

Editorial

Diversity and the migrant: a universal human right?

Mark RD Johnson MA PhD Cert HE (Warwick)

Editor, *Diversity in Health and Social Care*; Professor of Diversity in Health and Social Care, Mary Seacole Research Centre, De Montfort University, Leicester, UK

Paula McGee RN RNT MA BA Cert Ed PhD

Editor, *Diversity in Health and Social Care*; Professor of Nursing, Faculty of Health and Community Care, University of Central England, Perry Barr, Birmingham, UK

As this issue goes to print, the new Commission for Equality and Human Rights (CEHR) finally comes into being and the plethora of bodies dealing with discrimination against marginalised groups in Britain are shaken into one, while the Commission for Racial Equality goes down firing a final broadside against the NHS' failure to comply with the Race Relations Amendment Act 2000. Indeed, we read that 15 Government Departments are to be charged with breaching the Act, by failing to conduct race equality impact assessments, or failing to monitor service delivery and employment, including the NHS/DH, Home Office and Department for Communities and Local Government (www.cre.gov.uk). At the same time, the Chief Constable of Cambridgeshire makes a very public plea for additional funds to help her force deal with the additional and costly problems of migration in that county. It was nice to hear her state on the radio that migration brought very positive benefits, although this was less widely reported: more attention was paid to the pathological aspects; more knife-crime and drunk driving, and the additional costs and delays of working through an interpreter. Of course, the NHS and social care agencies do not have to follow European Court rules which insist on the right of the migrant to be charged and proceeded against 'in a language that they understand': welfare professionals can use underage children, relatives with poor knowledge of language or health care, and cleaners or other under-qualified staff to mediate in medical interviews, with impunity. It is true that many bodies, including the National Register of Public Service Interpreters and Chartered Institute of Linguists, are trying to get this changed, but so far the migrant has few rights.

There is one light in the tunnel. For the next six months, the Presidency of the European Union is with Portugal, a state which has historically sent out at least as many migrants as it now receives. They have,

therefore, declared that the health of migrants will be a key priority during this period and convened a conference and ministerial workshop: *Health and Migration in the EU - Better Health for All in an Inclusive Society*. Speakers from across Europe will debate issues and report on successful initiatives, and, hopefully, make recommendations that might make a difference to the lives of migrants and their descendants. As the website for the workshop states:

International migration is a widespread phenomenon that has reached all corners of the world. The intensity and pace of population movements have been constantly increasing in a global world and Europe is a converging point for migratory flows from different regions. Even if challenging, the EU needs migrants because of two different reasons: demographic and economic. Demographic issues impose an emerging challenge, as the population is ageing and there is no replacement, fertility rates keep decreasing while life expectancy continues to improve. All in all, the sustainability of the system is at stake in the near future ... Because Portugal realises the vital need for facing this critical moment, it has chosen Health and Migration as the central theme of the EU Council Presidency – Health. The election of this topic relies on the importance of health for EU citizens and newcomers, as it is a main avenue for migrants' integration and an issue of public health for the host society. (www.hmelisbon2007.com/site.asp?ID=2&IDIOMA=2)

We hope to carry a report on this conference in the next issue.

In this issue of our journal, we have selected papers which reflect concerns about health and migration. In particular, we have concentrated on information, training and refugees, which we see as key elements of the debate as forced migrants create new diasporas and flows, presenting **either** new challenges and creating new communities, **or** new dynamics and sectors within older settled groups. Consequently, health and social

care services require better knowledge about their needs as the migrants, and indeed their descendants, try to come to grips with their own health information needs and understanding of the services and resources available to them in their new homes. All of this has to be added to already crowded syllabi and learning schedules for doctors, nurses and healthcare professionals. This is a considerable challenge, compounded by evidence that suggests that there are also attitudinal problems to address including xenophobia and racism as well as ignorance that may stem from or even cause hatred or fear. At the same time, we recognise that migration and health are part of a global system, and so we have attempted to keep an eye out for developments in the developing countries, from whence many migrants come and in the states of which are many more migrants, from rural areas and disasters.

Our first paper, therefore, presents some findings from a project in Kenya. Notter and her colleagues address the challenge of improving community capacity to cope with the epidemic of HIV/AIDS-related illness and its implications for local economies. As they demonstrate, Kenya, like Europe, has many ethnic and religious groups and attention to that diversity has equally to be factored into models of service delivery. An innovative, community-based and realistic programme of intervention is described and the process of its implementation evaluated: it seems to hold great potential for wider use. Key elements include attention to the resource implications and the impact of local economies as well as considering how local people understood and explained the phenomena they had to deal with, and how they integrated their practice to local values. Thus we see that careful attention was paid to the importance of retaining a family's 'good name'. We look forward to hearing in due course what the service users felt about this programme, and how far health was improved.

