Foreword

Haringey has one of the most ethnically diverse populations in the country, with over half the population defining themselves as coming from a Black and Minority Ethnic group. This diversity brings a rich cultural vibrancy of which Haringey is justifiably proud.

Most of Haringey residents from Black and Minority Ethnic groups were born in the UK. Others have travelled to live, work or study in the borough as migrants. Some of these migrants will stay on, becoming permanent residents, while others will return to their countries of origin.

This migration brings significant benefits to the UK and, in particular, London where migration is concentrated, through the skills and flexibility of the migrant workforce and their contribution to the economy.[1] With our ageing workforce, this contribution will become more important to the UK's economy over time.

However, the rich diversity and important contribution made by minority ethnic groups and migrants is undermined by persisting inequity. There is clear evidence that people from some Black and Minority Ethnic groups and some migrant groups experience worse health and well-being than their White British counterparts.

The link between ethnicity and health is complex. Being a member of a Black and Minority Ethnic group or a migrant does not automatically lead to worse health than that experienced by White British people. A combination of factors, including housing, education, income and lifestyle, interact with genetic characteristics to determine health. But we know that individuals from certain Black and Minority Ethnic communities are more likely to report ill health in surveys, more likely to experience a range of health problems and less likely to use some services.

We cannot ignore this. The economic impact of days at work lost is huge. The grief experienced by families who lose a loved one to an avoidable early death is incalculable. Behind every statistic is the story of a real person's suffering.

We need to understand more about the complex links between ethnicity and health so that we can ensure services are accessible to and used by those who most need them. Above all, we need to actively engage with Black and Minority Ethnic communities to empower them to improve their own health and well-being.

I am delighted to present this Annual Public Health Report as an important contribution to this urgent problem. My thanks go to all those who have contributed to its production and to all the individuals and organisations whose work it reflects.

Dr Eugenia Cronin

Haringey Joint Director of Public Health, 2007–2009

Contents

NHS Haringey

1	Introduction	4
2	Focusing on ethnicity and health in Haringey	6
3	Engaging communities	18
4	Establishing a healthy start in life	26
5	Accessing health services	42
6	Improving lifestyles	56
7	A snap shot of Haringey's health	62
8	Conclusions and recommendations	70
9	References	74

1 Introduction

NHS Haringey

Why an Annual Public Health Report?

Every year NHS Haringey produces an Annual Public Health Report to draw attention to key issues of concern to public health and provide a snapshot of the health of the population of Haringey. The aims of this report are:

- To describe the epidemiology and health needs of minority ethnic communities and migrants in Haringey.
- To describe current public health interventions and provision of services for minority ethnic communities and migrants in Haringey.
- To provide examples of good practice.
- To identify gaps in data and services.
- To inform strategy and commissioning of health services.
- To improve access to services.

The report has been produced by NHS Haringey in partnership with Haringey Council and community organisations.

Why a focus on Black and Minority and migrant health?

Haringey's population is now estimated at 226,200[2], of which over 120,000 people are from a Black and Minority Ethnic group.[3] While most of these people were born in the UK, around 37% were born outside the UK and came here as migrants.[4]

Despite the significant size of this population, we still do not know enough about the health needs and health outcomes of Black and Minority Ethnic groups. However, we do know that some Black and Minority Ethnic groups experience worse health than White British residents of the borough and are less likely to use some key health services. The reasons behind this are complex and some of the difference in outcomes can be explained by the increased likelihood of certain ethnic groups experiencing deprivation, itself a cause of poor health.

We need to understand much more about the experiences of Black and Minority Ethnic communities so that we can better design and deliver our services. If we ignore this challenge, we risk exacerbating inequalities in health between ethnic groups and contributing to the persistence of injustice.

For this reason, we have decided to focus this year's Annual Public Health Report on Black and Minority Ethnic health. We have also sought to highlight the specific health issues experienced by migrants where possible, because we know that some migrant groups, such as refugees and asylum seekers, face particular barriers to accessing services.

The data

An emerging theme of the report is that data collection and analysis on ethnicity and health is inadequate. This report uses a wide range of data sources, including information on ethnicity, country of birth and ways of migration, where this is available. It is important to acknowledge that there will be some inconsistencies in the way in which data is presented, depending on the source and the way information is recorded. Furthermore, some data has started to be collected only recently, whereas other sources of data may stretch back a number of years.

The importance of partnership

NHS Haringey cannot solve the problems described in this report by acting alone. Many of the initiatives that are developing new ways of improving the health and well-being of Black and Minority Ethnic groups have been led by those communities themselves. Other service providers in the borough have also developed more accessible ways of delivering services. In this report we have highlighted some examples of new approaches to health and well-being that are proving effective.

What is clear is that addressing the health needs of Black and Minority Ethnic groups and reducing health inequalities will require improved partnership working and a commitment to real engagement with communities themselves. This report is intended as a first step in what we acknowledge will be a long-term challenge. We hope it will prove a useful resource for all those committed to improving the health and well-being of Haringey residents.

2 Focusing on ethnicity and health in Haringey

2.1. Ethnicity in Haringey

The ethnic origin of Haringey's population now

Haringey has one of the most ethnically diverse populations in the country. There are high proportions of people from all the continents across the world living in the borough and, according to school registers, over 175 languages are spoken by local residents.

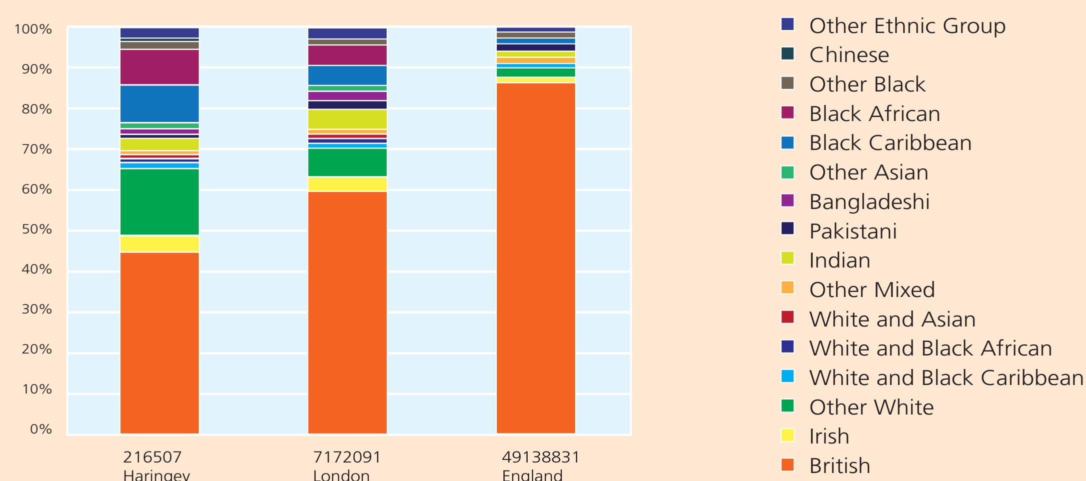
Every 10 years a census is undertaken. This is a count of all people and households and it provides invaluable information about ethnicity because people are asked to say which ethnic origin they use to describe themselves. It is the most complete source of information about the population that we have. Because the same questions are asked of everyone, it is easy to compare different parts of the country. The latest census was held in 2001.

The 2001 census shows that Haringey is more ethnically diverse than both London and England as a whole. In Haringey, approximately 45% of the population are of White British background compared to 60% for London and 85% for England (see Figure 1). Furthermore, within Haringey wards the proportion of White British varies considerably. The most ethnically diverse ward in Haringey is Northumberland Park where 28.9% of the population are of White British background. In contrast, the least ethnically diverse ward is Muswell Hill where 71.1% of the population are of White British background.

Migration

Migration is a process of social change in which an individual leaves one geographical area for prolonged stay or permanent settlement in another geographical area.[5] Migration is important in the planning of services as there is a need to know how the population has changed over time and is likely to change in the future.

Figure 1: Ethnic comparisons between Haringey, London and England



Source: Census 2001

Key messages:

- Haringey has one of the most ethnically diverse populations in the country. In 2001, 45% of the population were of White British background compared to 60% for London and 85% for England.
- The young population of Haringey are more ethnically diverse than the older population.
- In 2001, 63% of the population in Haringey were born in the UK. Nine percent were born in Africa, 8% were born in Asia and smaller proportions were from South America and Oceania. A Further 12.6% of the population in Haringey were born in a European country other than the UK.
- The relationship between health, ethnicity and migration is complicated. Many ethnic groups are more likely to experience poorer health outcomes than the general population.
- Data collection and analysis on health, ethnicity and migration needs to be improved.

