RACE ON THE AGENDA

DEVELOPING THE MAYOR'S HEALTH INEQUALITY STRATEGY FOR LONDON
STAKEHOLDER ENGAGEMENT ON RACE EQUALITY
12 OCTOBER 2007 EVENT REPORT

INTRODUCTION AND BACKGROUND

1. Race on the Agenda (ROTA) is a social policy think-tank that has been active since 1986. We work with London's Black, Asian and minority ethnic (BAME) communities towards achieving social justice by the elimination of discrimination and promotion of human rights, diversity and equality of opportunity. We achieve these aims by informing London's strategic decision-makers about the issues affecting the BAME voluntary and community sector (VCS) and the communities it serves and by making government policy more accessible to London's BAME organisations. MiNet, the regional BAME network joined ROTA in 2002. Its focus is on strengthening the voice for London's BAME VCS in the development of regional policy.

2. ROTA uses the term BAME to refer to all groups who are discriminated against on the grounds of their race, culture, colour, nationality or religious practice. This definition includes but is not exclusive to those people of African, Asian, Caribbean, Irish, Jewish, Roma, South East Asian.

3. ROTA was commissioned by the Greater London Authority (GLA) to carry out a consultation event to collect qualitative evidence to inform the Mayor's Health Inequality Strategy particularly in relation to issues around race, ethnicity and culture. Individuals from thirteen organisations attended the event which was held at the GLA on the 12th October 2007. The organisations represented all sectors (public, private and VCS) and although the majority were infrastructure bodies, front line groups were also present. The full list of participants is provided in Appendix A.

4. The discussion was broken down into four sections. These corresponded to the consultation areas of the Draft Strategy, *Reducing health inequalities – issues for London and priorities for action'*:
   - Area 1 - Life chances[1]
   - Area 2 – Healthy places
   - Area 3 & 5: Responding to existing health inequalities & Learning for Health
   - Area 4: the role of the voluntary and community sector in reducing health inequalities for London's BAME communities.

   However, as these are cross-cutting issues, this report will present the findings as they arose during the event.

5. The findings of this report are based on the following:
   a. The key points made by the participants who attended the consultation event

[1] "Life chances" is defined as the likelihood of a child achieving a range of important outcomes which occur at successive stages of the life-course, most importantly the chance to life a fulfilling and rewarding life.

b. ROTA's experience as one of London's key VCS policy infrastructure organisation working on issues affecting BAME communities.

6. ROTA's overall message is that London's BAME communities continue to be disproportionately represented in a number of the indices of poor health and experience the most barriers to health. We therefore see the development of the Mayor's Health Inequalities Strategy as a momentous opportunity to contribute to the shaping for the Strategy.

Teenage pregnancy and support for small community groups

7. A small group, WiseGem, based in Peckham was present at the event. The founder gave direct evidence in regards to teenage pregnancy as an issue in the health inequalities agenda.

Case study 1: WiseGem (text provided by WiseGem)

WiseGem is a community-based project. In 2006, it was presented to DfES by Southwark Council as Best Practice case of 'Young Parents Peer Education Programme in Schools'. It operates in Peckham but works across Southwark – one of the boroughs with the highest rate of teenage pregnancies and Sexual Transmitted Infections (STIs) in the UK. It targets young BAME people who are sexually active and at risk of contracting STIs or becoming pregnant. The project also works with young parents whose experience of unplanned parenthood are used to educate other young people.

Funded from public sources, WiseGem has been running for 3 ½ years and works in partnership with the local PCT, whose Teenage Pregnancy Unit it delivers services for. Thus reaching a target groups that are ordinarily not inclined to access this type of service from a public sector provider. Some of its aims are:

- To tell people about the issues surrounding teenagers, growing up, sex, sexually transmitted infections, and relationships.
- To help young people to learn, and understand how to prevent pregnancy and STI's.
- To support teenagers when they become pregnant or when parenting a baby so as to minimize hardship.
- To raise awareness of the realities of teenage parenthood through 'testimonies' of young parents.

