Good Practice Guide 4

Promoting health and wellbeing in black and minority ethnic (BME) groups, including Travellers and migrant workers

The conditions in which people are born, grow, live, work and age can lead to health inequalities – the unfair and avoidable differences in health status.

Actions to tackle health inequalities demand the efforts of government, statutory organisations, and the community, voluntary and private sectors. This Good Practice Guide to promoting health and wellbeing in black and minority ethnic (BME) groups, including travellers and migrant workers, is one of a series designed to capture information about health inequalities and highlight evidence-based interventions and key actions for improvement across sectors.

Other Good Practice Guides in this series can be accessed at www.publichealth.hscni.net/publications/good-practice-guides

Why do it?

In addition to indigenous Irish Travellers, black and minority ethnic individuals and communities have been settling in Northern Ireland for almost 100 years, with the first communities arriving from the Indian sub-continent in the 1920s.

In the last decade, significant numbers of migrants from the European Union Accession Countries have come to live and work across Northern Ireland. There has also been an increase in the number of non-EU nationals seeking work and in the number of refugees and asylum seekers dispersed to Northern Ireland.

Net migration flows to Northern Ireland showed a rise from a loss of 1900 people in 2000/1 to a gain of around 9800 people in 2006/7. Since then the figures have declined, with latest figures indicating a downward trend in international migration and a consequent fall in net migration. In 2008/9, there was a gain of around 2,100 people to the Northern Ireland population, possibly linked to the global economic downturn.

Local government districts with the highest inward migration were Belfast, Dungannon and South Tyrone, Newry and Mourne, Craigavon and Omagh.

Health and social context

BME communities have strong cultural beliefs and practices, many of which promote health and wellbeing, such as breastfeeding, a strong emphasis on traditional family meals and close social networks. However, some health issues and risk factors for disease and ill health are more prevalent in certain nationalities and cultures:

- diabetes is more prevalent in Asian and black ethnic groups (12.4% and 8.4% respectively) compared to Northern Ireland population (5.4%);
- life expectancy for Travellers is around 20% lower, with only 10% of Travellers aged over 40 and only 1% over 65;
- Lithuania has the highest rate of suicide in Europe; Northern Ireland has the highest proportion of Lithuanians resident in the region per head of population compared with the rest of the United Kingdom;
- women in BME communities are less likely to smoke than the general population and people of African-Caribbean origin have a lower prevalence of coronary heart disease compared to the white population but a higher prevalence of and mortality from hypertension and stroke.[1]

The term 'BME', while a convenient shorthand, underplays the diversity between these ethnic groupings of individuals and communities and can lead to a tendency to stereotype or generalise. The socio-economic and epidemiological differences between minority ethnic groups often transcends differences between them and the indigenous white population. In England, for example, 69% of Pakistanis and Bangladeshis live in poverty compared to 20% whites and 22% of Indians.[1]

Policy context

All migrants to Northern Ireland are subject to UK immigration law, policies and procedures. A number of significant legislation and policies at regional level and beyond underpin civic and national objectives to ensure an integrated, vibrant population within Northern Ireland, able to integrate socially, economically and able to engage with service

providers. Specifically, the strategies below provide all organisations with guidance for how they should work with and for the entire population in Northern Ireland:

- *The European Convention on Human Rights*;
- *The Race Relations (N.I) Order 1997*;
- *Section 75 of the Northern Ireland Act 1998*;
- *A racial equality strategy for Northern Ireland 2005–2010*;
- *A shared future and Racial Equality Strategy: first triennial action plan 2006–2009*;
- *Equality, Good Relations and Human Rights Strategy and Action Plan 2008*.

What works?

The evidence base for interventions and programmes that positively impact on the health and wellbeing of BME groups is limited. Much of the published evidence from the United Kingdom relates to BME groups primarily from the Indian sub-continent and African-Caribbean and Muslim communities.

Within Northern Ireland, there are many needs assessment and surveys on the new BME communities that highlight specific needs, health issues and make recommendations for action to address these [2,3]. However, published evaluations of effective programmes are very limited. The examples of projects listed below reflect programmes that have been evaluated.

For individuals/families

- The Wellness Recovery Action Planning Training (WRAP) facilitated by Northants NHS Trust for BME women aimed to build self awareness, advocacy and capacity.[4] As a result BME communities had increased awareness of mental health wellbeing and became better linked into services.

- A black and minority sports project, Voice East Midlands, improved long-term commitment and involvement of BME groups in sports and sports infrastructure.[5]

For communities/settings

- A national capacity building programme developed by the Council of Ethnic Minority Voluntary Sector Organisations engaged with BME service providers and their capacity increased.[6]

- Interagency partnerships for Traveller health and wellbeing in Nottingham and Doncaster improved community relations and decreased attendance of Travellers at accident and emergency departments. [7,8]

For schools/workplaces

- The Johnathan Ball Tiny Steps for Peace project ran drama workshops with six and seven year olds in schools.[9] There was increased awareness by children of diversity and ability to recognise exclusion.

- A coronary heart disease prevention and control service for South Asians held programmes in workplaces, mosques, temples.[10] There was a reduction in salt intake and use of oil in cooking, and a reduction in weight and blood pressure.

Policy level

- Improving government services for black and minority ethnic groups will involve practical advice from the National Consultative Committee on Racism and Inter-culturalism (NCCRI) for service providers, including check lists, training, language policies, consultation and examples of good practice.[11]

- The community planning model details ten actions to tackle inequalities.[12]

- All Ireland Traveller Health Study, which will report in 2010, will examine the health status of Travellers, assess the impact of services for them and provide a frame-work for policy development and practice in relation to Traveller Health.[13]

Measures for which evidence is lacking or unclear

- While there is much research published on the needs of BME groups in general, there is a lack of published evidence on initiatives which positively improve the health and wellbeing of BME individuals and communities within Northern Ireland.

- There is also little evidence on effective suicide prevention initiatives in BME individuals and communities.

What can we do?

Key actions for health improvement

The following are evidenced-based actions which will positively impact on the health and wellbeing of BME groups. Projects, both local and best practice models from elsewhere, are identified. Further details on these can be provided by the contact point for this guide.

Address racism through diversity training and awareness at all levels, starting with children in school environment.

Local projects include: An information pack for asylum seekers in Northern Ireland from the Refugee Action Group; diversity/cultural awareness/tackling racism training programmes in the public sector.

Improve language skills for non-English speakers to help them integrate and access services.

Local projects include: Bilingual advocacy project in the Northern area, including a health impact assessment; The VOICE programme, enabling volunteers to teach English to non-English speakers in Southern area; and the ESOL (English for speakers of other languages) programmes.

Build capacity within BME communities to influence and improve their own health and wellbeing and support their representation on service planning forums.

Local projects include: a BME health and wellbeing development project for north and west Belfast; BME access to services in Southern area; a review of relevant research and reports on BME groups in the Western area; and the Cross Border Traveller Health project.

Train and support BME individuals to work with their own communities in promoting their health.

Local projects include: Employment of BME/ Traveller/migrant individuals in delivering mainstream services and the Regional Interpreting Service.

Adopt tackling inequalities in community planning outcomes and include BME individuals and groups, including Travellers and migrant workers, in the process.

Best practice models include: A vision and value statement concerning newcomers in Vancouver; and the development of local race equality strategies by the Enfield Strategic Race Forum.[14]

Local projects include: Diversity training http://diversity.hscni.net; *Racial equality in Health and Social Care – A good practice guide.*[15]

References

A full list of references is available at: www.publichealth.hscni.net/publications/ good-practice-guides

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