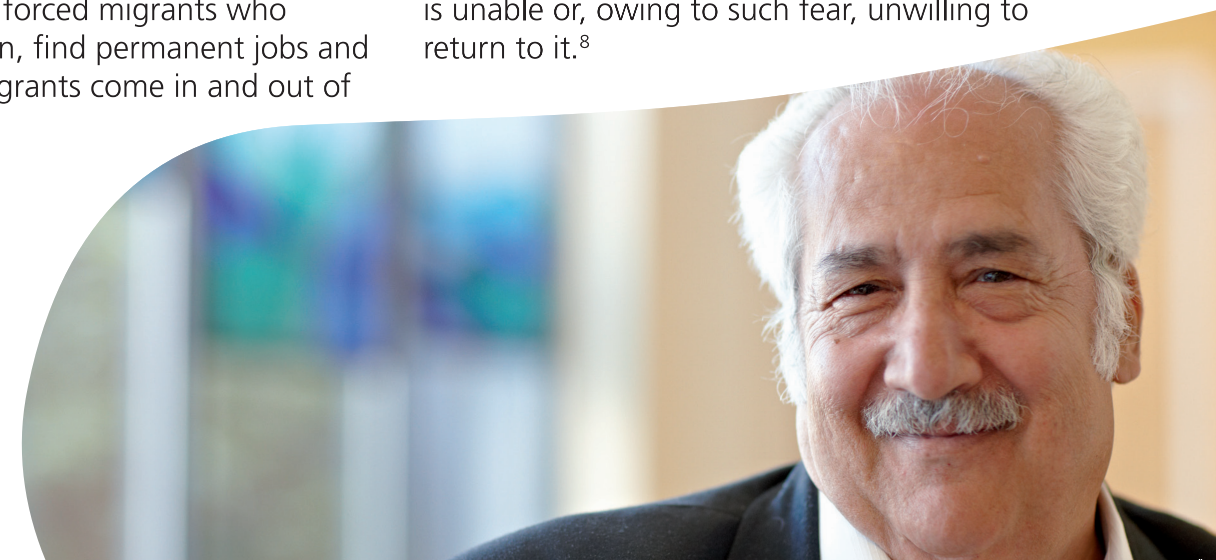
This requires an understanding of migration patterns, as well as the ethnic origin of the population.

Reasons for migration can be voluntary (sometimes called elective); for example, to study or for employment. They can also be forced; for example, the movement of people who are either internally or externally displaced as a result of natural or environmental disasters, slave trade, human trafficking, war and violence and ethnic cleansing.

In the UK there is no legal definition of migration. Traditionally, it has been associated with some notion of permanent settlement. Reality, however, suggests that the concept of migration refers to a general 'movement' embracing various types of mobility, with migrants often being able to transform into something else driven by the process of migration.[6] For example, refugees may come to exile as forced migrants who eventually settle down, find permanent jobs and naturalise. Labour migrants come in and out of labour markets.

Some migrants arrive as asylum seekers. The legal definition of an asylum seeker is a person who enters a country to apply for asylum on the grounds that if they are required to leave, they would have to go to a country to which they are unwilling to go owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.[7] Individuals undergoing the asylum process have their claims assessed.

The definition of a refugee is a person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of nationality and is unable, or, owing to such a fear, is unwilling to avail themselves of the protection of that country; or who, not having a nationality and being outside the country of their former habitual residence as a result of such events, is unable or, owing to such fear, unwilling to return to it.[8]



2 Focusing on ethnicity and health in Haringey

NHS Haringey

Migration to the UK and Haringey

The UK is home to many immigrants who have come from different parts of the world. Most recently, migration has been characterised by the arrival of migrants from other European countries and South Asia.[9] In 2001, 7.53% (approximately 4.3 million) people living in the British Isles were born outside the UK.[10]

The number of migrants in the UK has increased over time. For example, the number of people arriving in the UK each year increased from approximately 300,000 in 1995 to over 500,000 in 2005.

The majority of migrants are young adults of working age. They often have extremely diverse experiences of migration, ranging from those who left their home country in a search for better living circumstances and employment opportunities, to those who were forced to migrate due to war and violence.

Most migrants who arrive in the UK tend to resettle either in London or in the south-east of the country, although their geographical distribution varies according to country of origin. In London, most migrants tend to resettle in areas with the highest proportions of non-UK born residents, which also tend to be the areas with high levels of deprivation.

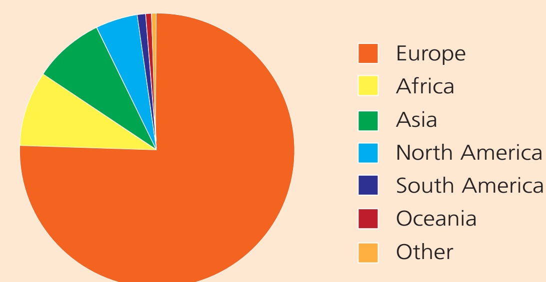
It is difficult to quantify the exact number of migrants in Haringey because of a lack of accurate data. Many services do not record information on immigration status. Ethnicity is usually used as a proxy measure for migration, but this category does not distinguish between recent immigrants and people who are descended by birth from migrants but were born in the UK.

Information on country of birth or country of origin would be a better measure of migration. However, it is not recorded systematically.

Migrants also tend to be excluded from surveys for several reasons. They are not always aware of their entitlements, they may be illegal immigrants or they may fear authority as a result of past negative experiences related to encounters with officials in their country of origin.[11] Insufficient knowledge of language, lack of professional interpreters and greater costs when conducting interviews with migrants may all lead to difficulties with engaging this population group in any systematic research on health outcomes.

Historically, migration into Haringey, as with other parts of London, was from the Caribbean and Asia. However, in more recent years migrants have arrived in the UK from many different countries. The largest numbers are now from Eastern Europe and other parts of the European Union, although there are still consistent flows from the other continents. This has been facilitated by the introduction of new member states to the European Union.

Figure 2: Country of birth of Haringey residents



Source: 2001 Census

The 2001 census asked residents of Haringey the country in which they were born (see Figure 2). This gives another indication of people who have migrated to Haringey from abroad as opposed to how people describe their ethnic origin. In 2001, 75% of the population in Haringey were born in Europe, 9% were born in Africa, 8% were born in Asia and smaller proportions were from South America and Oceania. Of the 75% of people who were born in Europe, the majority (63%) were born in the UK. Six percent of the local residents were born in Eastern Europe, 3.9% were born in other Western European countries and a further 2.7% were born in Ireland.

The NASS (National Asylum Support Service) regularly sends NHS Haringey details of people who have arrived in the borough seeking asylum. Table 1 describes the number of people who have been given asylum and were resettled in Haringey between 2003 and 2008. The number of asylum seekers has dropped by 82% between the beginning and end of the period, possibly due to the make-up of the European Union. The proportion of people migrating from different countries has changed over time and some countries from which asylum seekers arrived in the past are now part of the European Union. The highest proportion of people seeking asylum in Haringey were from Turkey (29%), mainly of Kurdish background.

