SECTION 3

ETHNICITY, EQUALITY & HUMAN RIGHTS:

ACCESS TO HEALTH AND SOCIAL SERVICES IN NORTHERN IRELAND

Ethnicity, Equality and Human Rights: Access to Health and Social Services in Northern Ireland

The issue of ‘race’ and ‘race relations’ in Northern Ireland has emerged in recent years from a position of almost complete obscurity to one of considerable legislative and political concern (Connolly, 2002:15). Connolly (2002:15) suggests that this development has been reflected in the growing number of research studies on ‘race’ and ‘racism’ in Northern Ireland.

Since the first literature review published in March 2001, new research has now emerged which identifies the many barriers experienced by Black and Minority Ethnic (BME) groups in accessing health and social services. Much of the new research reaffirms the barriers identified by Bunting (2001) in the initial literature review, but many additional barriers have also been identified in the more recent findings.

This section provides a brief review of this literature. Four main areas are examined including:

- an identification of the **most common barriers** to accessing health and social care experienced by Black and Minority Ethnic groups and individuals;
- a focus on the **language barrier** (which is assumed to be one of the greatest impediments to accessing health and social services);
- the difficulties faced by **specific Black and Minority Ethnic groups**, such as Irish Travellers. Access problems experienced by Migrant Workers and Asylum Seekers and Refugees are also explored; and,
- the difficulties experienced by Black and Minority Ethnic groups residing in **rural communities**.

Where possible recommendations have been identified which are aimed at addressing the inequities in access to health and social services. The final part of this section explores the issue of ethnicity, human rights and access to health and social services.

Barriers to Accessing and Utilising Services - Consistent Themes

Connolly (2002:7) identifies a number of difficulties experienced by Black and Minority Ethnic people which he suggests are consistent across a wide range of public services (including health and social services). These include:

- difficulties accessing existing services by those who speak little or no English (that is, **language barriers**).
- a general **lack of awareness** amongst Black and Minority Ethnic people as to what services are available.
- **low take-up of GP registration** amongst some Black and Minority Ethnic groups (for example, Irish Travellers find it difficult registering with a GP because of no permanent address).
- the need for more **staff training and cultural awareness** in issues relevant to Black and Minority Ethnic people.
- a failure to meet even the most basic **cultural needs** of Black and Minority Ethnic people (such as dietary requirements or religious observance).
- a significant level of **racism and racial harassment** (both direct and indirect, individual and institutional racism).

Connolly (2002:69-70) makes a range recommendations for improving service accessibility. It may be useful for the DHSSPS and relevant bodies to assess how effectively such issues are being addressed and to identify what further action still needs be taken.

Recommendations: BME Individuals and Communities and Access to Services
(Connolly, 2002)

- **That all Government Departments and Agencies should**

more effectively:

- **provide for the needs of those who speak little or no English.**
- **disseminate information about their services more widely and comprehensively to the minority ethnic population.**
- **increase the knowledge and skills of their staff in dealing with the needs of minority ethnic clients.**
- **ensure that the basic cultural needs of minority ethnic people are met.**
- **address racial discrimination and harassment both in their own particular areas of responsibility and collectively within others.**
- **examine how victims of racial harassment can be encouraged to report incidents and be given appropriate support.**

An Inter-agency Approach:

- **That Departments and Agencies must devise effective and imaginative ways of working together to meet the needs of minority ethnic people, especially in relation to pooling expertise and resources on (i) the provision of interpreters (ii) the development of multi-disciplinary outreach work (iii) the wider dissemination of information (iv) the development of staff training programmes (v) the development of broader educational campaigns in the media to raise awareness of issues such as 'race' and 'racism'.**

Service Planning, Delivering and Monitoring:

- **In order to ensure that services are appropriate for minority ethnic people Departments and Agencies should (i) develop effective minority ethnic monitoring procedures (ii) develop appropriate systems of consultation with minority ethnic communities (iii) develop effective equal opportunities procedures within organisations along with clear and comprehensive strategies dealing with racial harassment and discrimination.**

Language Barriers

In a report entitled "*In Other Words?*", Holder (2003:5) identifies language barriers as the most frequently cited obstacle for Black and Minority Ethnic people in accessing public services. Holder (2003:7) suggests that overcoming the barriers to direct one-to-one contact with service users could be facilitated through the increased usage of professional interpreters and an increase in the provision of information in languages other than English.

