Somali Community and the state of Health

Briefing for the Council of Somali Organisations

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Introduction

The coalition government set out clear aspirations to provide health services and to address persistent health inequalities in its 2010 White Paper[1] and in the 2012 Health and Social Care Act[2]. The key function of facilitating greater access to services tackling health inequalities by voluntary and community organisations was also recognised. Reviews, inquiry reports and several studies on health inequalities, notably the Acheson Inquiry (1998)[3] and the Marmot Review (2010)[4] have made reference to the need for additional capacity to tackle health inequalities. Over the years specific programmes were put in place to reduce inequalities through effective community engagement and by embedding the duty to promote equality throughout the National Health Service. Yet health disparities between different ethnic groups exist bringing the principle of health equity under scrutiny.

The most important statement from the Marmot Review was that inequalities in healthcare were indicative of other social inequalities in society. He noted,

"Lack of access to high-quality healthcare can contribute to health inequalities, and universal access is necessary to deal with problems of illness when they arise. But – and it is an important but – if the causes of health inequalities are social, economic, cultural and political, then so should be the solutions."[5]

Some improvements were made by introducing targets; this led to lower rates of infant mortality and longer life expectancy. However, gaps between disadvantaged groups and the rest of the population have persisted.

Somali population overview: What we know

[1] *Equity and Excellence: Liberating the NHS* (2010), Department of Health, London. Available at www.gov.uk/government/publications/liberating-the-nhs-white-paper
[2] *Health and Social Care Act 2012*, Department of Health, London www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets
[3] Independent Inquiry into Inequalities in Health (*Acheson Inquiry*) (1998), Report of the Independent Inquiry into Inequalities in Health.
[4] *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, Available at http://www.ucl.ac.uk/whitehallII/pdf/FairSocietyHealthyLives.pdf
[5] Tackling Health Inequalities: 10 Years On A review of developments in tackling health inequalities in England over the last 10 years, Department of Health, 2009, London, p.1 Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098936

The population in England and Wales is growing, ageing and becoming more diverse. Ethnicity profiles from 2001 and 2011 census reveal that the minority groups are on the increase and also tend to be younger compared to their white counterparts. Minority ethnic groups are not homogeneous and therefore it is important to acknowledge that terms such as 'African' and 'South Asian' tend to mask the heterogeneous nature of these groups.

According to the 2011 census data the total population of England and Wales was 56.1 million compared to 52.4 million in 2001; an increase of 7%. The black and minority ethnic population is 14.1% of the overall population in England and Wales, rising from 7.9% in 2001.

Ethnic groups 2001 and 2011, England and Wales

		2001 (%)	2011 (%)
White (excluding White British)	Irish	1.2	0.9
	Gypsy or Irish traveller[2]	0	0.1
	Other White	2.6	4.4
Mixed/multiple ethnic groups	White and Black Caribbean	0.5	0.8
	White and Asian	0.4	0.6
	White and Black African	0.2	0.3
	Other Mixed	0.3	0.5
Asian/Asian British	Indian	2.0	2.5
	Pakistani	1.4	2.0
	Bangladeshi	0.5	0.8
	Chinese[1]	0.4	0.7
	Other Asian[1]	0.5	1.5
Black/ African/ Caribbean /Black British	African	0.9	1.8
	Carribean	1.1	1.1
	Other Black	0.2	0.5
Other ethnic group	Arab[2]	0	0.4
	Any other ethnic group[1]	0.4	0.6

1. *Comparability issues exist between these ethnic groups for the 2001 and 2011 census*
2. *No comparable data exists for these ethnic groups in 2001 census*

Source: Census 2001 and 2011, Office for National Statistics

The Black African population increased from 0.9% in 2001 to 1.8% in 2011 and the Mixed White and Black African group increased from 0.2% to 0.3%. In 2011, 13% (7.5 million) of usual residents reported a country of birth outside the UK compared to 9%

in 2001. Other useful statistics in the census data is on country of birth which is also helpful to account for the Black African category.

Data on country of birth from census 2011 (England and Wales)

Categories	Countries	Number	Percentage
Total population	England and Wales	**56,075,912**	100%
Total from Africa		**1,312,617**	2.3
North Africa	No countries specified	**113,363**	**0.2**
Central and Western Africa		**397,068**	**0.7**
	Ghana	93,846	0.2
	Nigeria	191,183	0.3
	Other Central and West Africa	112,039	0.2
South and Eastern Africa		**786,216**	**1.4**
	Kenya	137,492	0.2
	Somalia	101,370	0.2
	South Africa	191,023	0.3
	Zimbabwe	118,348	0.2
	Other South and Eastern Africa	237,983	0.4
Africa: not otherwise specified		**15,970**	**0.02**

Source: Census 2011 England and Wales, extracted from Table QS203EW, Office for National Statistics

In percentage terms 1.4% of Black African groups come from the South and Eastern parts of Africa and Somalis, in amongst them, constitute 0.2% of the overall population of England and Wales.

What do we know about health issues in the Somali community?