Table 1: Ethnic composition of NASS notifications between 2003 and 2008

Nationality	2003	2004	2005	2006	2007	2008	2003 to 2008	%
Turkey	563	320	178	87	21	44	1,213	29.02
China	69	106	148	38	7	15	383	9.16
Somalia	143	70	52	52	17	16	350	8.37
Iran	44	48	57	32	6	25	212	5.07
Congo	46	41	28	11	5	5	136	3.25
Kosovo	34	33	15	15	0	2	99	2.37
Eritrea	19	10	23	24	7	14	97	2.32
Albania	21	23	21	18	3	5	91	2.18
Iraq	31	11	8	4	4	14	72	1.72
Ethiopia	19	18	14	3	5	4	63	1.51
Afghanistan	23	11	3	7	5	11	60	1.44
Algeria	17	14	20	5	2	1	59	1.41
Romania	47	8	0	3	0	0	58	1.39
Columbia	28	21	1	4	3	0	57	1.36
Uganda	16	10	14	2	3	8	53	1.27
Jamaica	16	4	18	5	8	1	52	1.24
Yugoslavia	23	15	3	2	2	3	48	1.15
Pakistan	8	7	14	13	4	1	47	1.12
Zimbabwe	15	4	3	2	2	10	36	0.86
Cameroon	7	6	7	4	3	5	32	0.77
Nigeria	6	5	4	8	0	8	31	0.74
Total	1,487	985	822	468	160	258	4,180	

Source: NASS

2 Focusing on ethnicity and health in Haringey

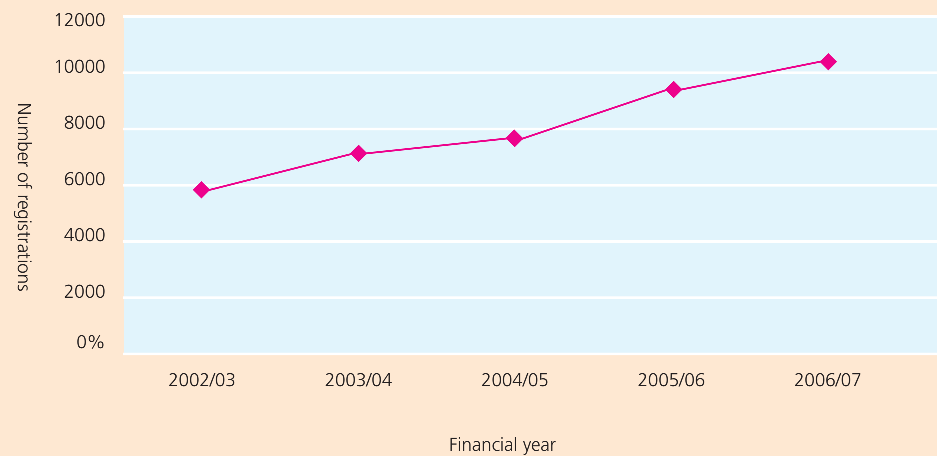


Figure 3: National insurance number registrations in respect of non-UK nationals, by local authority and country of origin, 2002/03 to 2006/07

Source: National Insurance Recording System (NIRS)

One of the other sources of data on migration to Haringey is national insurance registrations. Once someone arrives in the country and is seeking work they are required to register for a national insurance number so that they can legally work and pay national insurance contributions. However, this data underestimates the actual number of migrants in employment, because a proportion of people do not register for a national insurance number.

Between 2002/03 and 2006/07, the number of people registering for national insurance contributions rose steeply from 5,890 to 10,970, a shown in Figure 3.

The highest number of registrations between 2002/03 and 2006/07 were by people from Poland (8,770), accounting for approximately 24%. This was followed by registrations from Turkey, Italy, France and Australia, as shown in Figure 4.

How the ethnicity of Haringey's population is expected to change in the future

The London Health Observatory completed a study of birth trends in London in 2008. The analysis concentrated on the country of birth of the mother, grouping them into those born in the UK, those from A8 countries (European Union accession countries) and those from other parts of the world.

In London, 82% of additional births were from England and Wales and from the rest of the world, and only 14% were from the A8 countries. Births from A8 countries accounted for only 2% of all of the births in London. However, the pattern varied across London boroughs (see figure 5). The analysis showed that 50% of all additional births from A8 countries were from only nine boroughs (Ealing, Newham, Waltham Forest, Haringey, Brent, Barnet, Hounslow, Enfield and City and Hackney). The average proportion of additional live births across London was 2.3%, with the highest proportion in Ealing (5.6%) and Haringey (4.5%).

NHS Haringey

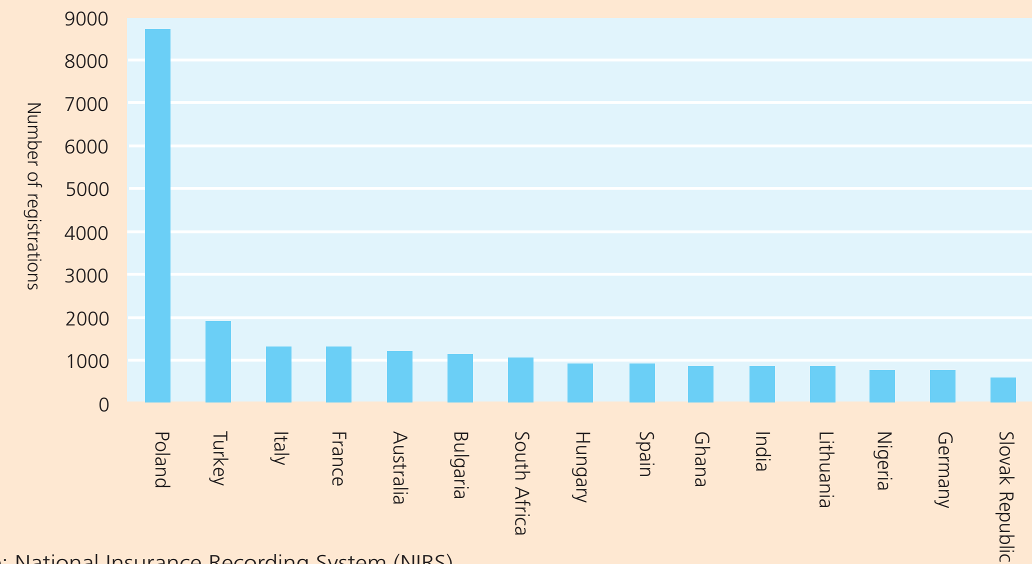


Figure 4: Number of national insurance registrations by country of origin, 2002/03 to 2006/07

Source: National Insurance Recording System (NIRS)

The Greater London Authority (GLA) has also completed a study of ethnicity of new birth registrations and has predicted how the patterns are likely to change across London. In 2001–02, 48% of births to Haringey women were from those of White ethnic origin (which includes White British, White Irish and White Other) and this is estimated to increase to 51% by 2025–26. Births among Black Caribbeans and Black Africans are expected to make up lower proportions

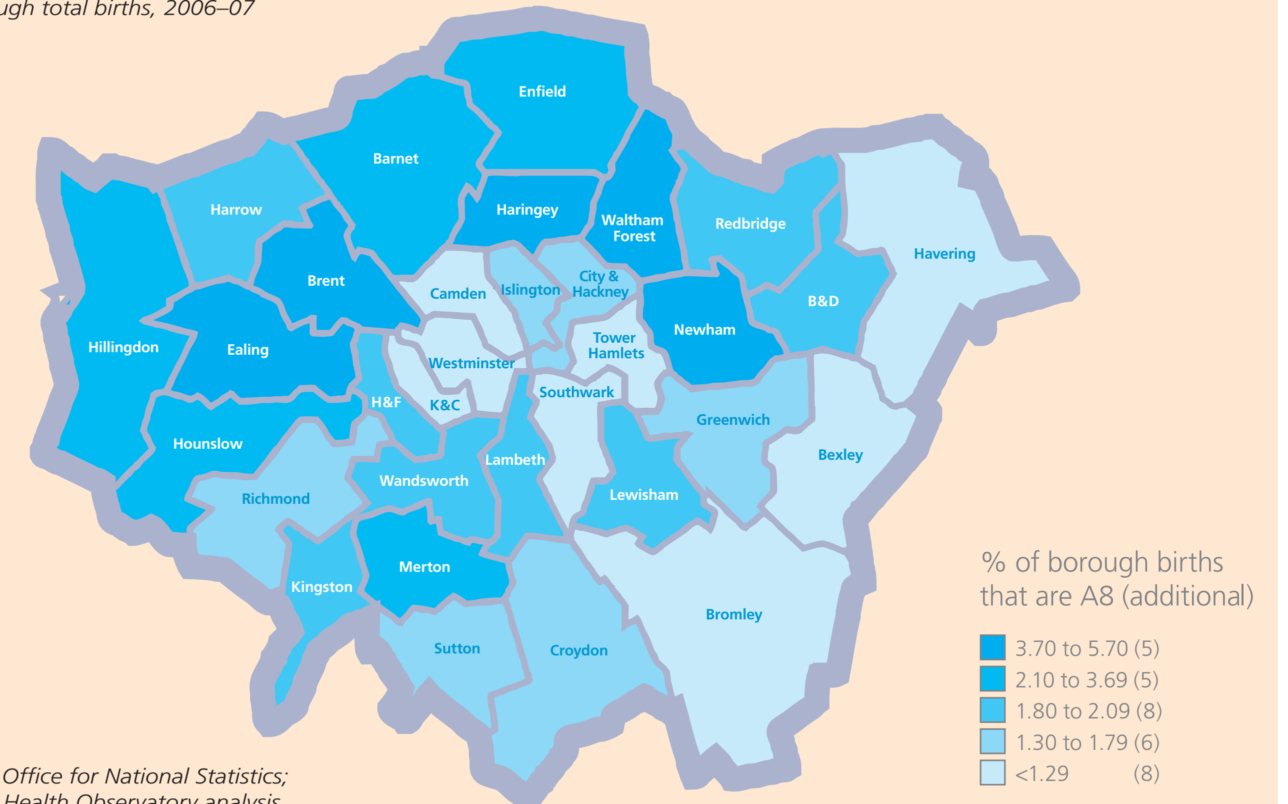
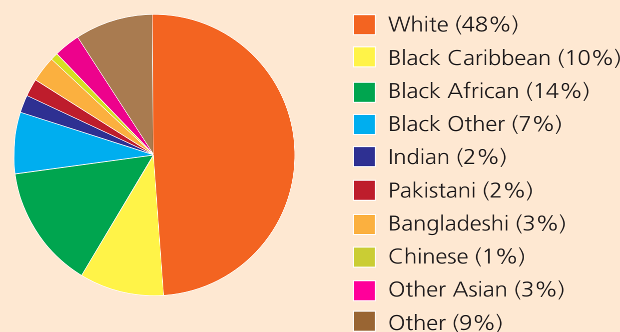