The DHSSPS, HSS Boards and Trusts have acknowledged that there are significant difficulties for Black and Minority Ethnic groups in accessing appropriate support due to language difficulties and have taken a number of steps to address these issues. This includes efforts to produce information leaflets in a range other languages, a racial equality in health good practice guide and the development of a regional Northern Ireland Health and Social Services Interpreting Service (NIHSSIS).

Holder (2003:7) maintains that whilst much has already been achieved, services continue to remain patchy with family members, including children, being inappropriately used as interpreters. He further suggests that there is a strong correlation between proficiency in the English language and other factors (such as age, gender, country of origin, socio-economic status and geographical location) and that service providers and commissioners must take these factors into consideration in the planning and delivery of services.

For example, the study highlights that men tend to be slightly more proficient in English than women. In terms of country of origin, there appears to be higher levels of English proficiency in some Black and Minority Ethnic communities (for example, the Indian and African communities) than in others. Occupation was also found to be an important factor (for example, 90% of Indian professionals are proficient in English compared to only 45-50% of Indians employed in businesses and trades). Where Black and Minority Ethnic people reside in Northern Ireland also has implications for service delivery (for example, there appears to be greater English proficiency in communities in Belfast and Craigavon than in more rural areas).

Holder (2003:25) makes a number of recommendations for addressing the language barriers experienced by Black and Minority Ethnic people in accessing health and social services.

Recommendations: Addressing Language Barriers (Holder, 2003)

- **There is a need for a centralised co-ordination of multi-lingual resources within statutory agencies. In the HPSS this should be carried out at Board level with the Communication, Resource and Information Service (CRIS) taking a lead role.**

- **There should be a more proactive approach in targeting materials to Black and Minority Ethnic groups, for example, the use of community newsletters, community databases (such as mailing lists), language broadcasts, materials placed in areas frequented by Black and Minority Ethnic people (such as supermarkets, cafes, workplaces, places of worship).**

- **More seminars and talks should be delivered to Black and Minority Ethnic communities by HPSS staff. DHSSPS, HSS Boards and Trusts should resource and support community groups to facilitate this.**

- **A resource library should be established in each Board area to co-ordinate materials. Existing CRIS resource centre in the EHSSB is a good example of such a model, it should take a lead role in sourcing material from outside NI and disseminate the information to other Board areas.**

- **The Black and Minority Ethnic population in Northern Ireland is constantly changing (for example, asylum seekers, refugees, migrant workers). Therefore, repeating the research conducted by Holder (2003) on a regular basis may be necessary to update the language map. This is crucial for the planning and delivery of services.**

- **HSS Boards should continue to take the lead in employing salaried translators.**

- **There is a need for staff awareness training on the importance of using interpreters. There is also a need to raise awareness amongst Black and Minority Ethnic groups on the importance of using an interpreter.**

Many of the issues raised by Holder (2003), particularly in relation to the provision of interpreting services, have been reiterated in a number of reports published by the Regional Health and Social Services Interpreting Project for Black and Minority Ethnic Groups. Both the "*More Than Words*" Conference Report (2003) and the *Black and Minority Ethnic Needs Report* (2004) have identified barriers which are perceived to prevent access to interpreting services.

The Black and Minority Ethnic Needs report (2004:42-43), for example, highlights that:

- interpreting service level provision was not sufficient to meet service level demand.

- there was a lack of awareness amongst Black and Minority Ethnic people of their entitlement to interpreting services, which included the lack of promotion of interpreting services amongst Black and Minority Ethnic groups.

- health and social service practitioners often lacked an understanding about how to access and how to use an interpreter and that this in itself prevented access to appropriate services and treatment.

The Northern Ireland Health and Social Services Interpreting Service (NIHSSIS) has been established to address these issues and to significantly improve access to health and social services for members of Black and Minority Ethnic communities in Northern Ireland.