Positive outcomes in areas such as health, education or employment rely heavily on the type and quality of information available. Ethnicity data in health, as in other areas, is usually self-defined. Due to their smaller numbers in the general population some minority population groups like the Somalis tend to be under-sampled in national

surveys and in national datasets such as health, education and criminal justice. The lack of information about different minority sub-groups is a product of systematic inequality.

The findings on ethnicity and health produced by the Association of Public Health Observatories (APHO)[6], as part of their '*Indications of public health in the English Regions*' provide us information that comes close to constructing the state of health in the Somali population at a national level. Interpretation must be treated with caution as Somali groups are a sub-set of the Black African sample to which the data pertains.

- *People from most ethnic minority groups are generally more deprived in terms of socio-economic status, and poverty as indicated by eligibility for free school meals. The Pakistani and Bangladeshi groups have the lowest proportion of the population in 'managerial and professional occupations'. The highest proportions of children eligible for free school meals are among the Travellers of Irish Heritage, Gypsy/Roma, Bangladeshi and Black African groups.*

- *A higher than average proportion of admissions due to diabetes is found in the Asian groups, Black Caribbean and Black Other group in most regions, reflecting the higher prevalence of diabetes in these groups.*

- *Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care in all regions. Along with the Other ethnic group, Black Africans also have the highest rates of tuberculosis.*

- *The regional pattern on partnership indicators such as treatment of drug misuse, HIV and tuberculosis is very mixed. In terms of care rates London has by far the highest rates of HIV and tuberculosis amongst the White group, but the reverse pattern is found in Black Africans. London's HIV care rate among Black Africans is significantly lower than other regions, although London accounts for 58% of all Black African HIV patients seen for care. Tuberculosis diagnoses rates are also lower than average among this group in London.*

[6] Ethnicity and Health:, available at http://www.apho.org.uk/resource/item.aspx?RID=39368

- *Asian, Black and Mixed minority populations have lower rates of setting a smoking quit date for both males and females.*[7]

The Migrant Health Guide published by Public Health England to support health practitioners recommends, among other things, to assess new patients' likely health needs using the checklist provided and by reference to the country specific pages. In relation to Somalia[8] they advise health practitioners to screen for tuberculosis, hepatitis B, polio, malaria, vitamin A and D deficiency and about female genital mutilation.

In a recent briefing the National Institute for Health and Care Excellence (NICE) has provided guidance[9] to local authorities and partner organisations on the use of body mass index (BMI) as a signal for preventive action against long-term medical conditions. It's focus is on black, Asian and minority ethnic groups, as chronic conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher in these groups. To address this in the South Asian, Chinese, black African and African Caribbean groups with a BMI of 23 kg/m2, pharmacological and lifestyle interventions are being used successfully to identify and manage pre-diabetes.

The NICE guidance recommends tackling the increased risk black and minority ethnic groups face at a certain BMI; early intervention meets a range of indicators in the public health and adult social care outcomes frameworks. These include:

- Proportion of adults meeting physical activity guidelines
- Encouraging uptake of the Health Check programme
- Self-reported wellbeing and health-related quality of life
- People know what choices are available to them locally and what they are entitled to
- People are protected as far as possible from avoidable harm, disease and injuries, delaying and reducing the need for care and support
- People are supported to plan ahead and have the freedom to manage risks in the way that they choose

[7] Ibid, pp 2-4.
[8] Country specific information available http://www.hpa.org.uk/MigrantHealthGuide/CountriesAZ/SubSaharanAfrica/Somalia/SomaliaChildrensHealth/
[9] *Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups,* NICE briefing, Jan, 2014. Available at http://www.nice.org.uk/advice/LGB13/chapter/Introduction

- Mortality from preventable diseases such as cardiovascular diseases (including heart disease and stroke) and cancer
- Preventable sight loss.

Local authorities, practitioners as well as organisations supporting health and social care play a vital role in meeting these new public health responsibilities. When the outcomes framework is weighed against the resources and capacity to monitor information there are real deficits within the Somali community. This is a real opportunity for the Council of Somali Organisations (CSO) to work with member organisations to collate data for high-risk groups within the Somali community and to ensure that these groups are involved in service planning and commissioning. It is also an opportunity to examine referral routes to specialist support services and to examine if specialist lifestyle intervention services are being commissioned to meet the needs of those at high risk of chronic diseases in the Somali population.

It is a fact that official statistics on key outcomes for the Somali community are sparse. For more qualitative information one has to rely on locally commissioned population sub-group studies or academic research studies and articles. Two local studies[10] on the Somali community in Bristol found:

- An increase in the number of Somalis in the local population was attributed to continued instability in Somalia and migration from Europe.
- Additional factors surrounding health problems include language barriers, legal (immigration) problems, housing, financial problems, family separation, bereavement and trauma.
- Somalis regard mental health as “madness”, or psychosis, as untreatable and as a taboo.
- Young people and parents who took part in the study emphasised language barriers between pupil, school and home.

