

Racial Equality in Health: Good Practice Guide

Consultation Document

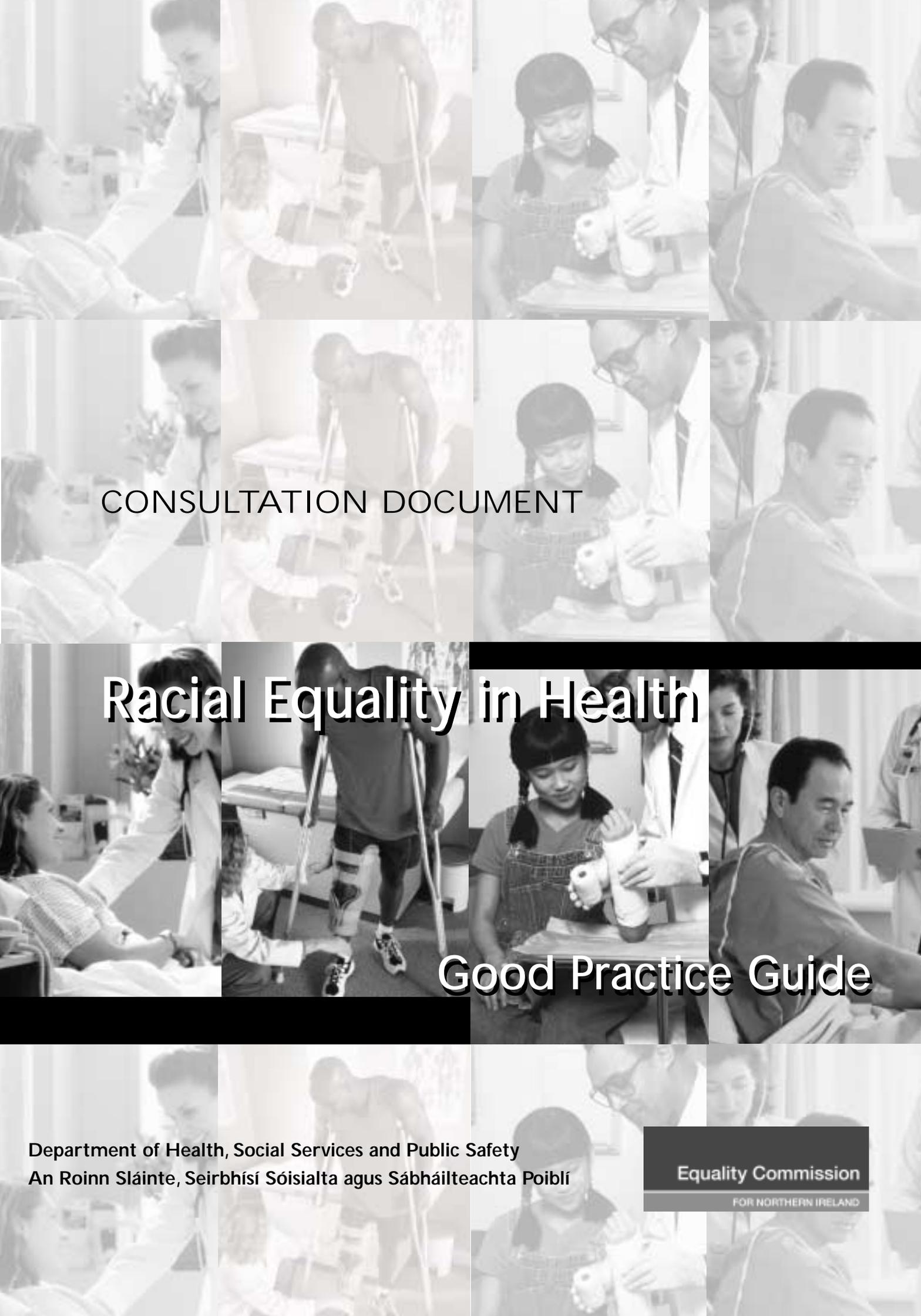
The Equality Commission NI, in partnership with the Department of Health, Social Services and Personal Safety, are pleased to issue, for consultation purposes, this Guide on Racial Equality in Health.

This is the second Guide of its kind which the Equality Commission NI has produced. The first, Racial Equality in Education, provides a similar framework in order to raise awareness about some of the particular difficulties faced by black and minority ethnic communities and help those involved in the planning and provision of services ensure that they do so in a non-discriminatory way.

We hope that you will find this consultation document to be of interest and welcome your comments on the contents of the Guide. All comments will be considered in detail before a final document is produced for use in the sector.

Comments should be forwarded no later than 28 June 2002 for the attention of Eleanor McKnight, Race Unit, Equality Commission for Northern Ireland, Equality House, Shaftesbury Square, Belfast, BT2 7DP.

25 March 2002



CONSULTATION DOCUMENT

Racial Equality in Health

Good Practice Guide

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Equality Commission

FOR NORTHERN IRELAND

Contents

	Page
PART I	
1 Introduction	3
2 Barriers to Good Health	5
3 Policy and Legislative Framework	8
4 Race Relations (NI) Order 1997: Practical Examples of Racial Discrimination in Health Care	12
5 Clarification of Terms	16
5.1 Health and Social Care	16
5.2 Black and Minority Ethnic Communities	16
5.3 Refugees and Asylum Seekers	18
5.4 Institutional Racism	19
PART II	
6 Strategies for Good Practice	21
6.1 Mainstreaming	21
6.2 Assessing Need of Local Populations	23
6.3 Community Consultations and Partnerships	25
6.4 Capacity Building	27
6.5 Training	29
6.6 Monitoring	31
6.7 Service Delivery	32
6.8 Dietary Needs	33
6.9 Religious Needs	34
6.10 Communication Needs	35
6.11 Registration, Medical Records and Appointments	36
6.12 Hospital Care	37
6.13 Maternity and Childcare Provision	38
6.14 Employment Issues	39

7	Interpreting Issues and Communication	41
8	Black and Minority Ethnic Communities in Northern Ireland: – contact list for interpreters, religious/spiritual leaders and training	51
9	Racial Equality in Health: At-a-glance Summary	64
 Appendices		
A	Race Relations (Northern Ireland) Order 1997	68
B	Section 75 of the Northern Ireland Act 1998: Statutory Duties	71
C	Equality Commission for Northern Ireland	73
D	References and Further Reading	74

PART 1

1 Introduction

- 1.1 This good practice Guide has been produced by the Equality Commission for Northern Ireland in partnership with the Department of Health, Social Services and Public Safety (DHSSPS).
- 1.2. The Equality Commission NI is the organisation responsible for the enforcement and promotion of the provisions of the Race Relations (NI) Order 1997 (the Order). It also oversees the implementation of Section 75 of the Northern Ireland Act 1998. It is the Commission's job to work to eliminate unlawful discrimination on grounds of race and to promote equality of opportunity and good relations between different racial groups.
- 1.3 The Department of Health, Social Services and Public Safety was established by the Department (NI) Order 1999. The Department administers the business of:
 - Health and personal social services, which includes policy and legislation for hospitals, family practitioner services, community health and personal social services.
 - Public health, which covers responsibility for policy and legislation to promote and protect the health and well-being of the population of Northern Ireland.
 - Public safety, which encompasses responsibility for the policy and legislation for the Fire Authority, Ambulance Service and emergency planning.
- 1.4 The Department's mission is to improve the health and social well-being of the people of Northern Ireland. It endeavours to do so by ensuring the provision of appropriate health and social care services, both in clinical settings, such as hospitals and GP surgeries, and in the community, through nursing, social work and other professional services. It also supports programmes of health promotion and education to encourage the community to adopt activities, behaviours and attitudes which will lead to better health and well-being.

- 1.5 This Guide concentrates on the quality, availability and accessibility of health care for black and minority ethnic service users, based largely on identified priorities in the areas of primary care and acute services. Primary care professionals, and principally GPs, are of course the point of entry for the public to the wider health service and they will decide what kind of treatment, support or advice is the most appropriate response to people's needs – for example, hospital referral. However it is hoped that social services settings such as day centres, domiciliary care, meals on wheels, mental health and other allied professions may also be able to avail of some of the practical guidance. Further guidelines in other areas may be considered following consultation feedback. In addition, the Guide recognises from the outset that individuals often face multiple disadvantage and as such an individual's race or colour should never be seen in isolation.
- 1.6 The objectives of the Guide are to help co-ordinate a more standardised approach by providing the following:
- A clear statement of policy which will help to eliminate racial discrimination and develop culturally competent services.
 - Clarification of how the legislation applies to health policies and practice.
 - Realistic and practical strategies to respond to the requirements of local black and minority ethnic communities.

Part I provides the contextual, conceptual and legislative background while Part II gives some simple guidance on service delivery in health – including who to contact for further advice and information.

2 Barriers to Good Health

2.1 There is a significant body of primarily qualitative research on the experiences of members of black and minority ethnic groups with the health care system in Northern Ireland. The research reports (as detailed in Appendix D) have provided us with evidence that racial discrimination, hostility and disadvantage is suffered.

2.2 Some of the barriers that currently exist are:

- Language and communication difficulties.
- Lack of access to appropriate information.
- Lack of culturally sensitive services in relation to religious and cultural needs.
- Institutional racism (see section 5.4).
- Different health belief systems and procedures.
- Negative previous experiences of the health service.
- Attitudes of some health staff.
- Fears about entitlement to health care.
- Immigration restrictions and confusion.

2.3 These barriers can best be illustrated through personal comments from the black and minority ethnic sector itself:

I never realised my husband would die. I thought he would get better. Maybe the doctor told me, many many times but I did not understand, I didn't know the words and I never saw anyone so ill before.

(Source: Multicultural Resource Centre)

I saw a woman the other day who had been all round the hospital departments. She had severe headaches and she had had every test under the sun. Finally the doctors decided it must be psychosomatic so they sent her to me. I was the first doctor who'd been able to speak to her directly, without her husband being present to interpret. It turned out the headaches were caused by her husband hitting her. She hadn't been able to tell anyone before.

(Source: Multicultural Resource Centre)

- 2.4 Travellers as a racial group face additional barriers. A report from the Eastern Health and Social Services Board on the Health of Travellers (Ginnety, 1993) included this comment: *'The major influences on the health of Travellers at the present time are dictated by the poor environmental conditions in which they live and their poor access to existing health and social services. It is illogical to talk about improving health without addressing these factors'*. Research consistently shows that the community has poorer than average health status. Infant mortality rates (up to the age of 10) are found to be 10 times that for the population as a whole. Overall life expectancy of Travellers is around 20% lower than the general population. Travellers are also eight times more likely to live in over-crowded conditions, in comparison with the settled population; and even on serviced sites many have extremely limited access to basic amenities such as running water, electricity and sanitation. In addition, nomadic Travellers experience further difficulties with the bureaucratic systems operated in both GP surgeries and in hospitals (Traveller Movement NI Newsletter, December 2000).
- 2.5 It is recognised that inequalities in employment, housing and education can adversely affect the health of many in our society, not just black and minority ethnic communities.