Black and Minority Ethnic Groups

Irish Travellers

Irish Travellers have a long shared history and value system including their own language, customs and traditions. The distinctive Traveller lifestyle and culture, based on a nomadic tradition, sets Travellers apart from the sedentary population or 'settled people' (Pavee, 2002).

The Traveller Health Strategy published by the Department of Health and Children in the Republic of Ireland (2002) provides a comprehensive review of the disadvantages faced by many Travellers in relation to accessing health and social services. The strategy also outlines a wide range of proposed actions. Whilst the strategy relates to the experience of Travellers in the Republic of Ireland, many of the issues raised are also of relevance to Travellers in Northern Ireland.

In relation to uptake and access to health and social services, the Traveller Health Strategy highlights the:

- lack of awareness amongst Travellers of **preventative health services** (for example, immunisation, screening programmes).
- lack of access to **health and social care information** (for example, health promotion, family planning) in appropriate formats (leaflets/booklets are often unhelpful given the low levels of literacy in the Traveller community).
- low level of uptake in certain **maternity services** including ante-natal and post-natal care amongst Traveller women (despite high fertility rates amongst Traveller women).
- low uptake of **family planning** and **sexual health services**.
- low uptake of **children's services** particularly child immunisation programmes and developmental paediatric services.
- lack of information on **Traveller men's health** needs.

- lack of information regarding Traveller **uptake in services** such as ophthalmics, hearing services, mental health services, speech and language therapy.

- lack of information on **Travellers with disabilities**. Disabled Travellers are often an invisible sub-group within the Traveller community, which can prevent access to support services such as home helps, occupational therapy and physiotherapy.

- lack of research in regards to **alcohol and drug misuse** in the travelling community. Anecdotal evidence suggests that young Travellers are being excluded from youth clubs and other such facilities and that this form of social isolation can lead to drugs and alcohol misuse.

In addition to these issues, the Traveller Health Strategy also reveals that:

- Little is known about the effects of **consanguineous marriages**[27] in the Traveller community. Given the fact that many Travellers have for successive generations chosen to marry within their own communities, there is clearly an increased risk of a rare gene mutation occurring[28]. Pavee, an organisation committed to the needs of Irish Travellers, identifies the need for sensitive genetic counselling in this area.

- In relation of **primary care** - GPs are often reluctant to make house calls to Traveller camps. Many Travellers are also reluctant to sit in GP surgeries or health clinics because of the hostilities from the settled population. The strategy highlights that often there are inadequate waiting facilities for women with small children in GP and health care facilities and that low levels of literacy amongst Travellers can make GP registration and other form filling difficult.

- There are also additional identified problems such as difficulties in accessing health care facilities due to **lack of transport**.

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[27] For example, marriages between second cousins.
[28] Information extracted from Pavee web page on Travellers and Consanguinity. http://www.paveepoint.ie/pav_consang.html

- **Continuity of care** is problematic as Travellers are often on the move and will see more than one GP during the course of a year.

- Traveller women suffering from **domestic abuse** experience difficulties in accessing appropriate services (due to institutional discrimination in accessing GP, Accident & Emergency services, and crisis services).

- the **nomadic lifestyle** of Travellers has implications for, registering with GPs, the issuing of hospital appointment letters and the maintenance of patient health records.

In light of the numerous access problems experienced by the Traveller community, it is strongly recommended that the DHSSPS takes into consideration the points of action outlined in the Department for Health and Children's National Traveller Health Strategy and, where appropriate, attempt to apply these actions to health and social services in Northern Ireland.