[10] Wall et. al (2008), *The Mental Health Needs of Somali 11 to 18 Year Olds In Bristol*, report for Bristol City Council and PCT joint commissioners of services for Emotional health and Wellbeing
Jabłonowski et. al (2013), Work and Health of Somali Migrants in Bristol, Wellspring Healthy Living Centre And Bristol Somali Resource Centre, Bristol

- Equally relevant was the finding that knowledge of services and how to access them was low compared to need which was high.
- The research provided evidence for recommendations which focus on appropriate and responsive services, better community engagement and better information. The research also recommended increasing awareness of contextual issues around mental health including employment and housing.
- Somali migrants usually work in low-skilled and poorly paid service jobs, and part-time work
- Upon losing their jobs Somali workers struggled to get back into employment. They also took long-term sick leave, usually in relation to preventable health conditions.
- There seemed to be lack of appropriate health and safety training as an underlying factor in many cases of work-related illness.
- The impact of economic inactivity and precarious work affected personal health, family well-being and community cohesion.
- Female genital mutilation affects the female members of the community with increased rates of caesarean sections.
- *Khat* dependency has negative outcomes in relation to employment which mainly affects male members of the community.

Findings from local research studies support pan-European research which highlights 8 barriers to accessing healthcare among migrants across 16 European countries:

- language barriers
- difficulties in arranging care for migrants without health care coverage,
- social deprivation and traumatic experiences,
- lack of familiarity with the health care system,
- cultural differences,
- different understandings of illness and treatment,
- negative attitudes among staff and patients,
- lack of access to medical history.[11]

[11] Hall, Alex. (2012), *Migrant Health Needs*, Transparency Solutions available at http://transparencysolutions.co.uk/wp-content/uploads/2013/02/TS_BNHS5.pdf

The studies also highlight tension areas in the patient journey which include registration, making appointments and finally consultation. The manner in which GP's are paid does not adequately account for ethnicity and language needs.

In another local study for the London borough of Camden, post-traumatic stress disorder (PTSD), depression, anxiety disorders are most common mental health problems in Somali patients who access healthcare services. Yet again it was found that Somalis have a high level of need for healthcare but a low level of service use. Barriers to access include distrust of the system, language difficulties, housing problems, and anxieties over immigration status. Mental health disorders are not acknowledged within the community because of fear of being stigmatised and due to a common perception that mental health conditions cannot be treated. Chewing of *khat* induces mental and physical health problems such as depression, anxiety disorders, sleep disturbance and dental problems. There exists a perception among Somali men that GP's do not know very much about effects of *khat* and might misdiagnose health problems. Research also suggests that khat users are unlikely to access treatment services.[12]

Building capacity for improved health outcomes

A key problem within the Somali community is the lack of collaboration and partnerships among Somali organisations. Somali community organisations should be better resourced to help address the health needs of the community. It is equally important to consider culturally specific training of health practitioners which incorporates Somali beliefs, practices and cultural background. Lack of access to culturally competent healthcare services is one of the most significant barriers in addressing health disparities. Further negative experiences arise from brief and rushed consultations with health practitioners. There are differences how men and women experience healthcare and these are all important considerations to construct gender and culturally specific services. Inter-generational gaps between young and old make it difficult to discuss sexual health issues which mostly affect young girls who are also at risk of genital mutilation and associated risks. Health issues are of particular concern

[12] ICAR (2007), *The Somali Refugee Community in the UK*, p.8 available at http://www.icar.org.uk/ICAR_briefing_on_Somali_Community.pdf

amongst the older generation of women, and a cause of frustration among young people who recognise the need for a stronger and louder advocacy role in relation to health.[13]

Community specific NHS factcards such as the ones produced by Migrant and Refugee Communities Forum is a good example of extending advice and information to and from the community. One produced for the Somali community in Kensington & Chelsea and Westminster[14] refers to the common health problems for the local Somali community which also include obesity, Chlamydia and high blood cholesterol. It advises Somalis about availability of services to address health problems which include:

- Talking therapies
- Therapeutic treatments
- Medication, such as antidepressants
- Community Services provided through a Community Mental Health Team (CMHT) or a Crisis Resolution Team (CRT)
- In-patient services

Women and youth-led organisations are crucial in addressing health related needs of the community. Building their capacity to better engage with disparities in health and other areas such as employment and education should be a priority.

Conclusion

It is clear there is lack of data on health related outcomes in official statistics which is sufficiently nuanced to be able to compare and contrasts the experiences of different ethnic sub-groups of the ethnic minority population. From the 2011 census data it can now be derived that the Somali population in England and Wales is 0.2% of the total population. Research evidence suggests a high level of need to access healthcare but local research studies charting the experience of Somali communities point to low levels of care and treatment of health problems. Communities and organisations that represent them need to make important contributions in analysing, interpreting and communicating specific health needs of the community to public health services. Current health outcomes framework and other health initiatives reflect community

[13] Change Institute (2009), *The Somali Muslim Community in England: Understanding Muslim Ethnic Communities*, Communities and Local Government, London, p.43
[14] Available at http://migrantforum.org.uk/wp-content/uploads/2012/09/somali-eng.pdf

health needs in provision and commissioning of services. There are gaps in this regard in relation to the Somali community. Addressing such disparities requires public sector and community organisations and infrastructure to work together.