However, the additional pressures of migration, cultural differences, lack of extended family and community support, individuals' lack of a sense of identity and belonging, and of course communication barriers also need to be recognised and addressed. In the 'Speaking Out' conference report on health and social needs of black and minority ethnic communities in Northern Ireland (1996) a bi-lingual lay health worker with the Asian community in Craigavon said: *'Even for young women in the community who have been born here, there is a continuing need for them to meet other young women from similar backgrounds in order to share experiences of growing up in Northern Ireland, talk about issues which directly affect them, such as racism and health, and to break the social isolation they still face because of lack of understanding of their culture and values ...'*

- 2.6 Again, Travellers may face even more significant exclusion due to the general lack of acceptance by the majority community of their common cultural background and identity as a racial group. A recent survey suggested that 40% of people in Northern Ireland do not believe that the nomadic lifestyle of the Traveller community is a valid one deserving Government support (Connolly, 2000).
- 2.7 For members of black and minority ethnic communities, recurring incidents of racism, both at home and at work, can have a major impact on an individual's lifestyle and contribute to stress related illnesses. The cumulative effect of all these factors, many of them hidden, is that these communities will tend to benefit less from health care provision than the population as a whole.
- 2.8 Finally, in this section, it is important to take into account that equality in health recognises that different people have different requirements. Providers should avoid a colour-blind approach which attempts to operate an open-door policy offering one standard of service for everyone. Recognising that a patient from a black or minority ethnic background may have different needs and face different problems from a white, settled patient is not discriminatory. However, providing the same service in the face of differing need, may be.
- 2.9 The DHSSPS and the Equality Commission NI, by recognising that such barriers exist, are committed to the establishment of a co-ordinated, strategic framework which will improve the interface with all black and minority ethnic groups and with Irish Travellers specifically. It is hoped that these guidelines will go some way towards building that framework.

3 Policy and Legislative Framework

- 3.1 For any service provider there are a number of reasons why the issue of race equality should be addressed, for example:
- It prevents possible waste of resources.
 - It helps ensure flexible and responsive services for all users.
 - Potential discrimination costs can be avoided.
 - Customers will find the service more accessible.
 - Moral, legal and professional obligations are fully met.
- 3.2 For health care providers in particular there are a number of specific legal and policy issues to be addressed.
- 3.3 In 1998 the independent Inquiry into Inequalities stated that:
'...failure to make specific consideration of minority ethnic issues risks increasing ethnic inequalities by unintentionally favouring policies that benefit the ethnic majority. Thus policies to consider inequalities in health should include consideration of the application of these policies to minority ethnic groups as a matter of course.' (Acheson, 1998)
- 3.4 Local and regional health strategies include the **New Targeting Social Need (TSN)** Initiative which aims to ensure that Government programmes are more effective in helping those in greatest need by directing resources and efforts towards tackling social exclusion. New TSN specifies that: *'Some groups have additional needs which, if not catered for, could place their most vulnerable members at risk due to social exclusion. Examples of such groups ...are Travellers and members of other ethnic minority communities'*.
- 3.5 **Promoting Social Inclusion** is a specific initiative within the Government's policy of New TSN that aims to bring different government departments, agencies and voluntary organisations together to examine the problems facing particular groups and to make recommendations as to how these problems can most effectively be addressed. A final Report of the working group on Travellers was produced at the beginning of 2001 and included a number of recommendations to both the DHSSPS and local Boards and Trusts.

- 3.6 The **Programme for Government 2001-2002** identified 'Working for a Healthier People' as one of its five priorities with a focus on, among other issues, reducing health inequalities. In its Priorities for Action guidelines the DHSSPS recognised the need to promote equality of opportunity and also its obligation to promote good relations between people of different religious beliefs, political opinion and racial groups.

The health problems faced by minority ethnic communities were first addressed in the DHSS 1992-1997 Regional Strategy which referred specifically to Traveller health needs and placed a requirement on Boards and Trusts to begin addressing those needs.

- 3.7 DHSSPS's consultation **Public Health Strategy 'Investing For Health'** (November 2000) which seeks to improve health while reducing health inequalities, aimed to be as inclusive as possible by enabling many traditionally socially excluded groups to give their views on its proposals. Among other things it recognised a real and urgent need to target the disadvantaged, socially excluded and vulnerable in society.
- 3.8 Since the introduction of the **Race Relations (NI) Order 1997** a legal imperative rests on health service agencies to address the needs of their black and minority ethnic groups. The Order makes it unlawful to discriminate against anyone on racial grounds; this includes the grounds of belonging to the Irish Traveller community. (Further guidance on the Order can be found in Part I, section 4 and Appendix A).
- 3.9 A second major piece of legislation is the **Northern Ireland Act 1998**. Section 75 of the Act requires public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity between persons of different racial groups and regard to the desirability of promoting good relations between persons of different racial groups. (See Appendix B for further details).

- 3.10 In 1995, the introduction of the **Children (NI) Order 1996** required Boards and Trusts to take account in their work of the different racial groups and placed an obligation on childcare agencies to consider the child's religious persuasion, racial origin and cultural and linguistic background in their dealings with families.
- 3.11 A new **European Race Directive** implementing the principle of equal treatment of people irrespective of racial or ethnic origin, is due to come into force in the UK by July 2003. This will for the first time guarantee a common legal framework of minimum protection across all 15 member states of the European Union. The scope of the Race Directive includes the provision of, and access to, goods and services, including health.
- 3.12 In the light of this rapidly developing legal and policy equality framework it is acknowledged that health service provision and training in Northern Ireland have not as yet been able to fully take into account the presence of the various black and minority ethnic communities. As a result they may sometimes be failing to meet specific needs and differing patterns of ill health.

For example, individuals from these communities may have lifestyles, family patterns, religious beliefs, dietary norms, expectations and priorities that differ significantly from those of the majority population. Health care which is appropriate for an Irish Christian patient may be inappropriate and unacceptable to a Bengali Muslim; this means that valuable time and resources can be wasted on ineffective care. (Mares/Henley/Baxter, 1985)

- 3.13 In order to provide a framework for addressing issues of race equality, the former Commission for Racial Equality (Northern Ireland) commissioned background research as part of the planning for this document. The research reviewed current policy and practice in the field of primary health care in Northern Ireland and how these policies and practices impacted upon black and minority ethnic groups.

- 3.14 The research, in its initial literature review, also took into account additional research reports, conference proceedings and practice guidelines produced in Northern Ireland and Great Britain, including the Commission for Racial Equality's Code of Practice in Primary Health Care Services (Lynch and Poulton, 1999). (A detailed reading list and additional resources can be found in Appendix D).
- 3.15 The research findings highlighted the need to have locally relevant and adapted guidelines in order to 'fast-track' policy implementation with regard to all health care provision and personnel in Northern Ireland including:
- Department of Health and Social Services & Public Safety.
 - Health and Social Services Boards.
 - Health and Social Services Trusts.
 - Health and Social Services Councils.
 - Professional organisations such as nursing and midwifery Boards.
 - Health providers such as GPs, dentists, pharmacists etc.
- 3.16 This Guide does not attempt to replicate but rather to build on recommendations already strongly articulated by the black and minority ethnic sector by linking them to requirements under the Race Relations Order.

4 Race Relations (NI) Order 1997: Practical Examples of Racial Discrimination in Health Care

- 4.1 In August 1997 legislation, based on the Race Relations Act 1976, was introduced in Northern Ireland by means of an Order in Council. Several provisions of this Order are relevant to the area of health care. The sections dealing with employment are also important because it is unlikely that there will be equality of opportunity in service provision without equality of opportunity in employment. The Equality Commission's *Code of Practice for Employers for the Elimination of Racial Discrimination and the Promotion of Equality of Opportunity in Employment* has been widely distributed to employers throughout Northern Ireland. These health guidelines should therefore be read in conjunction with the Employment Code. The Commission also offers free training and advice on recruitment and selection and wider employment practices. (At the time of going to print, the Northern Ireland Council for Ethnic Minorities, in partnership with the Equality Commission NI, has produced a racial equality audit which can also be referred to in the design and implementation of services.)

Brief descriptions of the relevant sections of the Order are given below. (For further details please refer to Appendix A of this guide.)

4.2 General Provisions

- 4.2.1 Article 5 of the Order defines the terms 'racial grounds' and 'racial group'. Racial grounds are grounds of race, colour, nationality, and ethnic or national origins. Groups defined by reference to these grounds are referred to as racial groups [Article 5 (1)]
- 4.2.2 'Racial grounds' includes the grounds of belonging to the Irish Traveller community, that is to say the community of people commonly so called who are identified (both by themselves and by others) as people with a shared history, culture and traditions including, historically, a nomadic way of life on the island of Ireland [Article 5 (2)(a)].

4.3 Defining Discrimination

Article 3 defines both direct and indirect racial discrimination.

DIRECT DISCRIMINATION

- 4.3.1 Direct discrimination occurs when someone is treated less favourably on racial grounds than others are or would be treated in similar circumstances.

EXAMPLES:

- Doctors in a Health Centre circulate a policy which states that all black people or people who do not speak English will be asked for passports to prove their right to free health care (Henley & Schott, 1999)
- A receptionist at a Health Centre tells an Indian woman that there are no appointments available for at least two weeks. She then proceeds to offer a white woman an appointment for the next day. (CRE Code of Practice in Maternity Services, 1994)

- 4.3.2 Racial harassment is a serious problem which can occur in any health care sector and may constitute direct discrimination. Harassment may be physical, verbal or written abuse or any other form of behaviour that deters people from using health care services.

- 4.3.3 Both service users and staff may experience racial harassment; patients may be harassed by other service users or staff, and staff by patients or other members of staff. For further information you may wish to refer to the Equality Commission NI's publication *Racial Harassment at Work: what employers can do about it*. The Commission can also be contacted for further advice and assistance in developing appropriate policies and procedures or to offer advice and assistance to individual complainants.

INDIRECT DISCRIMINATION

4.3.4 Indirect discrimination can happen when:

- A requirement or condition is applied equally to everyone but is such that a considerably smaller proportion of a particular racial group can comply with it,
- it cannot be justified on other than racial grounds, and
- it is to the detriment of the individual.

4.3.5 Indirect discrimination is more insidious and usually more difficult to identify. It can occur when exactly the same services are provided to everybody (so that they appear fair) but when, for cultural, religious, linguistic or other reasons, it is not possible for members of one or more black and minority ethnic groups to benefit equally from them.

4.3.6 Because indirect discrimination can be inherent in many organisational structures, a public authority which has not subjected its policies and procedures to review is more likely to be discriminating than not. Under the law it is the effects of any action on people that make it discriminatory, not the intentions of the individual(s) or of the organisations responsible for the action (Mares/Henley/Baxter, 1985).