Recommendations: Traveller Health
(Department of Health and Children, National Travellers Health Strategy, 2002)

Staff Training:

- **Appropriate in-service training for health and social care staff who come into regular or periodic contact with Travellers. The training should be prepared in consultation with representative Traveller organisations.**

Co-operation:

- **Taking positive steps to encourage active partnership and participation of Travellers and their representatives in determining the health care priorities of the Traveller community.**
- **Emphasis on building a community development approach which will include peer-led services and the development of new roles for Travellers within the health and social services as planners, service providers and promoters.**

Health Promotion Programmes:

- **Health promotion programmes should be culturally sensitive, with Traveller organisations having a central role in the drafting, design and dissemination of material (for example, taking into account issues such as low literacy levels, posters and videos rather than leaflets would be appropriate)**

Maternity Services:

- **Promoting the importance of proper ante and post-natal care, providing de-centralised ante-natal clinics where possible.**

Domestic Violence:

- **Monitoring Traveller women's access to refuges to ensure that no barriers exist and funding Traveller organisations to train and employ Traveller women to act as refuge workers and counsellors.**

Men's Health:

- **Conducting a needs assessment in relation to Traveller men's health, providing culturally appropriate material on men's health.**

Patient Records:

- **Piloting a voluntary system of patient-held health records for Travellers**

Medication:

- **Giving the level of illiteracy amongst Travellers, design easily understandable medication instructions for Travellers perhaps using a nationally agreed system of symbols and colours.**

Disabled Travellers and Older Travellers:

- **Development of a needs assessment of the experience and needs of disabled and older Travellers, given that very little is known about this group.**

Mental Health:

- **Commission research into the uptake of mental health services by the Traveller community. Steps should be**

taken to improve awareness in the Traveller community of available mental health services, including training in the identity and culture of Travellers to inform mental health providers. In co-operation with Traveller organisations, identify culturally appropriate models of mental health services for Travellers.

Many of the issues raised in the Republic of Ireland's Traveller Health Strategy (such as inequity of access to services and higher mortality and morbidity rates in the Traveller community) have also been identified in the final report of the Northern Ireland Promoting Social Inclusion (PSI) Working Group on Travellers. The Working Groups set 33 detailed recommendations in its report including inter-departmental recommendations and recommendations relevant to the DHSSPS and other statutory health and social service providers.

It is notable that much work has already been carried out in order to address these recommendations. The publication of the Racial Equality in Health Good Practice Guide, the commissioning by the DHSSPS of a Traveller Community Health Care Programme, and participation in an all Ireland Traveller Health Study in partnership with the Department of Health and Children in the Republic of Ireland are but a few examples of work in this area.

Refugees and Asylum Seekers

McVeigh (2002) estimates that there are approximately 2,000 asylum seekers and refugees[29] in Northern Ireland from around 30 different countries. Many of these people have endured acute hardship or have experienced physical and sexual abuse and other forms of persecution in their country of origin.

Through the use of secondary data, interviews, questionnaires and group discussions, McVeigh (2002) identifies a number of recurring problems in relation to refugees and asylum seekers and their access to health and social services.

[29] McVeigh (2002) notes that whilst the terms "asylum seeker" and "refugee" are used interchangeably in every day discussions, asylum seekers and refugees actually differ in terms of status. An asylum seeker is someone who is waiting for their application for refugee status to be considered by the Government, whilst refugees are those whose applications have been successful.

The first problem relates to interpreting and translation provision and the fact that many asylum seekers and refugees are often unaware of the availability of professional interpreters. The second relates to the "screening" of asylum seekers and refugees for communicable diseases. McVeigh (2002) highlights that this process could leave the HPSS vulnerable to accusations of racial prejudice. McVeigh (2002) suggests that whilst people do not object to being screened, it is the way in which it is conducted which could cause difficulties. McVeigh (2002) argues that advocacy and interpretation services must be provided when a person is screened as the provision of these services is crucial to the notion of consent to examination.

Further gaps in service provision for asylum seekers and refugees relate to the lack of appropriate counselling and support services. O'Neill (2001:95), for example, suggests asylum seekers have a range of special needs over and above those of minority ethnic groups in general for a number of reasons:

- they are involuntary migrants.
- they suffer from insecurity and loss of identity because of their experiences.
- they have worries about family/friends left behind in their home country.
- they fear the "long arm" of their home government.
- they may have particular medical/psychological problems on account of their experiences, especially in cases of torture and rape.

McVeigh (2002) notes that there is lack of refugee and asylum seeker specific services in the statutory sector and suggests that appropriate services need to be put in place. The DHSSPS has begun to recognise these needs and is currently taking steps to address the relevant issues. This includes the recent publication of policy guidance in relation to asylum seekers and refugees (DHSSPS:2003).