Figure 5: Borough A8 'additional' births as a percentage of borough total births, 2006–07

Source: Office for National Statistics; London Health Observatory analysis

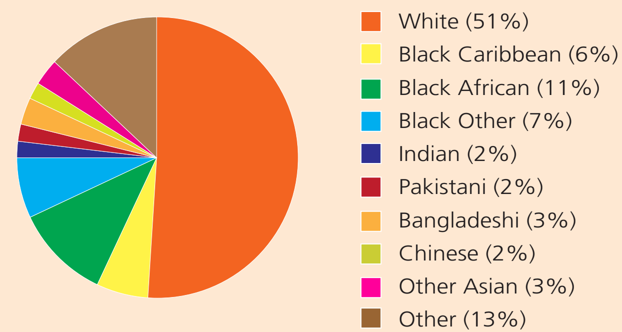
2 Focusing on ethnicity and health in Haringey

Figure 6: Ethnicity of births in Haringey, 2001–02, as a percentage of all births



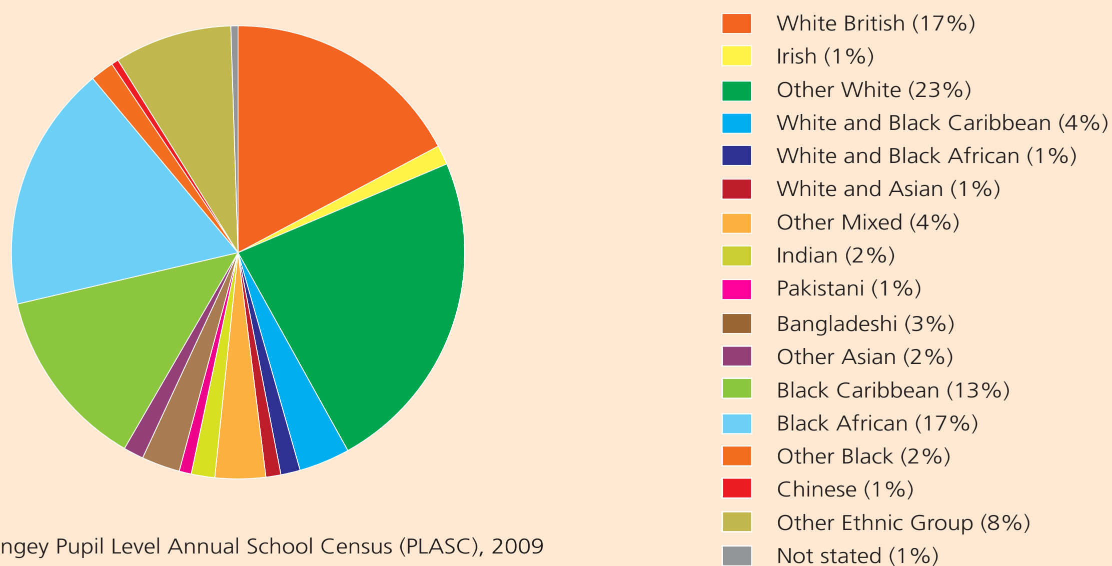
Source: Greater London Authority

Figure 7: Ethnicity of births in Haringey, 2025–26, as a percentage of all births



Source: Greater London Authority

Figure 8: Ethnic composition of children attending Haringey schools, July 2009



Source: Haringey Pupil Level Annual School Census (PLASC), 2009

in 2025–26 than they currently do and it is estimated that those from other ethnic groups are likely to increase from 9% of the total births to 13% (see Figures 6 and 7).

An additional way of looking at how the ethnicity of the population may change in the future is to look at the ethnicity of children at school. The school census, which takes place annually, describes the ethnic composition of younger people in Haringey.

The school census shows that the young population of Haringey is more ethnically diverse than the older population compared to the national census. According to the 2001 national census, 45% of the local population were of White British origin compared to data from the school census where only 17% of the local children were from this ethnic group (see Figure 8). Children from Black and Minority Ethnic groups make up by far the largest proportion of local children, and this is likely to result in a more ethnically diverse population as these young people progress into adulthood. Those groups in which the proportion of children is over-represented, when compared to the census, include those of Black African and Black Caribbean origin and those from the White Other and the Other ethnic group categories. Table 2 describes the difference between the ethnic composition of children attending Haringey schools and the ethnic composition according to the census.

2.2. How ethnicity affects health and health inequalities

A complex link

The interaction between ethnicity and health is complex. The prevalence and death rates of many diseases and disorders are known to vary by ethnic group. Compared to their White British counterparts, many Black and Minority Ethnic groups have poorer health outcomes. There is also well-documented evidence of inequities in access to prevention, treatment and social care based on ethnic groups. The difference in the quality of services received, access to treatments and outcomes related to varying access to healthcare by different ethnic groups is also well reported.

Some of the links are direct because some ethnic groups are more at risk than others of suffering from certain diseases. For example, thalassaemia and sickle-cell disease are more prevalent in people of Mediterranean, Black African and Black Caribbean origin than in the UK indigenous population. Lifestyle and health-related behaviour are shown to be linked with specific conditions. Smoking prevalence and use of alcohol tend to be higher in minority groups[12] when compared to the UK indigenous population. Dietary factors in South Asians have been linked to increased mortality from coronary heart disease and diabetes.[13] Furthermore, delayed access to services may also be a contributing factor to increased mortality in specific minority ethnic groups. Additionally, some minority ethnic groups may be less likely to access health services because of language difficulties or cultural barriers.