Migrants who leave their home country have many names. The term *Expatriate* conjures images of white British or American contractors and managers, while the overseas population of Indian background has increasingly adopted the soubriquet *Pardesi*. The word *Diaspora* was originally used in connection with the dispersal of the Jews from the Holy Land (or Palestine), but is increasingly being used to represent the collectivity of a group away from its homeland. One such group, hugely increased in numbers by recent events, is that of Iranian origin, in addition to the Persians who left following earlier changes of regime. Abdolreza Shaghagi and colleagues do us all a service in attempting to bring together the evidence about the needs of people from Iran. In particular, they have examined the methods used to research this group and the issues involved. As this journal prefers, they have adopted an inclusive approach to systematic review, covering qualitative as well as quantitative

research and searching out grey literature and research in progress, but insisting on clear and robust measures of quality. Usefully, a bilingual researcher (the PI) was able to extend the search beyond the English language literature, a rare event in our experience, even though he chastises himself for his inability to read in other European languages.

The results are useful in many ways. First, in providing a comprehensive and accessible list and chart of research about a specific group, and second, in showing what works or does not work, in recruiting minority respondents. It also provides a telling critique of much migrant health research which fails to consider the internal homogeneity of migrants and minorities. Diversity clearly rules; as they state, 'no single method ... can be considered a gold standard'. We thank the authors also for contributing to our *database of uncertainties* (see www.duets.nhs.uk/) by stating clearly what they did *not* find, notably here, research on common diseases like cancer, stroke and diabetes.

We next offer a complementary paper which will need to be added to the previous one's database, and will hopefully fill one of the gaps it identifies. This comes, like many of our recent new insights, from Australia and specifically addresses the health service use and satisfaction of Iranian settlers, alongside those of Afghan and Iraqi origin. Again, this comes from a junior researcher making a significant contribution to knowledge. Neale and her co-authors have followed what is increasingly being recognised as the most robust and effective way to research minority groups, using purposive sampling and semi-structured interviews in focus groups. Their findings may not be startling; people rely on friends and family for information, and lack of knowledge about health and healthcare. Both are familiar themes. However, it is important to establish this picture for new groups and the authors do show subtle but important differences between three populations that to an outsider might appear to share very similar geographical and cultural backgrounds. The recommendations are transferable beyond Australasia and we also note that a key barrier is the 'health workforce untrained in issues specific to refugee health'. It isn't necessarily language capability, important though that is, or knowledge of specific diseases, but the way of thinking that matters. This also applies to migrants who, in Australia as in UK, do not appreciate the benefits and the approach of the GP-led primary care health system and need to be advised about how it works. The authors further reflect on some of the methodological challenges they faced including issues of obtaining ethical consent, which may be very different from working with the majority, and provide a new barrier to increased understanding.

As our regular media continue to remind us, among the most vulnerable in society are children and, we

would add, especially those of refugee origin. Consider especially those whose parents take the desperate step of sending them away from home in the hope of a secure future, or those who, having lost their families, have to seek refuge by themselves. A team of concerned professionals in Haringey set out their findings and experience of working with adolescents of Albanian background. Counter to expectations, they found that younger children seemed to be coping better, perhaps because of differing expectations and the behaviour of reception agencies.

Haringey is, at least, a borough well used to diversity. They report 193 languages being spoken locally and services are both experienced and committed to helping groups such as this. They also appear, on the surface, to have some useful databases for monitoring activity. However, even this did not solve all their recruitment problems and we note that the team offered some payment to participants, which surely only reflected their real needs and was hardly an incentive. This is an additional issue to consider in working with marginalised groups, and from what we have seen, one rarely reported on. Interestingly, many of those who did not attend for interview appear to have been employed, probably outside legal protections, in unskilled building work. Hollins *et al's* paper reveals further a horrendous life of boredom, insecurity and lack of social support or help to understand health needs. But the resilience and ability to acquire English fluency of these young people is remarkable. We hope that our readers will find it as useful and inspiring.