The project works with young people living in a highly deprived neighbourhood and some of whom have low career aspirations, few employment opportunities, lack of knowledge about realities of early parenthood, and mixed messages about sex and contraception from adults.

WiseGem's approach include: referrals to GPs, TPU, social services, midwives and schools; focus groups/discussions on STI, teenage pregnancy; encouragement of parent-child communication and outreach visits to places of worship, schools and community centres.

The effectiveness of WiseGem is based on the fact that it is run by a team of volunteers, a number of whom have themselves been young, unexpected parents. These volunteers participate in visits to schools and other public places to raise awareness about unplanned pregnancy/parenthood. They also provide peer education support to those who have just or about to become young parents.

8. As the case study and the group discussion illustrated there are problems of awareness and access to information and advice. In addition, there was evidence of inadequate support to community based, local groups which often have to take on the role and work of mainstream health service providers. For example, the issue of teenage pregnancy within BAME communities is considered particularly sensitive due to the cultural and religious beliefs of some of these groups. Moreover, there seems to be a tendency to resort to trusted and localised solutions rather than be processed through the National Health System (NHS). This is primarily because they fear that NHS staff will be obliged to report the issue to their parents who may in a negative manner.

9. Sex education was put forward as a recommendation for increasing awareness on the matter. However, one participant noted that not all BAME communities would welcome this as it may conflict with their religious and cultural beliefs. It was agreed that the emphasis should be on increasing awareness within the given cultural context of each BAME group.

10. Recommendations:

- The contribution of small local groups to the issue of teenage pregnancy within BAME communities is acknowledged and supported appropriately through funding and advice.
- Existing mainstream health service providers are encouraged to become more aware and sensitive to the issues surrounding this matter. This would make public services more accessible to these groups.
- There needs to be an emphasis on prevention and this should not just happen at the national or regional level but also at the local level through Local Authorities.

Direct and indirect discrimination

11. The participants gave direct and hearsay evidence of different types of discrimination by health service providers.

12. Examples of direct discrimination given by the participants:
    - Emergency services not agreeing to go on to a gypsies/ travellers site.
    - Receptionists in hospitals and health centres being abusive (e.g. to refugees).
    - Receptionists in GP surgeries disclosing personal information in front of other people.
    - Ambulance staff refusing to treat a black boy because of his race.
    - Social services and police not attending to domestic violence incidents taking place at travellers/ gypsies sites.

13. Examples of indirect discrimination given by the participants:
    - Stereotypes e.g. Black men being perceived as aggressive because of the way they speak or appear
    - BAME people who have strong faith, religious and cultural beliefs could also have special needs such as those around dietary requirements, clothing and bathing. There is evidence to suggest that these are not seen as matters significant enough while providing them with healthcare services.
    - A 5 year old epileptic boy was circulated within the health system. This delayed access to the necessary treatment.

14. Recommendations:

- Better enforcement of the Race Relations (Amendment) Act and the positive duty on public authorities.
- Better enforcement of the Human Rights Act.
- A representative from the Equalities and Human Rights Commission (previously in the Commission for Racial Equality) noted that they have recently submitted a report to the Department of Health criticising them on their performance on race equality. It was recommended that the suggestions put forward in that document are followed up by health service providers and are considered by the Strategy.
- Provide training to frontline staff (particularly ambulance staff and receptionists) on empathy, respect and cultural awareness.
- The Equalities and Human Rights Commission has a specific obligation under the Equality Act to monitor human rights compliance of public authorities such as hospitals and health service providers. This should be a priority for the new body particularly when vulnerable groups are involved such as older and disabled BAME people.

Mental Health, access, treatment and stereotypes

15. A discussion was held in regard to mental health in which many participants noted that there was an overrepresentation of BAME people, especially from the Caribbean and African communities within the mental health system.

16. The participants also provided indirect evidence that suggested BAME people may be deemed mentally unstable or dangerous because they express themselves in a different way with stereotypes being used to define people.

17. Concern was expressed that BAME communities are over-represented in mental health treatment services and are more likely to be pathologised and to receive drug rather than talking therapies and may also be over-medicated. BAME communities, however, fail to access the community, primary care and mental health promotion services that could break the cycle.