However, the DHSSPS and associated relevant bodies should continue to take into careful consideration McVeigh's findings and subsequent recommendations (a number of which are outlined below).

Recommendations: Refugees & Asylum Seekers (McVeigh, 2002)

- **All Government Departments and Agencies should examine their services to asylum seekers and refugees as a specific category in the context of their Section 75 duties.**
- **The statutory sector should co-ordinate its approach to service provision for asylum seekers and refugees more effectively and further develop a multi-agency approach to asylum seeker and refugee services. Departments should begin to address the implications of a growth in asylum seekers and refugee numbers.**
- **It is essential to assess and address the needs of asylum seeker and refugee children.**
- **There is a need for the development of translation and interpreting services which are sensitive to specific asylum seeker and refugee needs.**
- **Funding should be made available for asylum seeker and refugee support workers to provide advocacy in terms of service provision.**

Migrant Workers

Two recent studies (Soares, 2002; Bell *et al*, 2003) have explored the lives of migrant workers in Northern Ireland. Bell *et al* (2003:3) define a migrant worker as, *"an individual who arrives in the host country either with a job to go to or with the intention of finding one"*[30]. Both studies highlight that migrant workers have become

[30] Note that there are a number of different and distinct categories of migrant workers or non-nationals who have varying rights to work in Northern Ireland; for further details see Bell *et al* (2003:3).

increasingly visible in Northern Irish society with Bell *et al* (2003:5) suggesting that this may continue due to EU enlargement.

The variety of different categories of migrant workers (some of whom require documentation whilst others do not) means that it is difficult to determine with accuracy the exact number of migrant workers currently in Northern Ireland (Bell *et al*, 2003:4)[31]. What is known, however, is that migrant workers are employed in a wide range of sectors here including food processing, agriculture, nursing and health care, education, hospitality and catering. They are spread over a wide geographical area. There are, for example, Portuguese communities in Dungannon and Portadown and other nationalities employed in food processing factories in Ballymena, Coleraine and elsewhere[32]. There are migrant workers employed in farm and agricultural businesses in Newtownards, Portadown and the border areas. Many migrant workers are also employed in various hotels across Northern Ireland and many HSS Trusts have employed health care workers, particularly nurses, from other countries (Bell *et al*, 2003:4).

Bell *et al* (2003:67-68) identify two particular barriers experienced by migrant workers in attempting to access health and social services. These difficulties include the lack of information on how and where to access services, and the problems in accessing services due to language barriers.

Lack of information on how and where to access services (Bell et al, 2003:67-68):

Many migrant workers were not aware of the structure of HPSS in Northern Ireland. For example, some migrant workers attended A&E Departments and minor injuries units because they did not know how to register with a GP or are not aware that GPs act as gatekeepers to other services.

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[31] Although as Bell *et al* (2003:4) note, Census data, the Labour Force Survey and Data on Work permits do give some indication of the number of migrant workers.

[32] Attention has recently been drawn to the lack of interpreters for a small but increasing number of Russian-speakers in Omagh. The Omagh Ethnic Community Support Group estimate that there are currently around 50 people from Russia and the Eastern Bloc countries in Omagh, many of which are workers in the area's meat factories. It is suggested that the lack of interpreters is preventing access to statutory services such as health and social care (Irish News Article, 23/09/04).

Lack of awareness by HPSS staff on the entitlements of migrant workers to health and social care. For example, a Serbian women had difficulties registering with a GP, several of the health centres she approached would not register her because they were unaware of whether there was a bilateral agreement between Serbia and the UK to provide health care.

Language Barriers:

- Many migrant workers were often unaware of the interpreting services they were entitled to. For example, a dentist was unaware that he could provide a Portuguese man with an interpreter and the client had to use an English/Portuguese dictionary to describe his symptoms.