Table 2: Comparison of ethnicity between school census 2009 and national census 2001

Ethnicity	PLASC %	Census %
White British	17.13	45.26
Irish	1.45	4.29
White Other	23.44	16.05
White and Black Caribbean	3.62	1.48
White and Black African	1.26	0.73
White and Asian	1.04	1.07
Other mixed	3.68	1.29
Indian	1.74	2.85
Pakistani	0.90	0.95
Bangladeshi	2.70	1.37
Other Asian	1.51	1.55
Black Caribbean	13.06	9.49
Black African	17.47	9.18
Other Black	1.57	1.36
Chinese	0.57	1.13
Other ethnic group	8.35	1.95
Not stated	0.52	

Source: PLASC and 2001 Census

2 Focusing on ethnicity and health in Haringey

NHS Haringey

Table 3: Proportional Admission Ratios for CHD by ethnic group (2005/06)

Ethnic group	Observed	Expected	PAR	Lower CI	Upper CI
White British	17,737	17,154	103	102	105
White Irish	1,140	842	135	128	144
Other White	2,969	3,446	86	83	89
White & Black Caribbean	69	167	41	32	52
White & Black African	46	99	46	34	62
White & Asian	85	94	91	73	112
Other Mixed	227	366	62	54	71
Indian	3,112	1,651	188	182	195
Pakistani	1,158	683	169	160	180
Bangladeshi	1,005	729	138	130	147
Other Asian	1,149	989	116	110	123
Black Caribbean	902	1,528	59	55	63
Black African	420	1,828	23	21	25
Other Black	271	1,121	24	21	27
Chinese	107	193	55	45	67
Other	1,475	1,694	87	83	92
Not known	1,994	1,585	126	120	131
Not stated	5,164	4,862	106	103	109
All Ethnicities	39,030	39,030	100	99	101

Source: Hospital Episode Statistics / analysed by the London Health Observatory

Other links are indirect. Some ethnic groups are more likely than others to have lower incomes and to live in deprived areas. The link between income and health is very well proven, so those groups who tend to have lower incomes are more likely to suffer from ill health. There is also a strong causal link between deprivation and poor health. As some ethnic groups are more likely to live in deprived areas, they show higher rates of poor health. Deprived areas also tend to have worse access to health services and poorer quality services, which exacerbates the negative health impacts of living in deprivation.

This means that it is very difficult to attribute health inequalities among different ethnic groups to ethnic origin itself, as opposed to the compounding effects of poverty, deprivation and stress.

Many of these inequalities are amenable to change and can be addressed using a range of evidence-based interventions to improve health and reduce ethnic inequalities in health and healthcare.[14] Reducing health inequalities is paramount to improvement in the overall health of the UK population and has been a focus of government policy. The NHS Plan, published in 2000, included actions and service development to tackle health inequalities, and there are national targets to reduce health inequalities.[15]

Health service utilisation among ethnic groups

Analysis of hospital admissions and outpatient and accident and emergency attendances suggests that some ethnic groups have varying levels of need compared to others. Some of this variation in need can be explained by different ethnic groups' predisposition to certain diseases, but it is likely that much of it is explained by the cumulative effect of inherited disease, attitudes to health and access to primary care.

Analysis of inpatient activity for selected diagnoses by the London Health Observatory suggests that certain ethnic groups have significantly more than expected attendances for certain diseases; this in turn suggests that ethnicity is a factor in determining admission rates within the London population. Table 3 describes the differences in the hospital admission rates for chronic heart disease (CHD) across London. Activity levels for the White British population are quite close to what would be expected compared to the distribution of this group among the total London population.

However, admission rates are much higher than expected among the White Irish and Asian communities.

Table 4 describes the activity by ethnic group that has the highest over-representations on selected diagnoses. This analysis clearly suggests that tuberculosis (TB) admission rates are very high for Black African and Asian groups and that schizophrenia admission rates are significantly higher than expected for Black communities (including Black Caribbean, Black African and Mixed Black groups). Irish groups also have a disproportional number of admissions for substance misuse and pancreatic and lung cancers.

Table 4: Proportional admission ratios 2005-06 (PAR) – top 20 by ethnicity and diagnosis

Diagnosis or cause	Ethnic group	Observed	Expected	PAR	Lower CI	Upper CI
Cervical cancer	Chinese	26	6	463	302	678
Tuberculosis	Black African	299	75	397	353	444
Tuberculosis	Pakistani	104	28	369	302	447
Cancer of the head and neck	Chinese	60	16	366	279	470
Tuberculosis	Indian	245	68	360	316	408
Schizophrenia	Black Caribbean	588	167	352	324	382
Schizophrenia	White & Black African	35	11	323	225	449
Tuberculosis	Other Asian	122	41	299	248	357
Acute hypertensive disease	Black Caribbean	416	140	297	269	327
Schizophrenia	Other Black	341	122	278	250	310
Substance use	White Irish	430	156	275	250	303
Pancreatic cancer	White Irish	112	41	272	224	328
Schizophrenia	White & Black Caribbean	49	18	268	199	355
Tuberculosis	Chinese	21	8	264	163	403
Schizophrenia	White & Asian	27	10	264	174	384
Non-Hodgkins cancer	Chinese	102	39	263	214	319
Leukaemia	Chinese	154	59	263	223	308
Lung cancer	White Irish	505	194	260	238	284
Renal failure	Pakistani	299	115	259	231	291
Tuberculosis	Bangladeshi	77	30	256	202	320

Source: Hospital Episode Statistics / analysed by the London Health Observatory

2 Focusing on ethnicity and health in Haringey

NHS Haringey

2.3. How migration can affect health

The health risks experienced by many immigrants

Although modern literature depicts the migration process as mainly beneficial, especially in relation to improving educational, political and socio-economic circumstances, the process itself can quite often be strenuous and traumatic. Migrants may be exposed to health risks before the migration process, during migration or after arrival in the resettlement country.

Conditions to which migrants may be exposed before migration may include natural disasters, experience of war, torture and violence, imprisonment, loss of relatives and loved ones, unfavourable socio-economic circumstances, infectious diseases, among others. Conditions during the journey may also be unfavourable and undesirable, resulting in further stress and health impairment. The process of displacement can be particularly damaging for vulnerable groups such as children and older people.

Some of the risks experienced after arriving in the resettlement country include imprisonment, long-lasting asylum seeking process and uncertainty, discrimination and marginalisation, all leading to stress and resulting in negative impacts on overall physical and psychological well-being. The process of resettlement in the new country and multifaceted integration process pose significant demand on coping mechanisms.

The migration process also influences risk behaviours and risk perception in many ways. Those affected by losses such, as loss of identity, family and possessions, may hold on to the past and turn their focus of attention on their past life in their country of origin rather than focusing on the future. Therefore, this group may be more likely to neglect health and to engage more readily in health-damaging behaviour.[16] Preoccupation with survival and socio-economic welfare is usually a much higher priority for migrants, especially refugees, than is their health and risk perception. All of this may have a negative effect on migrants' health.

Rates of infectious diseases, such as tuberculosis, HIV/AIDS and sexually transmitted infections, have been found to be more prevalent in migrants, especially asylum seekers and refugees who tend to migrate from deprived countries.[17]

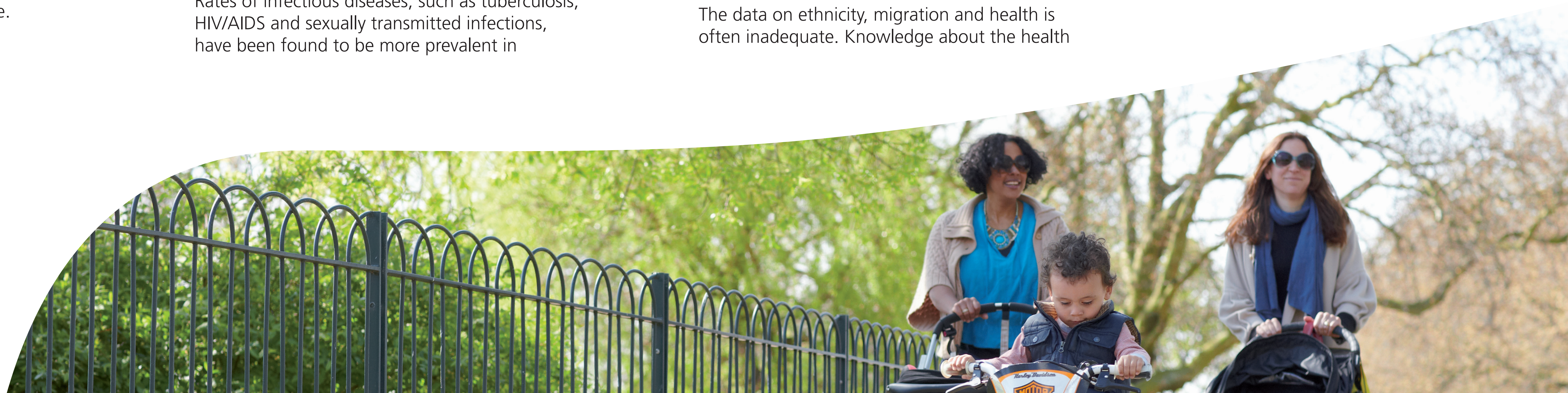
However, the migrant population is an extremely heterogeneous group and the health effects of migration depend heavily on the socio-economic and cultural background of migrants, their previous health history, the nature and quality of healthcare services they previously had in their countries of origin, their genetic make-up, their ways of migration and their living circumstances in the recipient country. Consequently, it is not possible to draw universally applicable conclusions about the impacts of migration on health.

