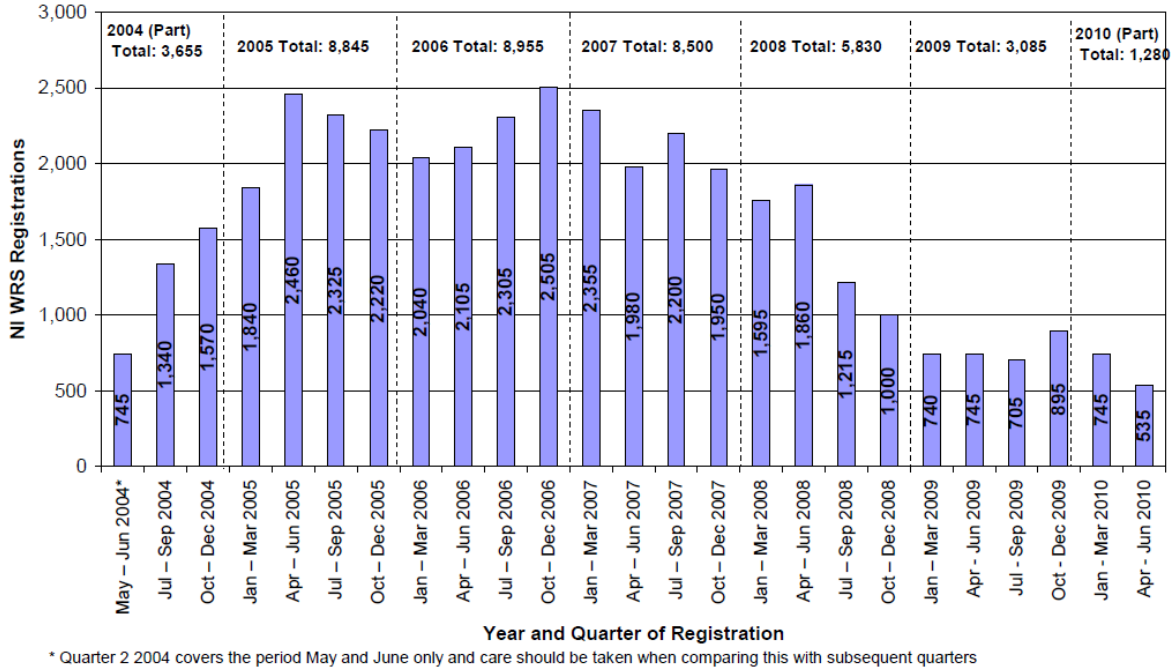
Appendix

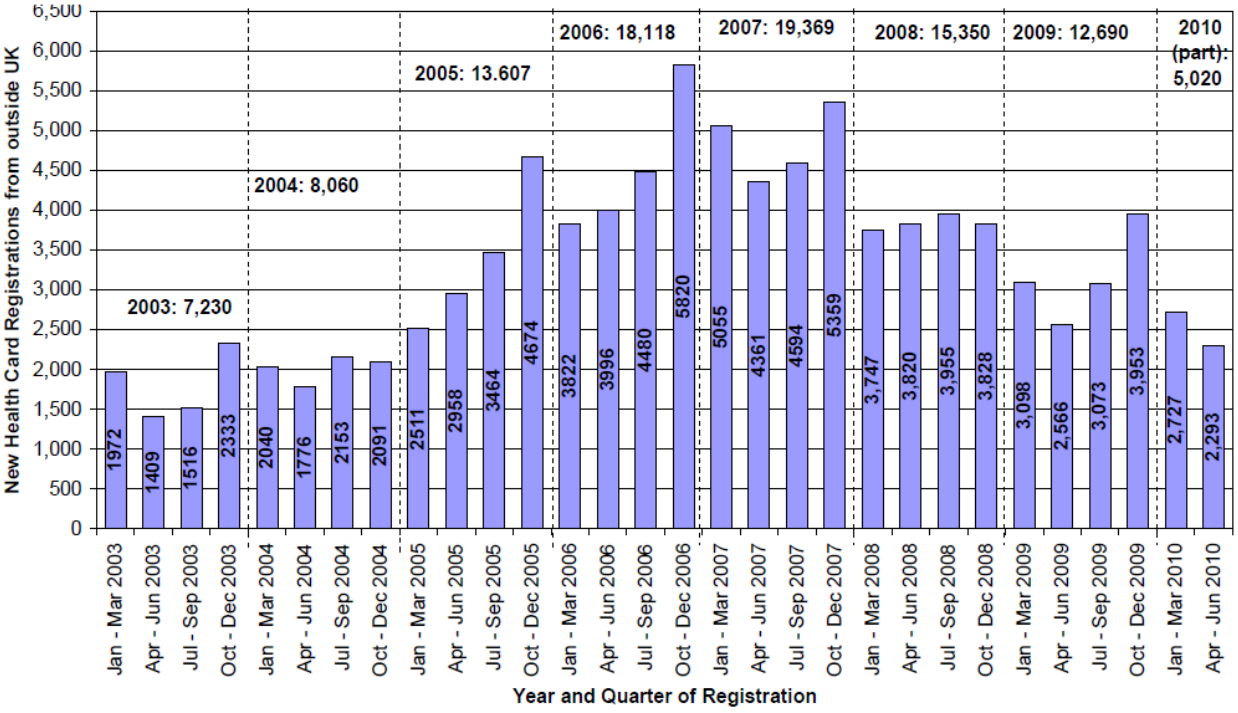
Population estimates (NISRA, 2010)

Figure A1. Number of NI WRS registrations by quarter (May 2004 – June 2010)



* Quarter 2 2004 covers the period May and June only and care should be taken when comparing this with subsequent quarters

Figure A2. New health card registrations from outside UK by quarter of application (2003-2010)



GP survey

Table A3. GP patient survey 2009/10 (Ipsos MORI, 2010)

		White	Non-white
Reasons for not being seen quickly	There weren't any appointments available	84%	74%
	Times offered didn't suit me	9%	22%
Reception	Feel they are overheard at reception and were not happy about it	24%	20%
Waiting times	Don't normally wait too long	71%	61%
	Have to wait a bit too long	18%	25%
Preferred doctor	Yes, have a preferred doctor	66%	59%
	See preferred doctor always/almost always	57%	42%
	See preferred doctor some of the time	18%	30%
Opening times	Desire for added opening times	49%	60%
	After 6.30pm	41%	23%
	On a Saturday	40%	55%
	On a Sunday	2%	6%
Rating of doctor			
... giving patient enough time	Very good	64%	54%
... asking about symptoms	Very good	62%	52%
... good at listening to patient	Very good	63%	55%
... explaining tests and treatments	Very good	57%	48%
... involving patient in decision about care	Very good	53%	44%
... treating patient with care and concern	Very good	62%	50%
Confidence and trust in doctor	Yes, definitely	79%	68%
Satisfaction with care at surgery	Very satisfied	62%	52%
Out-of-hours GP			
Know how to contact out-of-hours GP	Yes	82%	72%
Ease of contact out-of-hours GP	Very easy	51%	39%
Care received from out-of-hours GP	Very good	35%	28%

Note: baseline figures for each item vary; please see full report for detail

Ratings of practice nurses mirror those of doctors.