- Proficiency in the English language was an important factor in GP registration. In the survey conducted by Bell *et al* (2003) GP registration by migrant workers varied according to profession and English proficiency. A total of 93% of nurses and 100% of academics participating in the survey had registered with a GP. However, only 73% of factory workers did so. A total of 92% of respondents who spoke fluent English had registered with a GP, compared to only 68% of people who did not speak English.

- Receiving letters detailing appointments in the English language was also problematic resulting in people missing appointments because they could not understand the correspondence.

Targeting services and improving service accessibility is crucial for the growing number of migrant workers in Northern Ireland. If not already in the process of doing so, the DHSSP and associated bodies must take into consideration the findings and recommendations of the Bell et al (2003) study.

Recommendations: Migrant Workers
(Bell et al, 2003)

- **There is currently a limited amount of accurate data on the nature, scale and demographic breakdown of the migrant worker population in Northern Ireland. Bell et al (2003) recommend that consideration be given to identifying ways**

in which existing sources of information can yield better data on migrant workers so that policy development can proceed on a more informed basis.

- **Bell *et al* (2003) highlight that migrant workers would like a government-produced booklet containing information on their rights and responsibilities which should contain information on issues such as health care. This should contain practical advice and should be available in a range of languages. DHSSPS should work in association with other government departments to produce such information. These booklets should be targeted at migrant workers and available in a range of settings (for example, workplaces, health centres etc.**

- **Bell et al (2003) highlight that some migrant workers often do not know where to turn to for help when they encounter difficulties. HPSS staff should be aware of a range of existing organisations (for example, the Equality Commission, Law Centre for Northern Ireland, Multi-Cultural Resource Centre) which can provide assistance to migrant workers. Staff should be able to direct people to such service where necessary.**

- **HPSS staff, particularly staff at GP surgeries and health clinics should be made aware, through the provision of concise information, of the health care entitlements of nationals from different countries.**

Rurality and Access to Services

Very little Northern Ireland-based research exists (with the exception of Holder & Lanao, 2002;2003), which explores the barriers in accessing health and social services experienced by Black and Minority Ethnic people in rural areas.

Research conducted by de Lima (2001)[33] into Black and Minority Ethnic communities in Scotland does, however, identify a number

[33] study cited in *"Fair For All"*, NHS Scotland

of barriers in service accessibility in rural Scotland which may be of relevance in a Northern Ireland context.

Issues and access barriers identified by de Lima (2001) include:

- a myth that Black and Minority Ethnic communities *"look after their own"* and therefore required less access to health and social care.
- both overt and inadvertent racial discrimination on an individual and institutional basis including the perception in many rural areas that race equality was not a priority issue.
- a lack of an effective strategy to identify, make contact and consult with Black and Minority Ethnic groups in rural areas in regards to service planning.

Many of the issues highlighted by the de Lima (2001) study have been reiterated in a series of focus groups conducted by Holder & Lanao (2002; 2003) which explored the experiences of women living in rural areas of Fermanagh and Mid Ulster. The focus groups, however, also highlighted that mental health difficulties were an additional problem for Black and Minority Ethnic people living in rural areas. Many of the women participating in the groups believed that social isolation in rural areas often gave rise to mental health problems and this was especially problematic for Black and Minority Ethnic women. Participants felt that isolation led to depression and that Black and Minority Ethnic women living in rural areas often had no-one to turn to for help.

Recommendations: Rural Black and Minority Ethnic Communities

Advocacy & Consultative Mechanisms

- **DHSSPS, HSS Boards & Trusts should work towards empowering Black and Minority Ethnic people in rural areas. Consultative mechanisms must be developed to involve rural Black and Minority Ethnic communities in the design, planning and delivery of services. Service users should be enabled to articulate their needs and give feedback on the quality of services they receive.**

Capacity Building

- **Continue to support and engage with Black and Minority Ethnic groups and organisations, including providing support to help create rural Black and Minority Ethnic groups in areas where currently no structures exist.**

Transportation

- **Explore the barriers to accessing HPSS experienced by rural Black and Minority Ethnic groups as a result of lack of transportation.**

Black and Minority Ethnic Carers [see dependants section]

Disability and Ethnicity [see disability section]

Older Black and Minority Ethnic People [see age section]

Ethnicity, Human Rights and Access to Health and Social Services

There appears to be very little literature which explicitly explores the links between ethnicity, human rights and access to health and social care. There is a clear need for further research in this area and an increased effort to raise awareness of human rights throughout the health and social services.