EXAMPLES:

- A community health centre produces written leaflets in English about breast cancer and screening. These leaflets are distributed in an area where there are sizeable Sikh and Traveller communities. The health centre refuses to translate the leaflets into Urdu or to consider producing audio-visual materials. In effect this means patients are required to read and understand English if they are to benefit from important advice contained in the leaflets. (CRE Code of Practice in Primary Health Care Services, 1992). [*It should be noted that translating leaflets indiscriminately and in isolation will not necessarily improve access to information*].
- A GP assumes that a patient of African descent is more likely to be HIV positive and takes extra precautions with them rather than applying universal infection control precautions (Henley & Schott, 1985)
- Beds are allocated to Pakistani female patients on a mixed sex ward, when staff are aware of the cultural needs of these patients but ignore them. Consequently, those women from this community are unable to use the service or have to put up with insensitive and inappropriate provision (CRE Code of Practice in Maternity Services, 1994)
- Some non-English speaking patients are not offered the counselling services offered to other patients for dealing with psychological trauma after a major operation because there is no provision of the services in languages spoken by these patients. (Chinese Lay Health Project, Barnardos, 2001)

5 Clarification of Terms

5.1 Health and Social Care

Health and social care refers to an holistic approach to tackling lifestyle issues which can lead to premature death or long-term illnesses. It covers commissioning as well as the provision of a very wide range of services by a number of different health and social care professionals including independent contractors such as doctors, pharmacists, dentists and optometrists. Health care services are also delivered by a range of staff who are employed by Health and Social Services Boards and Trusts - community nurses and midwives, health visitors – and the professions linked to medicine such as occupational therapists, physiotherapists, dieticians and speech therapists. Together they provide a wide range of treatment and care in local communities.

5.2 Black and Minority Ethnic Communities

- 5.2.1 The Equality Commission NI and DHSSPS recognises that no single term is completely acceptable to everyone but has attempted to follow that most commonly used by large institutions in England, Scotland and Wales. For the black people who have adopted the term 'black' it is a term which underlines a unity of experience of racism, among people whose skin colour is not white. At the same time there are some people from minority ethnic communities who do not identify themselves as black but who, because of ethnic origin, language, cultural or religious differences, share a common experience of discrimination and inequality. We hope to make it clear that by using both terms we include any individual who suffers the effects of racism in whatever shape or form.
- 5.2.2 In Northern Ireland at present the largest minority ethnic group is the Chinese community. With approximately 8000 members, the community has built a strong infrastructure with 14 different support groups throughout Northern Ireland. The Traveller community and Indian (both Hindu and Sikh) community have much longer histories in the area, while more recent arrivals are the African and Muslim

communities, both representing diverse nationalities and backgrounds. Evidence suggests that smaller communities such as the Filipino, Bangladeshi and Sikh communities experience very real difficulties in accessing health and other services, resulting in their increasing marginalisation and vulnerability. It has traditionally been almost impossible for these groups to request specific services because their size, although not their respective needs, has remained so small in individual Trust or Board areas. Numbers alone should clearly not be the only determinant of priorities as health authorities have a responsibility to meet the needs of the most vulnerable and disadvantaged, which often include people from marginalised black and minority ethnic backgrounds.

- 5.2.3 The black and minority ethnic sector as a whole represents diverse and dynamic cultures with changing health needs and priorities. Newly arrived refugee communities may have very different health priorities from those communities living in Northern Ireland for generations. Recent research indicated that almost half of the members of black and minority ethnic communities were born in Northern Ireland; it should be recognised that the health needs of young black and minority ethnic children and teenagers may be somewhat different from those of first generation immigrants.
- 5.2.4 Service providers need to take into account that culture is never static and that there can be enormous cultural variations between social groups. For example the 'Chinese community' is often used to refer to people from Hong Kong, the People's Republic of China, Taiwan, Singapore, Malaysia and even Vietnam. In fact there is as much diversity in languages, attitudes and beliefs within this 'community' as within the indigenous white population and so people cannot be neatly pigeonholed into a particular cultural, national, religious or ethnic group. Health workers therefore need to be very careful about using 'cultural background' information as a basis for their professional response, and should rely instead on relevant and up-to-date research, consultation with the black and minority ethnic voluntary sector and in-service training.

Please refer to Section 8 for a full list of communities in Northern Ireland and Appendix D for further reading on local research on patterns of illness, social and psychological pressures of migration, poverty and ill health etc.

5.3 Refugees and Asylum Seekers

- 5.3.1 In the UK a **refugee** is legally defined as a person who has been granted refugee status by the Home Office.
- 5.3.2 An asylum seeker is someone who has come to the UK and applied for refugee status and who is waiting for a Home Office decision. This can take many months and even years; some asylum seekers who are refused refugee status are granted Exceptional Leave to Remain (ELR) which must be reapplied for at set intervals.
- 5.3.3 Numbers of refugee and asylum seekers in Northern Ireland remain fairly small although the diversity of background has increased since late 2000. Over 30 different countries are now represented and include Sri Lanka, Russia, Macedonia, Afghanistan, Bangladesh and Romania. Individuals and families have some of the greatest health needs, but are often least likely to have those needs met because of their status. The tendency for refugees to be registered as temporary rather than permanent patients means that they may be more likely to miss out on preventative health care measures. Primary care providers also need to be aware of mental health problems, although these may often present as physical rather than psychological symptoms. (Arora/Coker/Gillam/Ismail, 2000).
- 5.3.4 All asylum seekers, people granted ELR and refugees are entitled to statutory health services, including free medical treatment and registration with a GP. (Henley & Schott, 1999) In addition, the DHSSPS has issued a circular stating that costs for interpreters will fall in the first instance to the relevant Trust, which may then seek reimbursement from their Health Board. However a great deal of confusion remains about the rights and specific health needs of this group of people and it is important to check out relevant details with

a support organisation such as the Northern Ireland Council for Ethnic Minorities (NICEM) or Multicultural Resource Centre (MCRC). NICEM runs a one-stop service which can include help with getting to know Belfast, registering with GPs, working with nurses and social workers etc. (NICEM Annual Report 2000-2001). Contact details are included in Section 8.

5.4 Institutional Racism

- 5.4.1 While this Guide focuses on the provisions of the Race Relations (NI) Order 1997, it also acknowledges the Macpherson Report's more recent definition of 'institutional racism'. This Report was the result of the inquiry into the death of the young black man Stephen Lawrence. It has subsequently strengthened the requirement to address inequalities in health care.
- 5.4.2 Institutional racism was described in the Report as: *'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'*.
- 5.4.3 The definition acknowledges that individuals working within institutions may not be racially prejudiced but racism can still be inherent in the systematic operation of the institution.
- 5.4.4 It should be noted that many other definitions of institutional racism exist, many in use long before the publication of the Macpherson Report. The Multicultural Resource Centre has described it as: *services designed by the majority people for the majority people*.
- 5.4.5 Institutional racism can have a number of dimensions in health care, the most obvious being in terms of differential patient access and treatment. It can also be identified in employment policies, inadequate research, professional attitudes and health promotion.

5.4.6 Recommendations made in the Macpherson Report (which were intended to apply to all public bodies, not just the police) included:

- Institutional racism should be seen as a problem for the organisation as a whole.
- Everyone must accept responsibility, not just management.
- All racist incidents should be reported, recorded and investigated.
- Targets should be set to address underrepresentation.

PART II

6 Strategies for Good Practice

There are four key aspects to addressing inequalities in health and achieving cultural competence:

- Recognising and valuing diversity.
- Auditing systems and processes within an organisation.
- Creating a more inclusive organisational culture.
- Challenging individual attitudes and behaviour.

These aspects can be translated into very practical approaches to good practice within the health sector. The list which follows is by no means exhaustive.

6.1 Mainstreaming

6.1.1 Mainstreaming has been defined by the Department of Health as a:

'... means of automatically considering the race equality dimension of everything that is done. Getting there involves staff with the skills, knowledge, expertise and attitudes to do this so that they take responsibility for this as part of their professional practice.'
(Alexander, 1999)

6.1.2 Mainstreaming racial equality into the core of an organisation's work contrasts with the notion of 'special provision' whereby services are established specifically for the use of black and minority ethnic groups but not integrated into core funding, planning and service development. Such special provision can be offered from within a Trust, for example the post of Chinese community development worker with the elderly supported by the South and East Belfast Health and Social Services Trust [see also 6.3.2]. However in Northern Ireland at present the provision is more likely to be based within a black and minority ethnic organisation for example the project with older people in the Indian Community Centre or the health project for Traveller women run by Belfast Travellers Education

and Development Group [see also 6.4.2]. Appendix A gives further information on lawful positive action measures permitted under the Order.

- 6.1.3 These projects tend to be innovative, flexible and go some way to meeting needs. However, pilot projects usually access only short-term funding - with the exception of a permanent interpreter's post funded by the Eastern Health and Social Services Board and based in the Chinese Welfare Association [CWA]. The services – and the staff employed to provide them – are therefore vulnerable to financial cuts and lack a sense of permanency or a strategic approach. They may have very limited opportunities for personal or professional development and lack the status of those working in mainstream services.
- 6.1.4 A mainstreamed approach enables multi-agency working and a more holistic approach to health. Health Boards and Trusts could, for example, in considering the health issues of Travellers, build links with local district councils in order to be able to highlight the importance to health of a continuing programme of site provision, which will include clean water supply and rubbish disposal. In this way, multi-agency approaches help to ensure that in the long list of competing issues, black and minority ethnic health issues do not get 'lost' or become lower priority, as there are a number of voices involved in the debate.

GOOD PRACTICE:

- Commitment and leadership at senior levels to introducing more mainstreamed service provision is essential in order to take into account local diversity in all policies and planning processes. Making connections and building up links with other statutory agencies as well as community and voluntary organisations is the first step. Good practice models established in other regions and countries can be shared and adopted rather than starting from scratch and 'reinventing the wheel' which is both time-consuming and costly.
- Locally, the Health Action Zone initiative run by the North and West Belfast Health and Social Services Trust provides opportunities for interagency working, sharing resources and is inclusive of the Traveller community. The interpreter's post mentioned at 6.1.3 is another innovative and sustainable model which is regularly evaluated and is based on a strong partnership approach between Board and community or voluntary organisation.
- Mainstream provision should always complement, not compete with, direct service provision offered within the black and minority ethnic community and voluntary sector.

6.2 Assessing Need of Local Populations

6.2.1 We do not yet have access to an accurate population breakdown of black and minority ethnic communities as the 2001 Census of Population was the first Northern Ireland Census to contain a question on ethnicity. The profiling available from this should help identify black and minority ethnic families and individuals within individual Board and Trust areas. The next step is to find ways of engaging with these communities in order to begin to assess unmet needs. This exercise, which should be on-going and developmental, will be a means to an end of providing more effective services. It is important that the findings lead to action and bring about change so that communities see the process as beneficial in itself.

6.2.2 Ways of seeking views of black and minority ethnic service users might include:

- Talking to individuals and families, for example in hospitals, nursing homes or clinics.
- Holding public meetings to which community representatives are invited.
- Visiting local community centres and black and minority ethnic organisations.
- Utilising potential of local community workers and lay health workers in order to 'map' the work undertaken locally as a route to identifying unmet needs.
- Setting up equality liaison panels, patient participation groups or black and minority ethnic liaison committees.

The current lack of baseline data for black and minority ethnic communities requires designated needs assessments. However it is also important that a mainstreamed approach is adopted in order to address multiple identity issues, for example the needs of older people or those with a physical disability and also from a black and minority ethnic background.