18. A counter argument was put forward that at least BAME people with mental health issues were receiving treatment rather than being excluded from services as with some other health issues.

19. There is a missed opportunity for advocacy through the Mental Health Act.

20. Recommendation:

- Training and awareness raising of staff working on mental health will need to be provided to tackle with the misconceptions and stereotypes.
- Carry out outreach work so that both the VCS and health service providers are better able to engage with people facing mental health issues at an early stage (being proactive rather than reactive).

Language difficulties

21. Participants gave evidence to suggest that BAME people often face language barriers that not only prevent them from accessing written information, but also from voicing their concerns.

22. An Age Concern study was mentioned at the event to illustrate that there are very significant numbers of South Asian and Chinese/Vietnamese elders who face language barriers in accessing care services.

23. It is unrealistic to imagine that people who have reached a certain level of maturity can learn a new language.

24. This is also a problem that affects newer communities as well as asylum seekers and refugees.

25. Recommendation:

- Participants pointed out the significant role of "community interpreters" as opposed to translators. Community interpreters can act as advocates and provide a more comprehensive service to fragile and dependent individuals.
- Participants identified a role for the London Skills and Employment Board (e.g. in ensuring that there are provisions to increase English language skills).
- A toolkit for refugees and asylum seekers was not considered to be a good option. The participants agreed that there is a role for the Board for Refugee Integration in London (BRIL).

Health inequalities in the prison settings

26. Participants noted the over-representation of BAME people in the criminal justice system as well as the high numbers of BAME incarcerated boys suffering from mental health problems.

27. Health inequalities in prisons was considered by the participants to be an omission of the Draft Strategy. There is no explicit reference to inequalities happening in this context nor any explanation as to how the Mayor could link with existing structures.

28. Participants mentioned that health inequalities in prison are particularly prominent as the food is often of poor quality and living conditions are inappropriate.

29. The absence of cultural awareness was raised as a cause for dietary and other cultural requirements of BAME prisoners being ignored.

30. Recommendation:

- The Mayor's Strategy will need to link with existing structures such as the health pathway of the London Resettlement Board and the Regional Offender Management Service.
- The CRE carried out an extensive piece of research on the prison service and health inequalities faced by BAME groups within it including health inequalities. It was recommended by the participants that the Draft Strategy considers these findings.

Advice and support

31. Participants noted that many BAME people do not know how to access health services. This is particularly true for newer communities such as Eastern Europeans.

32. Participants also pointed out that BAME people, particularly the elderly, refugees and asylum seekers are not aware of complaint procedures.

33. Some BAME groups particularly older BAME people have issues with regards to access to available information. This is because it is not provided in a manner that considers their life style and limitations.

34. Recommendations:

- Participants saw a role for the Legal Services Commission in providing advice and information.
- Advice at the local level was also thought to be important. There is a role for community groups but additional support needs to be given to them.
- Advice and information should be made available in ways that corresponds to BAME groups' life styles e.g. outreach work for local groups and visits to places where local people go e.g. churches, hairdressers.
- Use of new media will need to be improved. This is particularly true for young people.
- Voluntary and community groups can reach BAME people in their own homes, know them locally and personally. This is a resource that has not been used appropriately and the strategy will need to consider it further.

Healthy places

35. Participants suggested that the Strategy does not interpret the term "places" as purely meaning a location. A certain London Borough may appear statistically to be doing better than other London Boroughs but that should not mean that BAME communities living in that area are also better off. Although location may play an important role in terms of available services, sometimes these services may not indeed be available to certain BAME groups.

36. Similarly to the aforementioned point, participants noted that even in the most rich London areas there are deprived neighbourhoods and this is where BAME people are highly represented. This has a direct impact on their health although they might be considered residents of a good area.

37. Places for young people and children to play and develop their personalities were considered by the participants to be an important factor for a healthy and happy life. They gave examples of their own areas where play grounds were demolished to be replaced by car parks of flats.