Making the connections between ethnicity and human rights in a health and social care context is vital not only to improve service accessibility for Black and Minority Ethnic communities but is also important if the DHSSPS, its associated agencies and staff are to prevent potential costly legal action for human rights violations.

There are numerous circumstances whereby HPSS providers could be vulnerable to potential breaches of the Human Rights Act 1998 in relation to racial discrimination. Outlined below are just two *possible* illustrations. It is important, however, that many more such examples are identified throughout health and social services policy and practice and that actions are taken to address any issues identified.

Potential Human Rights Violations in Health and Social Care:

Article 2 – the right to life: legal implications of deciding to withhold resuscitation can be particularly difficult when the cultural background of the doctor and patient differ. A Report by Cox et al (2003:4) maintains that communication regarding a decision of "do not attempt to resuscitate" instruction can become particularly complex if the doctor, patient or family members do not speak the same language. Article 14 of the ECHR prohibits discrimination on a number of grounds including language. Cox et al (2003:36) argue that there is a potential for a breach of human rights should the right to life (Article 2) be interfered with because of a failure to provide proper facilities for the translating of information from the health care provider to the patient and/or their family.

Article 8 (right to respect for private and family life): there are possible implications for social services if proposals go ahead to take the children of "failed" asylum seekers into care if their parents refuse to return to their country of origin.

As there is a lack of information regarding the health and human rights of Black and Minority Ethnic people in Northern Ireland it is strongly recommended that further research is commissioned in this area. There is a need to work in co-operation with Black and Minority Ethnic groups and organisations to both identify possible human rights violations and to raise awareness of human rights amongst Black and Minority Ethnic communities. There is also a clear need to mainstream Black and Minority Ethnic human rights issues in wider HPSS policy and decision-making.

Recommendations: Ethnicity, Health and Human Rights

- **DHSSPS, Boards and Trusts should continue to raise awareness of ethnicity and human rights issues through training and sessions and workshops involving frontline HPSS staff. Steps must continue to be taken to create a "human rights culture" in HPSS services and staff.**
- **DHSSPS, HSS Boards and Trusts should encourage HPSS facilities (hospitals, residential homes, day centres etc) to review and amend their policies and procedures in a bid to identify areas which are in violation of the human rights of people from Black and Minority Ethnic groups.**

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Useful Web-Links*

Resources

- **"Multi-Cultural Handbook for All Health and Social Care Staff"** (Armagh & Dungannon HSS Trust *et al)*
  http://www.shsscouncil.net/publish4.htm

- **"Racial Equality in Health: Good Practice Guide"** - Consultation Document (DHSSPS & Equality Commission)
  www.dhsspsni.gov.uk/publications/2002/RaceEqHealth.pdf

Websites

- **Multi-Cultural Resource Centre (MCRC)**
  www.mcrc-ni.org
  www.mcrc-ni.org/RAG/RAG%20home.htm (Refugee Action Group)
  www.mcrc-ni.org/mcrc/valery%20YPP.htm (Black and Minority Ethnic Children & Young People's Project)

- **Multi-Cultural Matters** - provides background information for all those who wish to raise awareness and understanding of the cultural differences within the diverse communities living in the UK.
  www.multicultural-matters.com

- **Northern Ireland Council for Ethnic Minorities (NICEM)**
  www.nicem.org.uk

- **Regional Health and Social Services Interpreting Project** - includes useful publication on the interpreting needs of the Black and Minority Ethnic communities in NI.
  www.interpreting.n-i.nhs.uk

- **Working with Diversity Website** - an initiative of the Eastern Area Equality Best Practice Forum which provides useful

information on religious diversity including religious and cultural days calendars.
www.workingwithdiversity.org
www.workingwithdiversity.org/calendar/week.php?cid=4&y=
(Religious & Cultural Calendars.

* Please note that this is NOT a definitive list of relevant websites