6.2.3 It is important to remember that the majority of black and minority ethnic community organisations operate on a voluntary basis and so should not be expected to put aside more immediate demands to act as unpaid consultants to white-led agencies. Anyone using these communities' considerable expertise should offer to cover the cost of distributing papers, hiring venues, childcare arrangements and travel so that individuals and volunteers do not end up out of pocket. Nor should assumptions be made about individuals representing community views. Those arranging consultation sessions should try to ensure that the representatives chosen are recognised and respected spokespeople who can give collective views with some authority. Black and minority ethnic organisations will also need to be resourced if they are to continue to organise training for their communities in order to ensure that participants are informed and enabled to participate more effectively in consultation exercises.

GOOD PRACTICE:

- In any needs assessment exercise consultation must mean more than simply seeking the opinion of the community; any user involvement should also give the community power to influence and make decisions about their own needs. Health care professionals' views of where the biggest gaps in service lie may not always coincide with users' views of this. It is also important to build in a mechanism for reporting back on how views and comments were incorporated into new policies and practice as well as assessing the impact of any new initiatives or policies.
- The strength of needs assessments is that they can help bridge any gap regarding baseline data and help develop an action plan, with measurable targets and outcomes for Trusts and Boards.

6.3 Community Consultations and Partnerships

- 6.3.1 It is difficult for any public body to deliver appropriate services on its own. It is therefore essential to start making links and developing partnerships, particularly with the community and voluntary sector, a valuable resource offering a wealth of knowledge and expertise. Bodies such as the Community Development and Health Network (NI) and Belfast Healthy Cities have shown considerable commitment to engaging with black and minority ethnic groups in developing their health plans and policies in culturally sensitive ways. Commissioning from the sector may also sometimes be an appropriate course of action.
- 6.3.2 Some Trusts have established black and minority ethnic liaison groups to develop and lead on the implementation of service provision. The South and East Belfast Health and Social Services Trust has developed a multi-agency and multi-disciplinary approach in order to meet the needs of the black and minority ethnic communities in its area. Members of these communities are on the liaison group and examples of good practice which have ensued include:

- A Chinese community development worker based in the Chinese Welfare Association to meet the needs of older people more effectively.
- A bilingual Community Development Worker focusing on black and minority ethnic issues based in the Trust team.
- Cultural Diversity days for staff celebrating black and minority ethnic cultures and traditions.
- Conferences organised in partnership with the black and minority ethnic voluntary and community sector.
- Cultural awareness training for staff.
- A communications project developing appropriate translated information and resources.

6.3.3 The Ulster Hospitals and Community Trust runs ante-natal and parent-craft classes with women from black and minority ethnic groups within the Trust's maternity outpatients department. The classes are run with the help of interpreters when necessary.

6.3.4 It is important that such initiatives are as inclusive as possible, ensuring that small groups without paid staff or representatives, and who may not be members of larger umbrella organisations, also have a voice in the process. Often individual health needs can be greater where there is no apparent community infrastructure.

GOOD PRACTICE:

- Health Boards and Trusts should consider more involvement of black and minority ethnic community and voluntary organisations in the process of developing health strategy and purchasing intentions. A more informal style of working with black and minority ethnic organisations could be used, including undertaking visits, workshops or focus groups and the development of appropriate forums rather than relying on paper-based communication.
- Local models of good practice which incorporate both community consultation and strategic partnerships include the Sure Start Programme in South Belfast which employs a Chinese worker to link with Chinese families who have children in the 0-4 age group. Sure Start aims to improve health by supporting parents in caring for children and promoting their health and development – particularly those who are disadvantaged.
- Healthy Living Centres are also based around local partnerships which promote an holistic view of health, recognising social, economic and environmental influences and focusing on preventive health care. Black and minority ethnic groups fed into proposals in both Belfast and Craigavon, each underpinned by the principles of inclusion and equality of access.

6.4 Capacity Building

6.4.1 Many black and minority ethnic community and voluntary organisations are unfamiliar with changing NHS policies and practice and may have little knowledge about who they should approach to secure support. However, many undertake valuable work which contributes toward achieving health improvements for their communities. With others, raising awareness of the potential for health improvements is a prerequisite if they are to participate effectively in national and local strategies. One of the key difficulties communities face is that, while health agencies talk of 'partnership' arrangements with the community and voluntary sector, in many areas the development work has not taken place for this to be a reality.

6.4.2 Relatively recent examples of innovative work building the capacity of individuals from the black and minority ethnic communities includes the training and employment of community based minority ethnic staff, for example:

- Belfast Travellers' Education and Development Group, in partnership with the DHSSPS, have developed a joint initiative preparing Traveller women to become lay health workers.

- Barnardos, in partnership with the Chinese Welfare Association, initiated the Chinese Lay Health Project in September 1994, a project founded on community development principles. This is the only health project in Northern Ireland which focuses specifically on minority ethnic health issues. It currently employs two Chinese lay health workers to work in Belfast and Craigavon. Three staff have successfully completed social work courses, sponsored by Barnardos.

6.4.3 In August 1999 the DHSS set out its view of the way forward in community development in the Community Development Working Group Report entitled Mainstreaming Community Development in the Health and Personal Social Services. This renewed the Department's commitment in this area and recommended that Boards and Trusts develop community development strategies which impact on all aspects of their activity.

GOOD PRACTICE:

- Community development and capacity building should be accepted as an integral part of working in partnership. Health Boards and Trusts can play an important role in strengthening the infrastructure of the black and minority ethnic community and voluntary sector through resourcing and capacity building, for example, by the creation of specific health posts. These might include community development workers, lay health workers, link workers and/or interpreters with responsibilities for the particular community in question. Such workers should not be expected to go beyond their duties and perform a wider role for which they are not trained.
- Consideration should also be given to lengthening the term of contracts to ensure greater sustainability and develop capacity of both individual staff and organisations so that they are more capable of influencing health policy and practice. Health agencies should build in performance indicators and monitoring and evaluation systems in order to take into account changing health needs and priorities.

6.5 Training

6.5.1 Training for staff employed within the health service is generally very limited with regard to black and minority ethnic issues. Participants may therefore infer that these issues remain marginal to the mainstream areas with which health workers are expected to concern themselves. Courses can also teach one set of norms and values without encouraging students to understand and respect that others are equally valid. Such courses can therefore fail to equip workers with the specific skills or information they need to work effectively with black and minority ethnic patients.

6.5.2 Cultural awareness training provides information on the customs, habits and lifestyles of different cultures, religious or minority ethnic groups. It is often oriented to a health care environment, for example customs about death, birth and diet. However it is a somewhat limited model of training and it can reinforce stereotypes such as:

- Minority ethnic groups behave in similar ways.
- Aspects of cultures are static and do not change.
- Staff trained in 'cultural' knowledge means that the health service is now culturally competent.

6.5.3 It is unrealistic for everyone to know everything about different cultures. Access to background information (see Appendix D) and developing the skills to ask appropriate questions is potentially more useful.

6.5.4 Anti-discriminatory training focuses more on actions than attitudes, and the use of policies and processes to address issues of direct and indirect discrimination as well as institutional racism. This training can be provided by a number of the agencies mentioned in Section 8.

GOOD PRACTICE:

- Boards and Trusts should consider the implementation of a comprehensive training programme on anti-discriminatory practice for *all* employees.
- Courses should be designed to address diversity in values and beliefs. They should equip participants with the skills to look critically at their own cultural values as well as considering different family and support systems, different possible expectations in the use of health services, the position of minority ethnic groups in society and the likely implications for health care needs. Consideration should be given to using black and minority ethnic trainers from the community and voluntary sectors where possible when delivering racial awareness training.
- Such training should be built into all training courses in health care and should be part of both the induction of new staff as well as in-service programmes. Outcomes should also be continually monitored and re-evaluated in order to accommodate changing needs.

6.6 Monitoring

6.6.1 Monitoring of service provision, as well as in employment, helps to ensure that there are no unintentional barriers to accessing health services because of a person's specific need or background.

Monitoring can be helpful in the following ways:

- It helps the provider get to know the local community.
- It indicates a commitment to equality in both employment and service delivery.
- It raises awareness of gaps in services.
- It improves access to services.
- It helps guide service provision toward the specific health needs of a variety of black and minority ethnic groups, therefore developing priorities and targeting resources more effectively.
- It enables better targeted health promotion and prevention programmes.
- It measures outcomes.
- It can assist in developing and implementing Equality Schemes as required under Section 75 of the NI Act (see Appendix B).

6.6.2 Given that employers in Northern Ireland have had experience of monitoring on the basis of religious affiliation, perceived religious affiliation and gender, the extension of monitoring to include ethnicity should prove less burdensome and costly than would otherwise be the case.

GOOD PRACTICE:

- Decide what information it is important to collect, how feasible it is to collect it and, most importantly, how the data will be used. As well as ethnic origin, questions commonly asked include: religious and cultural needs, language needs, advocacy needs, specific health beliefs and use of other health care systems. Given the relatively small numbers of black and minority ethnic people in certain Trusts, it may be more useful in these areas to consider qualitative data.
- Any monitoring procedures should be agreed with black and minority ethnic representatives to prevent any suspicion or resentment about why the information is being collected. Employees and service users should be clearly informed about the reasons for monitoring, given guidance notes on how to respond to questions and given an assurance of confidentiality.
- All staff within the organisation should be briefed/trained on the monitoring policy and guidance notes to ensure a standardised approach.

6.7 Service Delivery

6.7.1 Health service policies determine the way in which services are organised and also how staff work within institutions. There are a number of ways in which existing policies may indirectly (and often unintentionally) result in black and minority ethnic patients receiving less favourable treatment, for example:

- Arrangements for dietary and religious needs.
- Interpreting and communication needs.
- Registration, medical records and appointments.
- Hospital care.
- Maternity and childcare provision.
- Employment and training.

- 6.7.2 The most appropriate way to ensure equity of treatment for black and minority ethnic individuals and communities is to consult with support organisations and umbrella groups within a Board or Trust area.

GOOD PRACTICE:

- Equal opportunities policies should include the core values which will underpin services and provide a clear, explicit guide for action.
- Core values (such as those included in these guidelines) might state that different people have different requirements; everyone is entitled to fair access and appropriate health care services, regardless of numbers, location etc; appropriate services should be designed in partnership with the sectors; communication as a key to service delivery and so on.
- Any policies should be developed in partnership with the black and minority ethnic sector.

- 6.7.3 The guidelines which follow will enable initial steps to be taken in developing good practice within health policies. Particular emphasis has been placed on the needs of patients while hospitalised as this is where individuals often feel at their most vulnerable. It is again recommended that these policies and guidelines should be part of any induction programme for all new staff and circulated to existing staff through in-service training.

- 6.7.4 Further guidance and support can be obtained from the Equality Commission NI or relevant black and minority ethnic support organisations. Please also refer to the Racial Equality in Health checklist contained in Section 9 of these guidelines.

6.8 Dietary Needs

Many black and minority ethnic patients are unable to eat food from the standard hospital or day centre menu, either for religious reasons or because they are simply unused to a western diet. Clearly hospitals and other institutions have an obligation to provide appropriate choices of meals for patients. Good practice includes:

- Procedures to record information relating to diet and cultural and religious requirements on patient and nursing records.
- Menus available in community languages with details of ingredients if requested.
- Relatives should be free to bring in food from home and adequate storage and heating facilities (within appropriate health and safety guidelines & in consultation with hospital staff) for such food should be provided.
- Training for dieticians and catering staff in assessing and delivering appropriate diets.