There is a need for integrated policy and long-term public health promotion and education strategies to ensure that migrants have adequate access to appropriate health and social care services. Only those who are physically and psychologically healthy can participate in community life to their full potential.

Data limitations

The data on ethnicity, migration and health is often inadequate. Knowledge about the health status of migrants is very limited due to a lack of data. Ethnicity is usually used as a proxy measure for migration, but this category does not distinguish between recent immigrants and their descendants born in the UK.

The existing evidence does allow us to draw some conclusions about the relationship between health, ethnicity and migration. Most of the presented evidence suggests that morbidity among migrants and minority ethnic groups is greater when compared to the general population. However, there are exceptions and, as always, generalisations hide complexity. What is clear is that improved data collection and analysis would allow us to deepen our understanding of the important and complicated relationship between health, ethnicity and migration. In the following chapters, this report draws attention to these data deficiencies and makes recommendations to improve these. This will allow policy makers and service providers to respond more effectively to the health needs of Black and Minority Ethnic communities and migrants.



3 Engaging communities

3.1. The importance of local engagement

There is growing evidence about the importance of engagement with local communities in improving well-being. Well-being is crucial to health. Well-being can be described as feeling good and functioning well. Positive feelings include happiness, contentment, enjoyment, curiosity and engagement. Functioning well includes experiencing positive relationships, having some control over one's life and having a sense of purpose. All are important attributes of well-being.[18]

Most of the factors that affect well-being occur at a local level. They include family relationships, friendships, neighbourhood communities and school and work experiences. They are about neighbourhood and home environments. This means that the interventions that could increase well-being and resilience can be delivered at the same very local level and are under the direct or strategic control of local government and other local agencies.[19]

It is crucial that local agencies work together to engage communities in the development and delivery of interventions that meet local needs. Without such engagement there is a danger that initiatives will be ineffective and will contribute to a sense of powerlessness and alienation that risks undermining well-being. Evidence suggests that effective engagement with local communities in service planning reduces inequalities in provision. This is particularly pertinent to refugee communities.

Special efforts are often needed to engage people from Black and Minority Ethnic communities and migrants. There may be language and cultural barriers to the types of engagement typically used by organisations. In addition, there may be suspicion or hostility towards organisations that are perceived to be part of government. Many deprived communities are used to being ignored or excluded. They may therefore not respond to requests for involvement and may expect their views to be ignored if they do.

Engagement takes time, imagination and a real commitment to empowering excluded communities.

In May 2009, the Board of NHS Haringey endorsed a Race Equality Scheme. The Race Equality Scheme (RES) describes how NHS Haringey will meet its obligations in relation to the ongoing implementation of the RES. It also outlines a series of actions to ensure that race equality feeds into the planning and policies we develop as an organisation.

One of the objectives of the RES is to engage and listen to Black and Minority Ethnic communities, including asylum seekers and refugees, in order to influence our core business and strategic objectives. We hope to achieve good quality, equitable services and to improve the health of the local population through engaging and listening to communities.

Key messages:

- Local engagement is crucial to health and well-being.
- Health trainers are a new initiative to engage local communities in activities to improve health and well-being.
- NHS Haringey supports several community-based voluntary organisations to provide a range of health, advice and training services targeted at the needs of Black and Minority Ethnic communities, migrants and refugees.

3.2. Health trainers initiative

A new initiative

In the White Paper Choosing Health, the government announced the introduction of a new initiative to engage local communities in activities to improve health and well-being.[20] Health trainers (also known as community well-being workers) are accessible to people within a range of community settings, including neighbourhood health centres, community locations and other settings, such as the Selby Centre. They are visible and accessible to local people through living and working in the communities they serve providing support from next door.

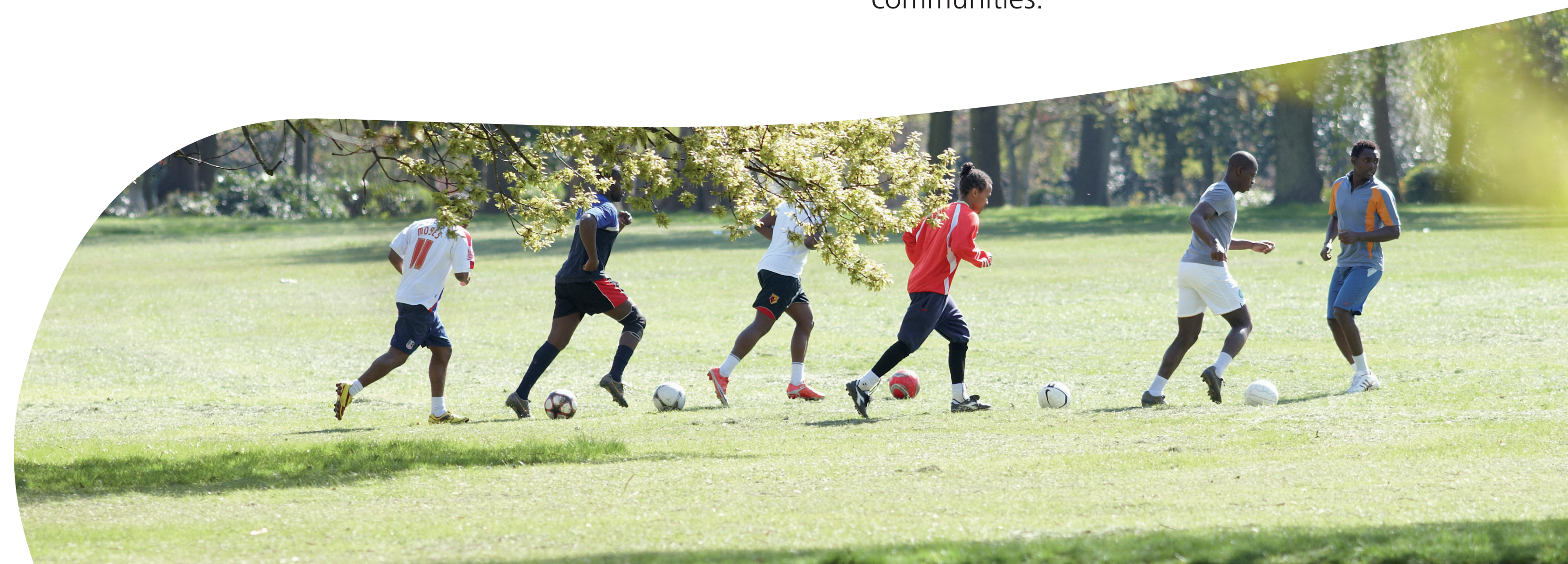
Health trainers are drawn from and are representative of the local community and so can deliver information and support in culturally and linguistically appropriate ways. Some of the trainers themselves are from refugee communities and focus on engaging with refugees.

Building on the previous success of Health for Haringey

The health trainers initiative builds on the success of Health for Haringey, which operated in Haringey for five years, run by Age Concern Haringey in conjunction with NHS Haringey. This project delivered diverse programmes of population-based activities offering traditional sporting activities together with yoga, chair-based exercise and general keep fit. There were 2,661 registered participants with an estimated 500 more taking part after project monitoring had been collated.

In total, 137 community projects were funded with:

- 113 in the east of the borough.
- 82 specifically for participants from Black and Minority Ethnic communities.
- 43 for people over 50.
- 24 for people with disabilities or living with long-term conditions.
- 14 from groups working with refugee communities.



3 Engaging communities

NHS Haringey

> “I can now run up the stairs without getting out of breath, I find I can do a lot more than I used to.”

> “It has offered me a great chance to get healthy again. … I have seen dramatic changes in my blood pressure and my breathing. … I feel more confident within myself and have greater control over my lifestyle.”