Table A4: Legislative context and entitlement to health and social care and security benefits for different migrant groups

	EEA	A8	A2	Non-EEA	Refugees	Asylum seekers
Employment	No restrictions	WRS registration After 12 months of continuous legal employment eligible for residency permit	Employer to apply for work permit Exempt: Self-employed Highly skilled Work scheme (seasonal agricultural; sector based)	Points Tier-based scheme	Full refugee status = British citizen	Not able to take any employment
NINo	Yes	Yes	Only if have right to stay indefinitely (ie are self-employed, student or self-sufficient; see 1.4)	Yes	Yes	
Health card	Yes	Yes		Yes	Yes	
Health and social care	All ordinarily resident persons (ie in NI for 6 months or longer) • Entitlement to register with GP; • Use of all medical and social services as required; • Secondary care provision (statutory charges for certain services such as dentist and opticians) Everyone, whether ordinarily resident or visitor – services free of charge: • Emergency, requiring immediate treatment at an A&E department • Treatment of diseases on the Notifiable Disease list (NOID) • Family planning services • Treatment for STI and HIV testing (HIV treatment is not free) • Compulsory psychiatric treatment					
Social housing eligibility	Only if individual or family member is working	12 months employed Entitled to homelessness regulation		Not if passport states 'no recourse to public funds' Not entitled to homelessness regulation – NIHE to advice and help	Yes, as any NI resident	Only if entitled to NASS placed in housing accommodation (not social housing)

Social security benefits						
Child benefit	Proof planning to live, work and settle	Not working not entitled First 12 months working + WRS registered	Can claim in first 3 months, then need employment If have Accession card	'persons subject to immigration control' have no 'recourse to public funds' – not entitled to any social security benefit	Yes, as any NI resident	
Means-tested (low income)			Only if have Accession card			
Non-means-tested	Sufficient NI contributions		Qualify for some benefits after 12 months of continuous employment	Limited circumstances where allowed job-seekers allowance (sufficient NI contributions)		If destitute, NASS = free housing and cash support which is 30% less than income support

Note: WRS registration scheme for A8 nationals ended in April 2011;
Accession period for A2 countries ends 31 December 2011, thereafter UK can extend restrictions if they wish (NICEM, 2011).

Please note, this overview is a very simplified summary and the actual immigration rules around these issues are complicated. Further clarification could be thought from the Law Centre (http://www.lawcentres.org.uk/).

Education

Rooney & Fitzpatrick (2011) summarise further concerns and issues around education and ME communities based on their research (survey, focus groups) and literature review. Key points are shown in the overview.

Table A5. Issues and concerns among ME groups regarding the education system in NI

Grammar school attendance/access	• 13.7% newcomers vs. 42.5% non-newcomers • 43.1% non-white vs 42.0% white pupils • Arrivals after transfer tests • FSM entitlement disadvantages ME pupils due to lower rate of eligibility (ie social security benefit restrictions) and/or no FSM uptake because of language, culturally unsuitable school dinners, lack of knowledge how to apply
Language	• Conversational proficiency within 2 years versus academic proficiency within 7 years (for EAL) – impact on SEN (over- and under-identification), tests and examinations • Encouraging home language: accreditation at PPS • Parental frustration over language barrier in helping with children's homework and communicating with teachers – lack of provision of interpreters
Racist bullying	• For extent see Table 17 • School measures addressing racial bullying, if implemented, perceived as unsatisfactory • No requirement of incident recording for schools
Religious Education	• Core syllabus in KS 1, 2, and 4 dedicated to Christianity (KS 3: sensitivity towards other religions) – perceived as narrowly focused and doctrinal; EQIA critique • Extent of RE opt-out is unknown (NICEM survey 26.4% of BME pupils), though opting out is a human right, it deprives pupils of GCSE option
School dinners	• Catering for different cultural and religious requirements • Lack of information and lack of appropriateness of school food: lists of ingredients and preparation method (eg Halal) not provided

Table A6. Any experience of bullying in last couple of months

	White NI %	**European migrant %**	**Asian %**
Teased	43	36	29
Excluded	38	45	20
Hit, kicked or punched	33	29	22
False rumours spread	40	35	26
Property or money taken	32	19	18
Threatened	33	25	20
Racist name calling	20	31	26

Source: Biggart et al. (2009); Please note that figures are percentage of those who were ever bullied

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