6.9 Religious Needs

Most hospitals set aside a room for use by Christian patients for prayer or worship. There may be nowhere for patients of other faiths to pray in private or simply to seek additional comfort and support. Good practice includes:

- The provision of a non-denominational quiet room for prayer or contemplation.
- Accessible list of religious leaders to be contacted on request or as part of the care of terminally ill or dying patients (see Section 8).
- Written information about access to religious and spiritual support translated into community languages.
- Provision in maternity services for staff to cater for religious requirements and ceremonies relating to childbirth.
- In the event of a death, consultation with the patient's carers regarding their preferences in relation to the preparation of the body and other religious requirements. Privacy and space for families to spend time together or to perform religious ceremonies should be allowed.
- Religious items, including religious and wedding jewellery to be treated with respect and not removed without the consent of the patient or their next of kin.
- Staff awareness of festivals, celebrations and holy days as these may affect procedures such as discharge.

6.10 Communication Needs

Service users whose first language is not English can be at a major disadvantage in getting access to health care. At the same time language is only one of the potential barriers to effective communication. Professionals and patients each bring their own expectations to any interaction.

Below are examples of ways in which some of the barriers to communication might be tackled. Please also refer to Section 7 with regard to working with interpreters.

- Trained interpreters for those community languages where there is sufficient demand and in particular for important discussions such as taking a medical history, discussing treatment options and obtaining informed consent.
- Register of hospital staff who speak less frequently needed languages for use in emergency situations within the hospital in question.
- Language point card to help front line staff identify the language a patient speaks.
- Training for health workers in the most effective use of interpreters.
- Recruitment of lay health workers and link workers who speak one or more of the community languages.
- Hospital and clinic signs in English and in the most commonly used community languages.
- Well-translated leaflets on important health topics and on topics of special relevance to people who are unfamiliar with NHS provision e.g. how it works, what to bring into hospital for an inpatient stay, how to get the help needed, how to choose and change your GP and patients' rights. Decisions on which leaflets to translate should be taken in consultation with the black and minority ethnic communities.
- Leaflets and other materials written in plain English or produced in audio-visual form so that they can be understood by everyone.

- Training for health staff particularly those on reception, as the first point of contact, to improve their own communication skills, including an opportunity to examine their own expectations of black and minority ethnic patients.
- Posters and leaflets etc reflecting the diversity of the population so that members of all groups realise that the service is there for them.
- Communication strategy to publicise the interpreting service and its availability to staff, patients, carers and black and minority ethnic community organisations.
- Recording and monitoring of the language and/or dialect of patients who do not speak English.

6.11 Registration, Medical Records and Appointments

Some black and minority ethnic groups have naming systems which differ from the British naming system on which NHS records are based, for example, the Chinese, Indian, Pakistani and Turkish communities. Experience has shown that patients from these groups are often subject to embarrassment, delays and confusion when attending clinics and surgery appointments and serious mistakes can occur over drugs and treatment. Examples of good practice include:

- Training receptionists, medical records staff and ward clerks in how to record names and how to avoid entering mistakes.
- Training for nursing staff and GPs in the different naming systems and how to address people correctly and politely.
- To improve continuity of care of nomadic Traveller families, health providers should be encouraged to issue patient-held family health records.
- Local Development Schemes allowing GPs additional time to spend with nomadic Travellers should be encouraged and if possible extended to other black and minority ethnic groups.

- Mechanisms to allow Travellers access to local GPs on a temporary basis, without necessitating new applications. Current system can be both difficult and time-consuming and potentially lead to Travellers accessing medical care only through the accident and emergency units of local hospitals.
- Consideration given to introducing clear, pictorial or colour-coded instructions on medication.

6.12 Hospital Care

Admission to hospital can be a stressful experience for anyone, but particularly so for people who have difficulties with language or who may have had negative experiences in the past. Some refugees and asylum seekers may have particular fears about medical examination and treatment if for example they have been subjected to physical or sexual abuse at the hands of medical staff in their country of origin.

In addition to religious and catering requirements (see above), it is also possible that black and minority ethnic patients may have preferences in personal hygiene and good practice which might include:

- The provision of full-length, long-sleeved gowns with adequate ties; full-length dressing gowns should also be made available.
- People for whom modesty is a particular issue should, when possible, have access to staff of the same sex.
- Both showers and baths should be provided on all wards.
- Hand basins should be available in the lavatories.
- The preferences and needs of dependent patients in relation to modesty, personal hygiene and hair care should be identified and met.
- People's cultural obligations in relation to visiting should be acknowledged and accommodated when possible. For example, in hospitals where there are large numbers of visitors due to patients having extended families, opening times may be a more appropriate system.

6.13 Maternity and Childcare Provision

The time surrounding pregnancy and childbirth is one when women are particularly vulnerable, both emotionally and physically. This may also be the first time that some women have had to come into close contact with a British institution. In addition, many parents may have approaches, practices and priorities in child-rearing which are different from those of the child health practitioner, but which are nonetheless equally valid. Specific examples of good practice should include:

- Sensitivity in teaching hospitals, for example, in making it possible for patients to request that only female medical students be allowed to observe an examination.
- Ante-natal classes run by bilingual health workers, or with the aid of an interpreter, for women whose mother tongue is not English (see 6.3.3 above). This might include a few intensive lessons to teach them the English they will need during their stay in hospital.
- Basic information and instruction sheets should be translated and circulated.
- Health education programmes should highlight the importance of both ante-natal and post-natal care.
- Training for staff in using culturally unbiased developmental tests which take into account environmental differences for children from different social groups.
- Support to meet the particular needs of mothers and children from black and minority ethnic groups, eg bilingual mother and toddler groups, appropriate childminding provision, play groups and day nurseries and support groups for women of different communities where they can relax and speak their own language.
- Active recruitment of minority health workers who share the cultures, values and backgrounds of local black and minority ethnic groups.
- Training in relevant cultural and religious needs for those named ante-natal midwives who are assigned to black and minority ethnic mothers.

6.14 Employment Issues

- **Staff training** (see Section 6.5)
- **Training and employment of more black and minority staff** (see Section 6.4) in order to establish models of minority ethnic participation – particularly in areas of health promotion and prevention.

- **Positive Action**

Positive action is allowed under the law in order to establish equal access or as redress for past discrimination. The aim of positive action is to ensure equality of opportunity. However the particular difficulty in Northern Ireland with regard to the positive action provisions in the Race Relations (NI) Order 1997 (see Appendix A) is that statistical information about the extent of black and minority ethnic participation in the workplace is not generally available. This may prevent employers and training providers from assessing the applicability of positive action provisions. This makes ethnic monitoring (Section 6.6) even more important.

Please refer to the Equality Commission's Code of Practice for Employers for the Elimination of Racial Discrimination and the Promotion of Equality of Opportunity in Employment or seek further advice and assistance with regard to positive action measures directly from the Commission.

GOOD PRACTICE:

- Specific measures to meet the special needs of black and minority ethnic individuals, such as language training, literacy skills or English as a Second Language.
- Specific courses for black and minority ethnic individuals under-represented in particular jobs. This could, for example, take the form of a management skills development programme for potential managers.
- Employers may also support training for people who are not their employees but who are from racial groups which are under-represented in particular work across Northern Ireland or a region of Northern Ireland:
 - directly, by providing or funding training in particular skills, perhaps with other employers or training organisations; or
 - indirectly, by providing work experience placements for trainees being trained by other organisations.

For further help and guidance, please refer to the Code of Practice for Employers on the Elimination of Racial Discrimination or contact the Equality Commission NI.

7 Interpreting Issues and Communication

- 7.1.1 The Race Relations (NI) Order 1997 places a legal duty on the way in which establishments provide their services. The legal duty to provide services without discrimination includes the duty to ensure that services accessible to the majority community are also accessible to members of a black and minority ethnic group. The need to communicate in languages other than English is often implicit rather than explicit. Nevertheless, failing to provide interpreting facilities in relation to service provision, when it is known that there is a language barrier, could be construed as unlawful racial discrimination.
- 7.1.2 In addition, Section 75 of the Northern Ireland Act 1998 imposes a duty on public authorities to have due regard to the need to promote equality of opportunity on grounds of race and due regard to the desirability of promoting good relations between different racial groups.
- 7.1.3 Providing an interpreting facility within the health sector:
- Improves communication.
 - Reduces language and cultural barriers.
 - Reduces the scope for wrong diagnosis and treatment.
 - Enables patients to make choices.
 - Increases patient satisfaction and reduces repeat visits.

7.2 What is an Interpreter's Role?

- 7.2.1 The main aim of the community interpreter is to assist clients from the community with which they work to get the best possible service from whatever agency they are dealing with. The starting point for this is good communication between the client and the professionals providing the service. Within the black and minority ethnic sector, there are a number of posts where interpreting plays a major role.
- 7.2.2 Interpreters' posts: Interpreters are employed full-time, part-time or on a voluntary or sessional basis to facilitate linguistic communication.

It is sometimes argued that interpreters offering word-for-word interpreting do not always provide the most appropriate service in health matters. The patient may not understand the implications of what is being said and feel vulnerable and powerless, whilst the professional often requires advice on the appropriateness of treatment and care with regard to the person's religious and cultural needs; a role beyond that of an interpreter.

7.2.3 Lay health workers or Linkworkers act as more of a bridge between clients and professionals. They can offer befriending and information to the client and, through their knowledge of the community, can offer cultural information to the professionals. They therefore become involved in the development of more appropriate and accessible services through feedback to the agencies.

7.2.4 The role of Health Advocates is to empower clients to articulate their own expectations and health needs by facilitating communication, advising them on their rights and providing them with information on the availability of health services, including the different options available to them. They are able to challenge discriminatory practice and help providers identify local need, gaps in local service provision and other inadequacies of the service.

7.2.5 For the purposes of the following sections we will focus on the role of Interpreter only.

7.3 The dangers of using untrained/unskilled interpreters

7.3.1 Black and minority ethnic individuals who are unfamiliar with the health service in this country often find themselves in particularly stressful situations with regard to their health, for example, the first time in hospital or house calls from the health visitor. This additional stress and fear can inhibit them from using the simple English they may already know. The patient and professional will probably be able to 'get by' in these circumstances but the quality of service is clearly impaired.

- 7.3.2 “Someone is usually there to help”. In most situations a child or other relative is relied upon to interpret. An assumption is being made that any bi-lingual person can interpret in any given situation.

The practice of using children disregards totally the harmful effects it may have on the child. Children may often be able to interpret in very general terms but their linguistic competence in both languages is almost certainly inadequate when technical or specialist language and concepts are used. In addition, the situation may involve a particularly disturbing matter (such as abuse in the home) or may require the child to ask intimate or embarrassing questions of his/her parent; in this instance the child may reword the question totally in order to minimise the embarrassment factor.