38. The issue of places was linked to crime particularly the gang, gun and knife culture that is rooted in the capital. BAME young people are often caught in this culture because they live in a deprived area and joining a gang is often the only way they see possible in keeping them alive.

Case study 2: The Bolton Project

One of the participants mentioned the "Bolton Project" to point out the significance of bringing communities together and the impact it can have on their health and well being. The project involved transforming an abandoned play ground from being a place for drag addicts to an open local market where BAME communities living in that are would meet on a regular basis. This was a community initiative that resulted in stronger community cohesion and better health.

39. Recommendations:

- The Strategy will need to link with the London Plan (3.1.6.A) and the Mayor's Housing Strategy (in terms of ensuring VCS organisations working in health have access to premises).
- The Strategy will also need to look at existing case studies and what has worked for voluntary and community sector organisations working at the local level supporting their constituents (BURA was mentioned as an example of an organisation holding information on successful regeneration projects involving health).

BAME representation in the health service and managerial posts

40. One participant noted that although there appears to be a fair amount of GPs from the Indian subcontinent, many are due to retire. This may mean a change to the demographics depending on the diversity of new doctors currently being trained.

41. Linked to the above was a point made by a participant who felt that doctors who share similar cultural or religious backgrounds may empathise better with their patients.

42. It was also suggested that one rarely sees BAME senior managers within the healthcare system.

43. BAME frontline staff are also not empowered by their managers to respond to cultural nuances and requirements of BAME consumers.

44. Recommendation:

- Positive Action and better enforcement of the positive duty and the Race Relations Act in terms of employment of health service staff was recommended.

The role of voluntary and community sector groups: engaging the community

45. The VCS promotes a feeling of empowerment and belonging in community groups. The VCS also establishes communication channels between individuals and government bodies, and enables small and large minority groups to have a say in policymaking, legislation and regulation of the country's affairs. Organisations working in the VCS enable communities who often feel isolated and let down by public services and government to have their voices heard.

46. The vast majority of VCS activity takes place at a local level, often addressing the needs of society's most disadvantaged groups. As partners, providers and advocates, VCS

organisations are ideally placed to work with local authorities and other statutory agencies (e.g. PCTs) to achieve results for local people - improving the quality of life and the quality of services in every area and encouraging strong and cohesive local communities. Therefore, regional governance bodies and strategic structures are increasingly relying on the VCS to help deliver on their human rights, equality, community cohesion and integration agendas. More importantly, they rely on the VCS and infrastructure organisations in particular, to provide a voice for 'hard to reach groups'.

47. Participants noted that the public trusts the VCS more than other sectors (e.g. on issues such as teenage pregnancy and inequalities). However, there is evidence to suggest that government does not engage with the VCS adequately. The GLA, the London Health Commission and other decision makers should see the VCS as a key partner for health inequalities.

48. Short term funding does not allow small community groups to provide long term, sustainable contribution to balancing health inequalities in their area. The significant of full cost recovery and Compact compliance was also highlighted.

Collection of evidence

49. Participants noted the gaps in the way certain equality groups are monitored.

50. It was also noted that research evidence collected by the VCS is given very little credibility. VCS organisations have strong links and networks with the communities they serve and can produce methodological pieces of work that can inform the strategy in a unique way.

51. Academic research on health is not made available to small community groups working on health inequalities at the local level.

Partnership work

52. Recommendation

- Participants thought that partnership work between VCS and mainstream health service should be the right way forward and a serious recommendation to be considered by the Mayor's strategy

Case study 3: Partnership work (provided by a participant)

London Borough of Brent has a significant population of people from BAME communities. A community-based but local authority run project is a major beneficiary of a central government grant that funds community-based, culturally specific mental health services to bridge gaps in services where there has been misdiagnosis due to inattention to the specific cultural needs of BAME service users.

Establishing this type of project has made people from BAME communities and service users more confident in using mental health services as a result of the attention the project has given to the cultural needs.

The project also work with other local agencies including NDC, local colleges, social services and community mental health service providers, to provide formal training for

people with mental health episodes as a pathway into work and further education. A recent evaluation of the project shows that 70% of its service beneficiaries have either moved in to the world of work or further education.