A new approach to health and well-being

Health for Haringey included four local initiatives to engage with refugee communities:

- **Haringey Somali Women's group:** 20 participants whose levels of fitness, self-esteem and confidence improved.
- **Ethiopian Centre UK:** 35 participants from African communities affected by HIV/AIDS took part in gentle exercise and keep fit. The project also helped with developing community support. They reported improved fitness and mental well-being, reduced stress and a greater awareness about healthy lifestyles.
- **Ugandan Community Relief Association:** 18 women, principally from refugee communities, many of whom were affected by HIV/AIDS, participated in low impact aerobics and a walking group. There were reductions in weight and BMI, in pain, stress and depression, and improved well-being and social support.
- **Cynthia Elcock Foundation:** 16 women, many of whom were refugees from Montserrat, undertook a programme of exercise, dance and relaxation. They reported improved fitness and mobility, reductions in weight and BMI, increased confidence to exercise and increased activity at leisure centres beyond the sessions.

Health for Haringey has enabled many people to go from being inactive to enjoying activity. The monitoring and evaluation has consistently indicated that participants feel fitter, more mobile and more confident to exercise. There have been many incidences of weight maintenance, reductions in Body Mass Index (BMI) and improved blood pressure levels.

> “The sessions have changed my life. They have restored my vitality and definitely improved my health.”

What made Health for Haringey different was that it worked with participants to devise ideas and activities. This approach is welcomed by communities as building trust and respect. Health for Haringey relied on the commitment and expertise of a team of dedicated volunteers to focus on promoting physical activities with two specific target groups:

- Black and minority ethnic communities: 83% of all recorded participants in Health for Haringey are from Black and Minority Ethnic communities.
- People from refugee communities: 14 projects within the Black and Minority Ethnic communities were specifically targeting people from communities with high numbers of refugees and asylum seekers.

3.3. Community groups providing health services

There are many community-based voluntary organisations that provide health services to Black and Minority Ethnic and migrant communities. Some of these organisations and initiatives that NHS Haringey supports are described below.

Polish and Eastern European Family Centre (PEEC)

PEEC Family Centre works with people from all sections of the community, particularly those living in North London from Polish and Eastern European families who find it difficult to access any other service provision. The Centre's work focuses on improving access to health provision in North London, mainly in Haringey. The team provides a range of services, including: information and guidance on local health issues; healthy food promotions; help with registering with a GP; interpreting in GP practices, hospitals and health centres for particular clients who find it difficult to communicate; counselling; one-to-one support and advice; keep fit classes; and help for homeless Polish and Eastern European people. For more information contact: 020 8365 9090.

3 Engaging communities

NHS Haringey

Embrace UK Community Support Centre (Embrace UK)

Embrace UK was established in 1994 to provide information, advice and guidance to disadvantaged groups, such as migrants, refugees and asylum seekers, on education and training, housing, immigration, welfare benefits, money and debt, health-related issues such as sexual health, mental health and general health, and to conduct research as necessary. Embrace UK provides its services to over 52 different nationalities, including African nationalities, Caribbean, Turkish, Kurdish, Albanian, Portuguese, Greek Cypriot, Irish, Thai and British, among others. Some of the services provided by Embrace UK are described below. For more information contact: www.embraceuk.org.

The Pan African and Caribbean Sexual Health Project (PACSH)

The overall aim of the PACSH project is to raise HIV awareness among African and Caribbean community members and help them to be HIV educated, empowered and equipped, with access to clear, accurate and reliable information and quality sexual health services. It also aims to reduce the number of undiagnosed people within African and Caribbean communities through promoting Voluntary Counselling and Testing (VCT) and by providing support, advice and signposting to other services for HIV-positive people.

The PACSH project runs several primary and secondary HIV prevention programmes, including the condom information and resource distribution project that aims to reduce HIV transmission and spread and new HIV infections, through raising basic awareness and knowledge among African and Caribbean communities residing in Enfield and Haringey. It also aims contribute to the reduction in the spread of HIV and sexually transmitted infections (STIs) through improved access to and availability of condoms (male and female) and through increased and effective use of condoms by African and Caribbean communities living and working in Enfield and Haringey.

The PACSH project also runs the HIV awareness and test promotion project, which aims to reduce HIV transmission, spread and reduce new HIV infections, through raising basic awareness and knowledge among African and Caribbean communities residing in Enfield and Haringey. It is also aimed at reframing participants' thinking about their sexual behaviour through a combination of behavioural interventions and an information intervention with a focus on explaining the benefits of HIV and STI testing services. The project is designed to reduce a reliance on written information and to signpost service users into other services.

Community Support Service

The Community Support Service provides information, advice, guidance and emotional support to HIV-positive people and people who are leaving hospital after an episode of care. It seeks to provide a single contact point for community-based emotional support and advice. It offers access to training and volunteering opportunities and support with accessing healthcare, financial help and, where appropriate, access to immigration and other specialist advice services. It also offers support around disclosure of HIV status, relationship support and support to establish and sustain safer sex with partners, including distribution of free condoms. The project seeks to reduce stigma and discrimination surrounding HIV and to improve the health and well-being of African and Caribbean people living with HIV. It also seeks to contribute to improving HIV awareness and empowerment and providing access to clear, accurate and credible information and quality services.

Newly Diagnosed Pregnant Women Support Service

The aim of this service is to support pregnant women newly diagnosed with HIV and those who have recently delivered their babies and who are receiving treatment and care at the North Middlesex Hospital. It aims to reduce stigma and discrimination surrounding HIV and to improve the health and well-being of African and Caribbean people living with HIV.

The 'Love Safely' home visit programme

This is a home visit and interactive programme focusing on promoting safer sex practice and improving levels of awareness of local African and Caribbean people. It engages individuals in discussion for a minimum of 45 minutes in a safe setting where they feel free to talk about issues related to sexual health. Its main aim is to encourage African and Caribbean people living in Enfield and Haringey to go for an HIV test, where appropriate.

The chlamydia screening programme for Black and Minority Ethnic men

This programme provides targeted advice on chlamydia and access to screening for Black and Minority Ethnic men aged 15–25 years in Haringey. If untreated, chlamydia may cause fertility problems and because it is often symptomless, many of those infected do not know they are.

3 Engaging communities

NHS Haringey

Advice services

Factors such as employment, training, benefits, housing and immigration have an impact on health and well-being and it is therefore important that people can access advice and support services for help when they have problems. Black and Minority Ethnic and migrant communities may find it difficult to access this provision. Embrace UK provides the following advice services:

- The Business Development Project provides information, advice, guidance and training on business start-up and employment issues. It also supports existing businesses by providing training on, for example, taxation, financial management, company registration, business planning, VAT registration and PAYE for employees.

- The Advice and Support Project provides money and debt advice to, and raises financial assistance from the British Gas Energy Trust for, disadvantaged groups who cannot afford to pay their utility arrears. Embrace UK is an authorised agency for British / Scottish Gas and EDF Energy Trust in raising financial assistance on behalf of groups.

- The Information and Advocacy Project provides housing, immigration and welfare benefit advice and advocacy on behalf of clients.

- The Refugee Development Project provides support to people who need help with regard to benefits. This also helps people to avoid depression and mental illness.

The Interpreting Services Project provides interpreting services and works particularly with Haringey Council in the provision of trained freelance interpreters. It has trained around 26 language speakers.

Training and support services

Embrace UK provides training and support services designed to improve health and well-being, including:

- Strengthening Families, Strengthening Communities: this is a training course aimed at parents in marginalised communities. It is designed to help parents understand the behaviour of their children, to increase parental self-esteem and confidence and to achieve positive change in family relationships. In addition, the programme aims to reduce child behavioural difficulties and help parents build child self-esteem.

- NVQ Level 1, 2, 3 Health and Social Care, Child Care and Skills for Life: NHS Haringey works in conjunction with other training providers to give NVQ training. This training benefits particularly volunteers who are assigned to different projects and have been helping the organisation.

- Opportunities for volunteering: NHS Haringey provides volunteering opportunities for those who wish to spare some time to contribute to the progress of the organisation. We currently manage over 30 volunteers who are attached to different projects managed by the organisation.

Research and policy

Embrace UK has undertaken a number of research and policy initiatives in conjunction with Middlesex University, including:

- A research project led by Embrace UK into Ethiopian migrants, their beliefs, refugeedom, adaptations, calamities and experiences in the UK.
- A research project led by Safer UK into the sexual abuse and maltreatment of unaccompanied minors in the UK.

The research findings have been used to improve and shape policy and service design and delivery.

