A network of people from Black, Asian and Minority ethnic (BAME) communities, health services and organisations, working together to reduce health inequalities linked to ethnicity and culture.
HAREF: Health and Race Equality Forum

• HAREF is a network of over 80 organisations and practitioners focused on reducing health inequalities and maximising wellbeing and health for people living in Black, Asian and Minority Ethnic (BAME) communities

• We work in partnership with key agencies in the health, local government, university, voluntary and community sectors to ensure agencies can support BAME communities to access health services

• HAREF became part of Newcastle CVS in June 2017
HAREF: Health and Race Equality Forum

• Support health service improvement
  – Facilitate opportunities for services to work together
  – Hold onto important issues e.g. Interpreting services when accessing healthcare
• Engage with BAME communities
  – Actively seek participation from BAME communities
  – CCG Consultation for Focus Groups
• HAREF monthly bulletin
Information

• Newcastle is a very diverse city and in the recent 2011 Census 14.5% identified as BAME, and in Gateshead, 3.7%

• The BAME community in Newcastle is predominantly of the South East Asian, African, Eastern European and the Middle Eastern communities. In Gateshead there is a large Orthodox Jewish community

• These communities differ in regards to religion, language and cultural practices and are intergenerational

• They may differ widely but what they do have in common are health inequalities and inequity of access to health services
Information

• In the 2001 Census, Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of ‘not good’ health

• Children of South Asian origin in the UK are 13 times more likely to have Type 2 diabetes than White children (Diabetes UK 2009)

• HAREF research in 2014 found people who moved to UK / Newcastle from Central and Eastern Europe have higher support needs on how to use NHS
Barriers to accessing health services

• New to the area or country

• Lack of knowledge or understanding of services

• Language

• Cultural or religious barriers

• Living in deprived areas or with poor accommodation
Barriers to accessing health services

• Immigration status and NHS charging regulations

• People’s misconceptions based on previous experience of services or discrimination

• Professionals do not feel confident to ask questions so may stereotype or make assumptions

• People often do not access mainstream health services as their first point of access
Case study: MESMAC

• Work with men and deliver HIV and sexual health awareness and rapid HIV testing
• ‘Bobby’ is asylum seeker who has been in UK 2 years. He fled Nigeria due to his torture and arrest as he was gay
• He was dispersed to Northeast and dropped in at Mesmac by chance
• Over a number of one to one sessions with him they found:
  – He had not heard of safe sex or seen a condom
  – He had not had a HIV test
  – He was not registered with a doctor
  – He was traumatised by his experiences in his home country
How did MESMAC help?

- Completed HIV test and provided information on safe sex
- Registered him with a local doctor
- Supported him with his TB diagnosis
- When he was refused asylum and NRPF, they helped him submit a further asylum claim, and spoke to his TB nurse to ensure his treatment continued
- Paid for his expenses to ensure he could access services and support
- Referred him to Freedom from Torture for therapy
- ‘Bobby’ was given leave to remain in UK and is now studying hospitality
- He still accesses Mesmac services for support and HIV testing
How is HAREF helping?

• Some examples of our work:
  – Leaflets for service users on accessing NHS
  – Hepatitis C within communities
  – Regulations on upfront NHS charging and extension to community health services
  – Ramadhan calendars
Key points

• BAME communities can find services hard to reach, and are not always linked into main stream services
• Community organisation’s are key to working with BAME communities
• Health service provisions needs to be flexible and consider venue and timing
• Always consider cultural, language and access issues
• There is a direct link between good engagement and better health outcomes for communities
• We want to hear from more communities and organisations!

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