Situations like these can mean that the parent becomes dependent on the child, involving a total role reversal. The child is also unlikely to be mature enough to handle this new role of gaining power and knowledge over their parents.

On a practical level, the child may regularly be kept away from school, for it will not only be on matters of health that the child is required to interpret, and this can affect educational progress as well as lead to conflict and resentment in the home.

“They think we don’t mind. Of course we do. And of course we would very much like the hospital to provide someone who could interpret for us. There are many things my son should not know at his age and they ask him all these questions to ask me and explain to him all these things. And he knows I am embarrassed, and of course some of the things I cannot tell him, even if I think they are really important, like some pains that I get, or bleeding. But I am not going to tell a boy of his age; I am worried about how all this will affect him later. But what else can I do when it is left up to me?”
(Romanian woman)

- 7.3.3 Using other relatives or friends also gives rise to difficulties. A personal relationship between patient and 'interpreter' can prevent impartiality and client confidentiality. The 'interpreter' may withhold important information - for example, a woman who is depressed because of her marriage may not be able to get to the root of the trouble if her husband is acting as interpreter. Since the patient is known to them, the 'interpreter' may report what they think they ought to say, rather than what was actually said. Moreover, it may turn out that the relative/friend has only a little more English than the patient. The situation can create an unwelcome sense of dependency and undermine the position of the patient.
- 7.3.4 "We usually use a member of the hospital or health centre staff". Some professionals claim that interpreters are not necessary since they can access someone on their own staff who speaks the relevant language. However, although this is preferable to using friends or relatives, it is generally not good practice (except in emergency situations) since these members of staff were employed to do a particular job, not to act as interpreters.

Bilingual staff may resent being put in such a situation but feel obliged to comply. In addition, a conflict of interest might arise. Interpreters who are seen by the patient as spokespersons for the service-provider may be viewed with mistrust. The staff may feel pressure from both sides as a result. It is also important to remember that the member of staff may come from a completely different background and have nothing in common with patients from the local black and minority ethnic community. A Hindu doctor from South India and a Muslim women from the rural Punjab may both be perceived as 'Asian' yet have nothing else in common, not even language.

- 7.3.5 Additional shortcomings of using untrained interpreters include:
- No assurance of competence of individual in language(s) he/she claims to speak.
 - No obligation to maintain honesty, confidentiality, trust or impartiality.

- Possible misuse of power.
- Imposition of subjective views, often with the good intention of being 'helpful'.
- Time offered may be extremely limited.

7.4 Where can we access an Interpreter?

- 7.4.1 The public authority should take the initiative, and the responsibility, to provide an interpreter when requested or required.
- 7.4.2 Full-time/part-time interpreters based in Health Boards or Trusts. *There are none in Northern Ireland at the time of going to print.*
- 7.4.3 Full-time/part-time interpreters based in black and minority ethnic community centres. *As of January 2002, there were six in the Chinese community and two in the Asian community. One position is fully funded by a Health Board and the others are all part-funded by Boards and/or Trusts. Two are full-time and six are part-time.*
- 7.4.4 Centralised, independent, multi-agency interpreting service. *This is not available in Northern Ireland.*
- 7.4.5 Regional health interpreting service with a register of sessional interpreters. *An initiative is currently underway, led by the Social Services Inspectorate.*
- 7.4.6 Telephone interpreting: National telephone interpreting services are already used by a number of Health Trusts. However, while useful for emergencies and for less common languages, these can be expensive services which are not ideal as the main or only means of inter-cultural communication. A number of black and minority ethnic community organisations also offer telephone support.
- 7.4.7 Sessional interpreters from either black and minority ethnic community centres or commercial interpreting agencies.

- 7.4.8 Other bi-lingual staff, both paid and unpaid, based in black and minority ethnic community centres, such as community workers or administrative staff may be available in an emergency.
- 7.4.9 A list of black and minority ethnic organisations and other agencies providing interpreting facilities is included in Section 8.

7.5 What can a professional expect of an interpreter?

Reasonably

- to be proficient in both languages
- to be able to interpret accurately

- to respect confidentiality

- to be impartial
- to be mature, patient and even tempered

- to ensure both parties feel included at all times

- to show evidence of experience and/or qualifications

Unreasonably

- to be a linguistic expert
- to speak the same language as the client simply because they both appear to be of the same ethnic origin
- to be familiar with all agency jargon & detailed procedures
- to initiate or lead discussion
- to take on the professional's work
- to wait around for hours

- to advise the client or try to solve their problems

- to provide the service free of charge

7.6 Interpreters' Responsibilities

- To make communication between client and professional as effective as possible.
- To respect confidentiality.
- To interrupt the interview if there is the need for explanation or clarification.
- To remain impartial throughout interview.
- To encourage the client not to withhold information with regard to health.

- At same time, to respect the right of the client to withhold information.
- To make sure all information is transferred accurately.
- To make sure that both parties understand why he/she was talking to the other for a long time, that is, not to let either the professional or the patient feel left out.
- Not to misuse his/her power over the two who cannot communicate directly.
- Not to take responsibility for specialised information, but ensure that the professional does.

7.7 Interpreters' Rights

- To be treated and respected as a professional.
- To ask for the time to do things properly before, during and after the interview excluding emergency situations.
- To be an interpreter, not a doctor, social/community worker, secretary etc.
- To get support, particularly when cases are particularly distressing or difficult, if possible.
- To stop the interview if demands are too great, if it is felt that it is beyond his/her capacity or beyond the boundaries of the interpreter's role.
- Not to interpret, but rather to withdraw the service if discriminatory attitudes or behaviour are demonstrated and to report immediately to his/her line manager.
- Not to be expected to be an 'expert' on medical or cultural issues.
- To get training.
- To get paid.

7.8 How to work well with an interpreter

- Clarify the method of payment early in order to prevent any confusion or embarrassment.
- Give adequate notice of the interview.
- Ensure the interpreter and patient speak the same language and dialect.

- Match the gender of the interpreter and patient if appropriate.
- Always treat the interpreter as a professional.
- Do not expect the interpreter to be an 'expert' on cultural matters.
- Avoid making false assumptions or generalisations about either the interpreter or patient.
- Respect the interpreter's independence and impartiality.
- Allow time for the interpreter to establish rapport with the patient and to clarify his/her role.
- Try to speak to the patient, addressing them directly, not the interpreter.
- Speak in clear sentences with pauses in between for interpretation.
- Avoid jargon, abbreviations, specialist terminology and colloquialisms if possible.
- Check that the patient has understood fully and whether they want to ask anything else while interpreter is present.
- Allow time for post-interview discussion with the interpreter on his/her own, particularly after distressing situations.

7.9 Improving Communication in General

- 7.9.1 There will be times when an interpreter cannot be accessed and in these situations it is very important for health professionals to think about how they put their message across.
- 7.9.2 Non-verbal signals: Health workers and patients may misinterpret each other's intention if the non-verbal signals they use are based on different conventions. Many of these conventions are culture-based and largely unconscious. It is important that assumptions and judgements are not made without checking them out first.

At one point I was interpreting in a health centre. The doctor asked me "Why won't these people look me in the eye? Are they afraid of doctors?" It was difficult to explain to her that for our people it's just being respectful, looking down. I think she wanted me to tell people to stop doing it because it irritated her, but I felt it would have made things worse – people would get very embarrassed because they would think it was rude not to look down (Vietnamese interpreter)

7.9.3 Conventions of courtesy: words and gestures associated with politeness and good manners also vary from culture to culture. For example in many Asian languages, the words please and thank you are not normally used except on very formal occasions. Gratitude and polite requests are expressed in other ways through forms of address, etc. Understanding such differences can help avoid misunderstanding and resentment.

7.9.4 Simplifying communication: there are many ways to improve the process, including:

- Speak clearly and slowly but do not raise your voice.
- Use simple English and avoid using idioms such as 'spend a penny' and 'red tape'.
- Avoid using pidgin English which can be patronising and ambiguous.
- Get the patient's name right and try to pronounce it correctly.
- Always check back to make sure the patient understands and avoid questions which require only 'yes' answers. This is often the first word that one learns in a second language but can easily hold a variety of meanings.

7.10 Training

It should be noted that the way in which health workers present advice or instructions has a significant effect on how much patients remember and whether they act on the information received. Health workers and others are increasingly aware of the importance of communication in health care; the issues referred to above can be built

into in-service cultural awareness and anti-racism training in order to more effectively bridge the language and cultural gaps in service provision. Health staff will also benefit greatly from training in how to make the most effective use of interpreting resources. Agencies providing training are included in Section 8.

8 Black and Minority Ethnic Communities in Northern Ireland

Contact list for interpreters, religious/spiritual leaders and training

Contact name:	Sunita Patra
Organisation:	Indian Community Centre
Address:	86 Clifton Street BELFAST BT13 1AB
Telephone Number:	02890 249746
Fax Number:	02890 278922
E-mail:	Info@iccbelfast.org.uk

Opening Times:	9am-5pm only	Evenings ✓	After 10pm ✓
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Nature of work/service:

- Community Development
- Hindu temple used as a base for religious events

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered?		
<ul style="list-style-type: none"> • Hindi • Punjabi • Kannad 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓ Hindu priest	No
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TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc)		
<ul style="list-style-type: none"> • Anti-racism • Cultural awareness • Indian cookery classes 		

Contact name:	Mrs A.S. Khan
Organisation:	Al-Nisa Muslim Women's Group
Address:	c/o 46 Mount Eden Park BELFAST BT9 6RB
Telephone Number:	02890 228135
Fax Number:	02890 228135
E-mail:	

Opening Times:	9am-5pm only ✓	Evenings ✓	After 10pm
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<p>Nature of work/service:</p> <ul style="list-style-type: none"> • Community work • Language classes (English, Urdu, Arabic) • Social activities/cultural events • Capacity building

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
<p>If yes which languages are offered?</p> <ul style="list-style-type: none"> • Urdu • Arabic • French 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No
------------------------------------------------------------------	-------	----

TRAINING

Can training be accessed through you?	Yes ✓	No
<p>If yes, which kind? (anti-racism, cultural awareness etc)</p> <ul style="list-style-type: none"> • Cultural awareness (Muslim culture and tradition) • Training pack and fact sheets on health, education, policing and social services 		

Contact name:	Jamal Iweida
Organisation:	Belfast Islamic Centre
Address:	38 Wellington Park BELFAST BT9 6DN
Telephone Number:	02890 664465
Fax Number:	02890 913148
E-mail:	jamaliweida@hotmail.com

Opening Times:	9am-5pm only ✓	Evenings ✓	After 10pm
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Nature of work/service:

- Religious, cultural, social, educational training
- Interpretation, translation, presentations
- Women's and young people's activities
- Information centre

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered?		
<ul style="list-style-type: none"> • Arabic • Urdu • Bengali • Malay 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No
------------------------------------------------------------------	-------	----

TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc)		
<ul style="list-style-type: none"> • Religious and cultural awareness • Anti-racism (anti-Islamophobia) • Contemporary Islam and Muslims in NI 		

Contact name:	Paul Yam
Organisation:	Wah Hep Chinese Community Association
Address:	Brownlow Health Centre 1 Legahory Centre Brownlow Craigavon BT65 5BE
Telephone Number:	02838 341143
Fax Number:	02838 345983
E-mail:	