ROTA's concluding remarks

53. ROTA has witnessed a failure of culture of respect for equality and human rights in the provision of public services at large. In relation to health and social services, we identify the following issues:
    - The Race Relations Amendment Act and other equality legislation are not always reflected in institutional procedures, service delivery and internal/ external policies.
    - Frontline staff and managers lack awareness of equality legislation.
    - BAME communities have either low or no awareness at all of their entitlements under equality legislation.
    - Discrimination and health inequality are not single-dimensional phenomena. Many BAME people have multiple needs and can suffer from discrimination based on more than one aspect of their identity; gender, ethnicity, age, disability, sexuality, income, family and social networks, beliefs, material circumstances, nature of migration, area of living, type and level of care needed. Many BAME people have unmet needs which affect their participation in wider society. Many have experienced disruption in their family structures, the challenges of growing older in a country where it may not have been their intention to stay, and a lifetime of discrimination and disadvantage. ROTA has not witnessed yet a culture where healthcare services respond to BAME people's needs in a way that promotes independence and acknowledges their individuality.
    - In terms of geographical location, BAME people, gays and lesbians and some faith communities are more likely to be settled in large urban areas than elsewhere. A consequence of this is that while some large, urban authorities may have developed appropriate services for these groups, other authorities may believe that it is not necessary for them to do so as numbers are small and or/unknown.
    - Some groups of BAME people need to be provided with services that take into account their religious beliefs and practices. These are not always considered important in the provision of health services.

54. Some of the practices which, in our experience, have impacted positively on access to health and better take up of health related service include:

    - User involvement in service design.
    - Provision of language support though community interpreters, especially for non-English speakers who are sometimes the most in need of basic services. For example, this has proven to prevent misdiagnosis (translation services can indeed be useful but does not extend to advocacy).
    - When the diversity of service delivery staff reflects the makeup of the community the health agency serves.
    - When services provided are culturally sensitive and appropriate. The phrase 'culturally appropriate' may sound overused but it is still very relevant because the evidence suggest that disregard of the subtlety of the culture of potential service users can be a barrier to uptake of services, which further exacerbate health inequalities.

- Beliefs and values are equally important to people from BAME communities. Things that are as basic as lack of understanding of the dietary needs and habits and religious beliefs and practices of ethnic minority service users do often act as barriers to access.

Some BAME individuals are losing faith in mainstream health service provision because they sometimes do not provide what these communities want. Community-based services which are more accessible are now increasingly seen as a viable option for better quality service.

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Appendix A: List of participants

	ORGANISATION	REPRESENTATIVE	TYPE OF ORGANISATION
1	Afiya Trust	Ros Guthrie, National BAME Mental Health Programme Manager	VCS BAME
2	London Voluntary Service Council	Alison Blackwood, Senior Policy Advisor	VCS Infrastructure
3	Equality and Human Rights Commission	Emma Siami, Policy and Programmes Advisor	Independent Governmental Body
4	London Development Agency	Amanda Little, Senior Policy Manager	Public body
5	Royal College of Nursing	Sharon Dennis, Regional Director	VCS
6	Department of Health	Jazz Bhogal, Public Health Manager	Government
7	Peckham Teenage Pregnancy community group	Esy Oluwafemi, Founder	Community Group
8	Race on the Agenda and MiNet	Dinah Cox, CEO	VCS BAME
9	London Civic Forum	Lorraine Dongo, Community Involvement Coordinator	VCS Infrastructure
10	Promise	Roy Langmaid, Director and psychologist	Private, consultancy
11	The Irish Traveller Movement	Yvonne Macnamara, CEO	VCS BAME
12	Greater London Authority	Cheikh Traore, Health Inequalities Programme Lead	Public
13	Greater London Authority	Alex Bax, Policy Adviser Health and Sustainable Development	Public
14	Age Concern London	Wei Ha Lem, Policy Officer	VCS Age

For more information about this response please contact Theo Gavrielides theo@rota.org.uk **020 7729 1310**

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