Returning to an African perspective, and away from the usual UK focus on London, especially when considering people of African descent, Okereke and colleagues report on participatory and empowering approaches to health needs assessment. They introduce a technique they refer to as *meta-planning*, which may have wider value for rapid needs assessment at a community level, and which demonstrates that *experts* may not always get it wrong. The inclusion of grassroots voices is important in determining appropriate solutions and matters of emphasis. In particular, such an approach helps to steer researchers and policy planning away from well-trodden paths to consider **other** health concerns, moving away from stereotypes towards understanding within-group variations better. We might also feel that participatory methods are beneficial in their own right and may enhance the health of those involved. Certainly they will reduce the friction and cost of research bedevilled by mistrust and past failures to represent fairly or act upon the expressed needs of marginalised communities. However, as the authors recognise, all stakeholders, including the professionals, need to participate to ensure validity is, to create a new term, '360 degree' assured. This can only be attained if all partners are confident of each other and exhibit trust and respect for their own areas of

expertise. Only then can *meta-planning*, negotiation of joint outcomes, be achieved. The paper seems to show that such progress can happen and provides a workable model for transfer to other settings and groups.

As advised in an earlier issue, we intend to carry a regular section of Education Papers which will combine research and lessons for teachers and trainers. In this issue, we have a challenging paper from Mary Tilki, who is well known for her writing on nursing education. She and her colleagues have exposed themselves and their department to a searching and critical examination. They are to be congratulated on their honesty and their understanding of how and why lecturers adopt essentially racist practices. Confidence, on both sides, is important and so is recognition of fear and other emotional stresses. Their findings cannot be confined to one institution or one profession, but have resonance for all of us in Higher or Further Education. Further, they show clearly, as others have reported, that knowledge is not enough but nor is attitude; both must move together: a *colour-blind* or generic focused approach is equally flawed and fails us all. The problem may be that racism is what we once called a 'four-lettered word' and the malady that cannot be named. Only by honest and open reflection and discussion can such structural and personal illnesses be addressed. This paper provides another model example of how to achieve progress. One key methodological factor, as with the previous paper, was triangulation and involvement of stakeholders from all parties including both the apparently oppressed and the reputedly oppressive, as well as critical friends in an atmosphere of trust. The conclusions should be written on the tables of all teachers.

At the end of this issue we turn to the regular Knowledgeshare section, edited by Lorraine Culley, Professor of Social Science and Health at De Montfort University. The items she has found for us reflect in a large way the themes of this issue: the needs of refugees and asylum seekers, resources for teaching and training, and our underlying and continuing call for culturally competent and inclusive research. We are also pleased to include her very positive review of Raj Bhopal's text on ethnicity and health and to report on practical progress in meeting the needs of refugee professionals as well as an initiative to involve black and minority ethnic communities in research. But diversity is not only about ethnicity and migration, and we have resources which will reduce the disadvantages faced by lesbian, gay, bisexual and transgendered people, and guidance on setting up single equality schemes to mirror the creation of the new Commission on Equality and Human Rights. In future issues we shall try to increase our awareness and support for diversity in terms of age, disability or impairment, and gender.

And finally: while on holiday in Italy, in an area confusingly known as Sud Tyrol where German is spoken, rather than Italian, for most purposes, one of your editors visited the Bozen museum where rest the remains of Ötzi the Iceman, one of the earliest migrants of whom we have certain and unequivocal knowledge. This man, dated to have lived and died at least 5300 years before our present time, was a migrant who lived on the borders of present-day Austria and Italy, where borders have changed more than once in living memory enabling change of nationality without moving house. He clearly paid little attention to such matters, but traded and worked where opportunities took him; his last meal has been traced by pollen and other biochemical analysis to more than 20 miles walking from his last resting place. The reconstruction of his life and artefacts, and the care with which he clearly looked after his things, proved a revelation: our ancestors were very subtle,

highly developed and adventurous folk with whom we have more in common than school texts and cartoon reconstructions of 'stone age man' would suggest. I was also impressed by the respect that had been shown to this long-dead man, and the similarities between his values, lifestyle and technology and ours that could be deduced by science. It is unavoidable that we must conclude that, if we are so similar to those who lived so long ago, then the differences that divide us in modern society, whether on grounds of age, culture and religion, nationality and language, disability or sexual preference and personal identity, are negligible in comparison to the things which unite us. We must have the freedom to differ – and to travel or move and migrate, as this is one of the fundamental characteristics of our society which makes us human and essentially similar to other humans across the globe and across the ages!