Opening Times:	9am-5pm only ✓	Evenings	After 10pm
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<p>Nature of work/service:</p> <ul style="list-style-type: none"> • Community development • Family support • Youth work • Interpreter services • After school club • Chinese school • Adult English classes • Chinese festivals • Summer activities – family outings and classes, workshops etc

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
<p>If yes which languages are offered?</p> <ul style="list-style-type: none"> • Chinese • Cantonese • Limited service in Mandarin and Hakka 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes	No ✓
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TRAINING

Can training be accessed through you?	Yes ✓	No
<p>If yes, which kind? (anti-racism, cultural awareness etc)</p> <ul style="list-style-type: none"> • Anti-racism • Cultural awareness 		

Contact name:	Anna Manwah Lo
Organisation:	Chinese Welfare Association
Address:	133 –135 University Street BELFAST BT7 1HP
Telephone Number:	02890 288277
Fax Number:	02890 288278
E-mail:	cwa.anna@cinni.org

Opening Times:	9am-5pm only ✓	Evenings ✓	After 10pm ✓
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<p>Nature of work/service:</p> <ul style="list-style-type: none"> • Community development – Regional Chinese Community Forum, after schools club, older peoples group, youth group, Derry Sai Pak Chinese Community Association, Oi Kwan women's group, English classes • Direct services – welfare rights and immigration advice, interpreting and translation, racial incident monitoring • Community relations – working with other statutory and voluntary organisations • Cultural awareness and anti-racism training • Multi-cultural and cross community project management

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered? <ul style="list-style-type: none"> • Cantonese • Hakka • Mandarin 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No
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TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc) <ul style="list-style-type: none"> • Anti-racism • Cultural awareness 		

Contact name:	Patrick Yu
Organisation:	Northern Ireland Council for Ethnic Minorities
Address:	3rd Floor, Ascot House 24 – 31 Shaftesbury Square BELFAST BT2 7DB
Telephone Number:	02890 238645
Fax Number:	02890 319485
E-mail:	info@nicem.org.uk

Opening Times:	9am-5pm only ✓	Evenings	After 10pm
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Nature of work/service:

- Capacity building for ethnic minority community groups
- Policy and information on race equality and Section 75
- Anti-racism and anti-discrimination training
- Immigration, asylum and refugee services
- Provides accredited training for community interpreters

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered?	<ul style="list-style-type: none"> • Italian • Hakka • Spanish • Urdu • Arabic • Cantonese • French • Hindi • Polish • Mandarin • Portuguese • Punjabi • Russian 	

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes	No ✓
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TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc)	<ul style="list-style-type: none"> • Anti-racism • Anti-discrimination 	

Contact name:	Daniel Holder
Organisation:	Multi-Cultural Resource Centre
Address:	12 Upper Crescent BELFAST BT7 1NT
Telephone Number:	02890 244639
Fax Number:	02890 329581
E-mail:	daniel@mcrc.co.uk

Opening Times:	9am-5pm only ✓	Evenings	After 10pm
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Nature of work/service:

- Health and social well being project
- Resource library
- Active citizenship project with outreach and community development role
- Weekly drop-in for women and young children

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered?		
<ul style="list-style-type: none"> • In exceptional circumstances will assist in finding interpreters in lesser used languages , eg. Laos, Hungarian and Korean 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓ Can provide referrals	No
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TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc)		
<ul style="list-style-type: none"> • Anti-racism and training can be arranged through MCRC • Briefing sessions for practitioners and students can be arranged 		

Contact name:	Una Goan
Organisation:	Barnardos Chinese Health Project
Address:	100 Lisburn Road BELFAST BT9 6AG
Telephone Number:	02890 668766
Fax Number:	02890 681604
E-mail:	una.goan@barnardos.org.uk

Opening Times:	9am-5pm only ✓	Evenings	After 10pm
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Nature of work/service:

- Bi-lingual health advocacy and support service to Chinese children and their families in Belfast and Craigavon areas
- Ongoing casework with families and links with statutory service providers ensuring equality of access and provision
- Researching need and lobbying policy makers and service providers to address identified needs

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered?		
<ul style="list-style-type: none"> • Cantonese • Mandarin 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes	No ✓
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TRAINING

Can training be accessed through you?	Yes	No ✓
If yes, which kind? (anti-racism, cultural awareness etc)		

Contact name:	Maria Qureshi and Rukhsar Ali
Organisation:	Al-Nur Muslim Women's Association
Address:	Moylinn House 21 Legahory Centre Brownlow Craigavon BT65 5BE
Telephone Number:	02838 346607
Fax Number:	02838 346607
E-mail:	

Opening Times:	9.30am-3.30pm only ✓	Evenings on mobile ✓ 0787 6675221	After 10pm
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Nature of work/service:

- Interpreting service in the Southern Board area for Health and Social Services, Education and Social Security

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered?		
<ul style="list-style-type: none"> • Urdu • Punjabi 		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No
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TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc)		
<ul style="list-style-type: none"> • Culture and tradition • Islam and Muslims in NI 		

Please note that a number of private interpreting and translation agencies offer a language service. For further advice and assistance the following organisations can also be contacted. This is not an exhaustive list.

Norma Simon
Belfast Hebrew Congregation
The Wolfson Centre
49 Somerton Road
Belfast BT15 3LH

Tel: 028 90 77 7974

Hare Khrishna
140 Upper Dunmurry Lane
BELFAST BT17 0HE

Sikh Community Project
163 Cavehill Road
BELFAST BT15 5NB

Tel: 028 90 28 4400

Pippa Cookson
Belfast Baha'i Community
442 Springfield Road
BELFAST BT12 7DW

Tel: 028 90 32 1752

Dr James Uhomoibhi
NI African Cultural Centre
60 Lisburn Road
BELFAST BT9 6AF

Tel: 028 90 24 4401

Margaret Donaghy
Traveller Movement NI
30 University Street
BELFAST BT7 1FZ

Tel: 028 90 202727

Paul Noonan
**Belfast Travellers Education
and Development Group**
13A Glen Road
BELFAST BT11 8BA

Tel: 028 90 20 3337

Mary McMahon
**Belfast Travellers
Support Group**
Units 1-3
77 Springfield Road
BELFAST BT12 7EA

Tel: 028 90 20 5330

Norman Richardson
NI Interfaith Forum
c/o Stranmillis College
Stranmillis Road
BELFAST BT9 5DY

Tel: 028 90 38 4328

Eva McKelvey
Northern Ireland Filipino Association
c/o NICEM
24-31 Shaftesbury Square
BELFAST BT2 7DB

Tel: 028 90 23 8645

Dr Lan Li
Mandarin Speakers Association
c/o Flat 31
38 Windsor Park
BELFAST BT9 6FS

Anastacia Walls
Mid Ulster International Group
40 Piney Hill
MAGHERAFELT BT45 6PZ

Tel: 028 79 30 1995

Mr Rob
Bangladeshi Welfare Association
24 Greenwell Street
NEWTOWNARDS BT23 7LN

Tel: 028 90 42 1218

Margaret Boyle
Derry Travellers Support Group
Ballyarnett Park
Race Course Road
DERRY BT48 8NG

Tel: 028 71 35 9340

Inez Keenan
Craigavon Travellers Support Group
21 Legahory Centre
CRAIGAVON BT65 5BE

Tel: 028 38 34 2089

Tony Browne
Sai Pak Chinese Association
45 Clooney Terrace
LONDONDERRY BT47 6AP

Tel: 028 72 28 8858

Charo Lanao
Latinoamercia Unida
c/o MCRC
12 Upper Crescent
BELFAST BT7 1NT

Tel: 028 90 24 4639

Antrim Chinese Community Association
c/o CWA
133-135 University Street
BELFAST BT7 1HQ

Tel: 028 90 28 8277

Coleraine Chinese Community Association
c/o CWA
133-135 University Street
BELFAST BT7 1HQ

Tel: 028 90 28 8277

J Porghmans
Dutch Community
3 Hillside Gardens
BANGOR BT19

Luigi Rossetti Sorieta
La Societa Italiana
Irlanda du Nord
9 Vernon Park
BANGOR BT20 4PH

Vida Lake
Omagh Ethnic Support Group
20 Birchwood
OMAGH BT79 0ES

Tel: 028 82 42 6660

Maria Ellis
Women of the World
c/o 14 Foothill Road
ENNISKILLEN BT74 6AW

Sau Mei Lai
Chinese worker
Sure Start
9 Lower Crescent
BELFAST BT7 1NR

Tel: 028 90 94 2525

Mid Ulster Chinese
Community Association
c/o CWA
133-135 University Street
BELFAST BT7 1HQ

Tel: 028 90 28 8277

Sumi Ito Loughran
Japan Society of NI
19 Brianville Park
BELFAST BT14 8JZ

Tel: 028 90 71 0158

Satya Roberts
Multicultural Women's Group
c/o Windsor Women's Centre
136-144 Broadway
BELFAST BT12 6HY

Tel: 028 90 23 5451

Mr Yasin
Pakistani Community
Association
7 Casaedona Gardens
BELFAST BT6 9RQ

Tel: 028 90 79 7671

Dr Panesar
Sikh Cultural Centre
Simpsons Brae
Waterside
DERRY BT47

Tel: 028 71 34 3523

Catherine Li
Home School Liaison Officer
South Eastern E&LB HQ
Grahamsbridge Road
DUNDONALD

Tel: 028 90 56 6200

Organisations working with Refugees and Asylum Seekers

Refugee One Stop Service

c/o NICEM
24-31 Shaftesbury Square
BELFAST BT 2 7DB

(see contact details above)

National Asylum Support Service

58 Howard Street
BELFAST BT1 6PD

NI Housing Executive

9th floor
32-36 Great Victoria Street
BELFAST BT2 7BA

Law Centre (NI)

124 Donegall Street
BELFAST BT1 2GY

Family Trauma Centre

1 Wellington Park
BELFAST BT9 6DJ

South & East Belfast Trust

Knockbracken Health Care Park
Saintfield Road
BELFAST BT8 8BH

Red Cross

125 University Street
BELFAST BT7 1HP

9 Racial Equality in Health AT-A-GLANCE SUMMARY**1 Resources & Policy implications**

- Commitment to adequate funding.
- Policies & procedures to be circulated with clear senior management commitment.
- Mainstream racial equality.

2 Staffing

- Ethnic monitoring of all staff to be undertaken.
- Rolling programme of anti-discrimination and cultural awareness training.
- Positive action measures to address previous disadvantage and under-representation (employment of interpreters, linkworkers, lay health workers).

3 Ethnic monitoring of patients

- Ethnic monitoring of patients should be undertaken for all services.

4 Communication

- Patients should be able to communicate with health workers in the language they feel comfortable with.
- Services which patients may need to use should be clearly sign-posted, enquiry points clearly marked, and essential written information regarding the services made available in the community languages or using visual aids.
- Standardise communications policy.

5 Diet

- Meals should meet the cultural requirements of service users.
- Dietary information should be available to suit differing local community cultural requirements both in hospitals and in the community.

6 Religion

- Ensure that cultural and religious beliefs are appropriately observed and recorded.

- Provision of multi-faith facilities for inpatients with information for patients about their availability, translated into required languages. Protocols for death and bereavement to be circulated.

7 Patient Choice

- Patients should have the choice of a female clinician and information made readily available regarding this option.
- Single sex facilities to be provided wherever feasible.

8 Patient complaints

- Ethnic monitoring of complaints should be introduced, publicised and analysed.

9 User perspective/representation and involvement

- Maximise role of black and minority ethnic voluntary and community sector.
- Improve involvement of black and minority ethnic communities at planning stages and beyond.
- Identify unmet needs (user surveys and feedback).

Appendices

Appendix A

The Race Relations (NI) Order 1997

In addition to Article 3(1) which defines direct and indirect racial discrimination and Article 5 which defines 'racial grounds' and 'racial group' (see section 4) other provisions of the Order relevant to this Guide include:

Segregation (Article 3(2))

For the purposes of the Order segregating a person from other persons on racial grounds is treating him or her less favourably than they are treated.

Victimisation (Article 4)

Article 4 extends the definition of discrimination to cover the victimisation of a person. A person is victimised if he or she is given less favourable treatment than others in the same circumstances because it is suspected or known that he or she has brought proceedings under the Order, or given evidence or information relating to such proceedings, or alleged that discrimination has occurred.

EXAMPLE:

- An administrator in a community health clinic gives evidence in the county court against a doctor accused of having made racially discriminatory remarks about pregnant Asian women. The administrator is subsequently dismissed from her post without good reason.

Instructions or pressure to discriminate

Articles 30 and 31 make it unlawful for a person who has authority over, or influence with, another person to instruct or attempt to put pressure on that person to contravene the Order. Such pressure need not be applied directly; it is unlawful even if it is applied in such a way that the other person is likely to hear about it.

EXAMPLE:

- A midwife refuses to follow what she thinks is a discriminatory policy and is threatened with disciplinary action by the health authority.
- Liability for discriminatory acts rests both with the person who does the discriminating as well as the person who gives the instruction or applies the pressure to discriminate.

EXAMPLE:

- Following a number of complaints, an inquiry shows that midwives at a maternity unit within an NHS Trust knowingly gave black and minority ethnic women fewer details about the services on offer. The hospital has a racial equality policy, but has not issued staff with any guidance on this subject. As the midwives' employer, the hospital is liable for their discriminatory actions.

Health provisions

Article 21 makes it unlawful for anyone concerned with the provision of health care services to discriminate on racial grounds by refusing or deliberately omitting to provide the services; or as regards their quality; or the manner in which, or the terms on which they are provided. (See Section 4 for examples).

Exceptions

Article 35 **permits** discrimination to provide access to facilities or services to people from a particular racial group in order to meet their needs in respect of education, training, welfare, or access to any other ancillary benefits.

Article 8 **permits** discrimination when recruiting for a job that involves providing people of a particular racial group with personal services concerning their welfare, and when these services could best be provided by someone from that racial group. This exemption only applies when an employer does not already have employees from the racial group in question

who could do the job. Employers should be able to demonstrate the need for such an appointment; it is not enough just to believe that someone from the same racial group would be preferable.

EXAMPLE:

- A district health authority advertises for a Chinese health visitor to give counselling and information on maternity services to other Chinese women. A large proportion of the Chinese women in the area understand very little English, and would find it easier to discuss their maternity needs with someone who understands, and shares, their cultural outlook.

Rights of individuals

Anyone who thinks he or she has been discriminated against on racial grounds has the right to bring legal proceedings.

Article 64 gives the Equality Commission NI power, in certain circumstances, to help individual complainants to take their cases before the tribunals or courts. Other voluntary and community organisations (for details, see Section 8) may also be able to assist individual complainants.

Appendix B

Northern Ireland Act 1998

Under **Section 75** of this Act, public authorities, in carrying out their functions, are required to have due regard to the need to promote equality of opportunity –

- Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation
- Between men and women generally
- Between persons with a disability and persons without
- Between persons with dependants and persons without

A public authority is also required to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Equality Schemes

The equality duties are implemented by the public bodies themselves. Public bodies are required to prepare Equality Schemes, which must be submitted for approval to the Equality Commission NI. The equality impact of policies must be assessed and the outcomes published.

Consultation

Consultation with those affected by public policy decisions is at the heart of these legislative provisions. Equality Schemes must spell out the authority's arrangements for consultation on matters relating to the duties and on the likely impact of policies. In addition, there is a requirement to consult on the Scheme itself.

Impact on Policy

Public authorities have to show that they have considered what measures might lessen any adverse impact the policy may have on the promotion of equality of opportunity and that they have also considered how any alternative policies might better achieve the promotion of equality of opportunity.

Enforcement of duties

The Equality Commission NI will keep under review the effectiveness of the duties imposed by Section 75 and offer advice to public authorities and others in connection with those duties.

Complaints

If the Equality Commission NI receives a complaint of the failure by a public body to comply with an approved Scheme, it can either investigate the complaint or give the complainant reasons for not investigating.

Further information

The Northern Ireland Council for Ethnic Minorities has produced the following information on Section 75 to assist the black and minority ethnic sector:

- A general leaflet on the statutory duty on equality.
- A general flow-chart on the statutory equality duty.
- A pamphlet on equality schemes and consultation.
- A pamphlet on screening and impact assessment.
- A specific pamphlet on complaints.
- A 'jargon buster' which identifies and explains key terms and concepts used in dealing with equality duty.

(See Section 8 for NICEM's contact details). Please also refer to the Equality Commission's guidelines on the implementation of the statutory duties and equality impact assessment.

Appendix C

The Equality Commission for Northern Ireland

Section 74 of the Northern Ireland Act 1998 established the Equality Commission for Northern Ireland which, on 1 October 1999, assumed the functions of the following bodies:

- Commission for Racial Equality for Northern Ireland
- Equal Opportunities Commission for Northern Ireland
- Fair Employment Commission for Northern Ireland
- Northern Ireland Disability Council

In relation to racial discrimination, the Equality Commission for Northern Ireland derives its remit from the provisions of the Race Relations (NI) Order 1997 which states in Article 42(2) that it has the duties to:

- Eliminate racial discrimination.
- Promote equality of opportunity and good relations.
- Keep under review the provisions of the Order and make recommendations for its amendment.

The Equality Commission for Northern Ireland has certain powers conferred upon it under the Order and under Section 75:

In relation to the Race Relations (NI) Order 1997 the Commission can:

- Advise and assist individuals who feel that they have been discriminated against on racial grounds.
- Conduct a formal investigation in certain circumstances into alleged discriminatory behaviour.
- Issue non-discrimination notices.
- Take action in relation to discriminatory advertisements.

In relation to the Section 75 statutory duties the Commission is to:

- Keep the effectiveness of the duties under review.
- Offer advice in connection with those duties.
- Carry out the functions set out in Schedule 9 of the Act.

Appendix D

References and Further Reading

Northern Ireland

Al-Nisa Muslim Women's Group. (2001) *Muslim culture and traditions information pack*; including section on health (Belfast)

Braid, L. & Gadd, D. (1999) *Who cares?, Conference Report on the Health related quality of life and individual level of need of Chinese elderly in NI* (CWA, Belfast)

Commission for Racial Equality (NI). (1998) *Racial Harassment at Work; what employers can do about it*

Connolly, P. & Keenan, M. (2000) *Racial Attitudes and Prejudice in Northern Ireland, Report No 1* (NI Statistics and Research Agency, Belfast)

Department for Social Development (2001) *Consultation on the Final Report of the PSI Working Group on Travellers*

Ethnic Minorities Working Party on Health (1997) *Speaking Out*, Conference Report on Health and Social Needs of Ethnic Minorities in Northern Ireland (EMWPR, Belfast)

Equality Commission for NI. (1999) *Code of Practice for Employers for the elimination of racial discrimination and the promotion of equality of opportunity in employment*

Equality Commission for NI. (2000) *Racial Equality Advice and Assistance*

Equality Commission for NI. (2000) *Guide to the Statutory Duties: A Guide in the Implementation of the Statutory Duties on Public Authorities Arising from Section 75 of the Northern Ireland Act 1998*

Equality Commission for NI. (2001) *Section 75 of the Northern Ireland Act 1998: Practical Guidance on Equality Impact Assessment*

Fay, R., Kavanagh, D. & Quirke, B. (1996) *Primary Health Care for Travellers* (Eastern Health Board, Dublin)

Ginnety, P. (1993) *The Health of Travellers*. Based on a Research Study with Travellers in Belfast (Eastern Health and Social Services Board, Belfast)

Ginnety, P. (1998) *Prevention is better than cure: an evaluation of the Chinese Health Project* (Barnardos, Belfast)

Lynch, U. & Poulton, B. (1999) *Policy and Practice in Primary Care: a research study exploring the experiences of minority ethnic groups in Northern Ireland*. (CRE NI. Unpublished)

Mann Kler, D. (1997) *Out of the Shadows: An Action Research Report into Families, Racism and Exclusion in Northern Ireland* (Belfast: Barnardos, Belfast Travellers Education and Development Group, Committee on the Administration of Justice, Chinese Welfare Association, Craigavon Asian Women and Children's Association, Indian Community Centre, Northern Ireland Council for Ethnic Minorities, Save the Children)

Mason, C. (1998) *Health Issues and Ethnic Minorities in Northern Ireland: in* Hainsworth, P (ed.) *Divided Society* (Pluto)

Multicultural Resource Centre (1996) *Caring for Children from Ethnic Minorities in Northern Ireland* (Belfast, Bryson House)

Northern Ireland Council for Ethnic Minorities & South and East Belfast Health and Social Services Trust (2001) *Asylum Seekers and Refugees: Seminar Report* (NICEM/S&EBHSST, Belfast)

Northern Ireland Council for Ethnic Minorities & South and East Belfast Health and Social Services Trust (2000) *Health for Everyone*, Conference Report (NICEM/S&EBHSST, Belfast)

Ryan, M. (1996) *Another Ireland: an introduction to Ireland's ethnic-religious minority communities* (Stranmillis College, Belfast)

Traveller Movement (NI) Newsletter (December 2000)

Cultural awareness/translated information

Bloomsbury Patient Advocacy Service (1991) *Coming into Hospital: available in Arabic, Bengali, Cantonese, English, Greek, Gujarati, Punjabi, Turkish, Urdu and Vietnamese* (National Extension College)

Lothian Racial Equality Council (1992) *Religions and Cultures: a simple guide to patients' beliefs and customs for health service staff* (LREC, Scotland)

NI Ireland Inter-Faith Forum (2001) *Caring for Minorities: a guide to the special needs of hospital patients from Northern Ireland's Ethnic-Religious Minority Communities* (NIIFF, Belfast)

Ulster Community and Hospitals Trust (2002) *Minority Ethnic Care Handbook*

[Refer also to Benefits Agency, Mares and Henley below]

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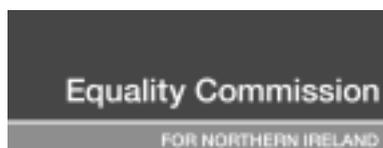
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