Media and communication

NHS Haringey supports a media project run by Embrace UK, which involves radio, website and newsletters as means of communication with the general public and our service users.
The radio is on air for four hours a week, Saturday and Sunday from 4 to 6 on Sky Channel 0185. The website with live broadcasts is www.spectrumradio.net and all archives can be found on the website www.embraceuk.org. The radio programme is broadcast in Amharic, an Ethiopian language, and English. More detailed information about the services provided can be found on the Embrace UK website www.embraceuk.org.

4 Establishing a healthy start in life

4.1. The importance of a healthy start

There is overwhelming evidence that what happens in childhood has a huge impact on health in later life. The building blocks for good health and development are laid in early childhood, starting in the womb. This includes physical health – obesity, heart disease and mental health are all affected by early childhood experiences. It also includes mental development and life expectations that determine educational achievement and income, which themselves have a direct impact on health.

We know from the data that children from many Black and Minority Ethnic communities and migrant families have poorer childhood outcomes using a range of indicators. This chapter examines this data.

4.2. The link between education and health

A well-proven link

Education has a significant impact on the health and well-being of children and young people throughout childhood, adolescence and into adulthood. A broad-based education and positive experience of school equips young people with the skills, knowledge and aspiration they need to achieve a healthy and happy life. Low educational attainment is a key determinant of inequalities in health because it influences socio-economic status, employment, income, housing and other psycho-social factors.

Education in Haringey

Schools in Haringey experience high mobility, with a large number of new arrivals that include refugees, asylum seekers and economic migrants from overseas, internal migrants (those from within the UK, including, for example, Roma, Gypsy and Traveller children) and unaccompanied asylum seeking children. New arrivals have varying needs depending on their previous schooling and individual circumstances. While many experience a smooth integration into the UK schooling system, some have greater needs and challenges to overcome. Some new arrivals have a fractured educational history or no previous schooling and experience cultural disorientation and feelings of loss and isolation. They may also be recovering from shock or trauma, be living with parents experiencing emotional difficulties or be experiencing changes in their family situation, including separation from one or both parents.[21]

Many new arrivals have English as an Additional Language (EAL) or are new to the English language when they arrive in the UK. This presents interesting challenges and opportunities for Haringey schools, which are embracing the multi-cultural and diverse populations that they serve. The number of different languages spoken by children in Haringey schools has been estimated at 175.

Haringey holds very limited information on the educational performance of new arrivals because it is difficult to collect this data. The school census information on pupils enrolled in Haringey schools records ethnicity only and does not distinguish refugee or asylum seeking status or length of time in the UK. Data is held on Roma, Gypsy and Traveller children. However, this does not always provide an accurate picture because parents/carers may not disclose this information.

There is often considerable school mobility among migrants arriving in the UK, as well as among internal migrants. There is evidence that school mobility influences educational performance in Haringey as there was a substantial difference in attainment for reading, writing and mathematics at Key Stage One between pupils who had been at their school for more than two years and those who had been there less than two years.[22] At the end of primary school, 20% of pupils had been in their school for less than three years prior to taking their School Attainment Tests (SATs). The attainment of these pupils was significantly below that of other pupils.[23]

In terms of ethnicity, there continues to be differences in attainment between White British pupils and pupils from other large ethnic groups in Haringey primary schools. In 2007, Haringey African pupils were 1% below their national peers, Caribbean pupils were 3% below and White UK pupils were 8% above their national peers. The educational performance of most minority ethnic pupils for the older age groups has improved considerably and the gap in attainment of five or more A* to C grades at GCSE has decreased.

NHS Haringey

Key messages:

- Experiences in early childhood are crucial to health outcomes in later life.
- There is a strong link between educational achievement and health. Pupils from certain Black and Minority Ethnic groups have lower educational attainment than White British pupils.
- The number of low birth weight babies, a proxy indicator for infant mortality, is higher in the deprived wards in the east of the borough.
- Antenatal care is important for the health of the mother and child. Some Black and Minority Ethnic groups are more likely to present late for antenatal care.
- National data indicates that rates of teenage motherhood are significantly higher among women of Mixed White and Black Caribbean, Other Black and Black Caribbean ethnicity.
- Black African and Caribbean and Other Black groups, mixed race White and Black groups and Bangladeshi, Pakistani, White Other and White Irish groups are more at risk of childhood obesity. However, this may be due to deprivation rather than ethnicity.
- New integrated service models, such as children's centres, are proving effective at offering services to hard-to-reach communities.

4 Establishing a healthy start in life

Figure 9 shows that although there has been an improvement in educational attainment across the board and that this improvement has been significant among the major ethnic groups in Haringey, it is still clear that those from minority ethnic groups continue to have lower educational attainment than White British pupils.

Haringey Children and Young People's Service is committed to providing excellence in education for all their learners and overcoming any barriers to learning. Haringey participates in government strategies and schemes to improve achievement of diverse groups, including Making a Big Difference, New Arrivals Excellence Programme, Ethnic Minority Achievement Programme and Gypsy, Roma and Traveller support programmes.

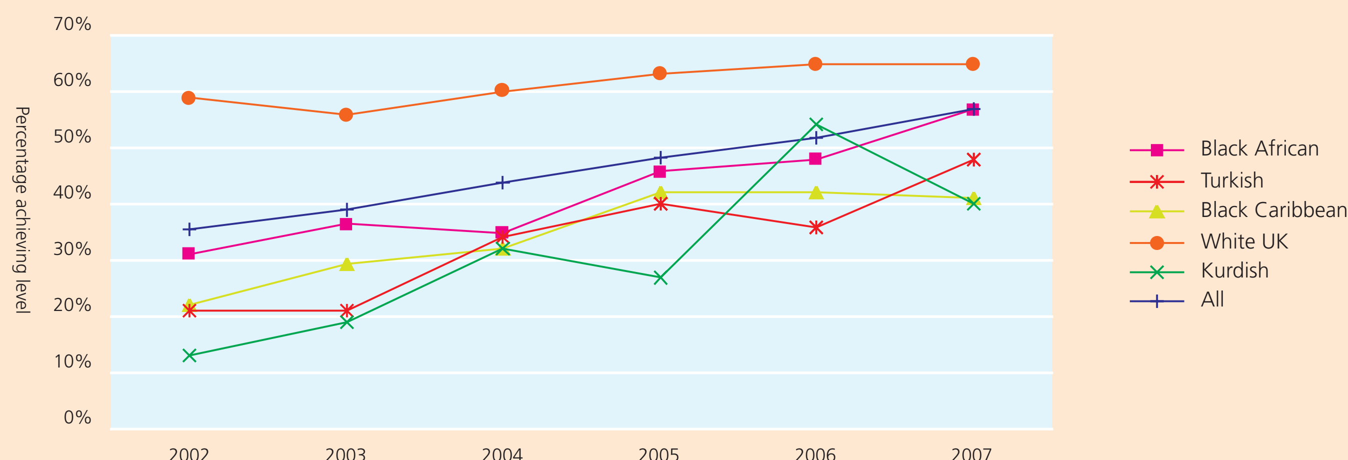
4.3. Infant and child mortality

An important indicator of health inequalities

Infant mortality, defined as deaths in children under one year old, is a sensitive measure of the overall health of a population. It reflects the apparent association between the causes of infant mortality and other factors that are likely to influence the health status of whole populations, such as their economic development, general living conditions, social well-being, rates of illness and the quality of the environment. The government has made infant mortality a priority in its tackling health inequalities strategy. The infant mortality element of the target is:

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.*

Figure 9: Percentage of children obtaining 5 Grade A to Cs at GCSE, 2007



Source: Office for National Statistics

* The routine and manual group includes those in lower supervisory and technical, semi-routine and routine occupations. Typical examples might be porters, cleaners, bar staff, waiters/waitresses, sales assistants, catering assistants, train drivers, people working in call centres, electricians and sewing machinists.

Infant and child mortality in Haringey

While the infant mortality rate (IMR) for England is at an all-time low, rates in Haringey are significantly higher than those for England and London. Table 5 compares the infant mortality rate in Haringey with those for England and London.

Table 5: Infant mortality rates, 2005–2007

	England	London	Haringey (Rate and number)
Under 1 year	4.9	4.8	6.1 (75)
Neonatal (infant deaths under 28 days per 1,000 live births)	3.4	3.3	4.5 (55)
Deaths under 7 days (per 1,000 total births)	2.6	2.5	3.3 (41)
Stillbirths	5.3	6.2	6.1 (76)

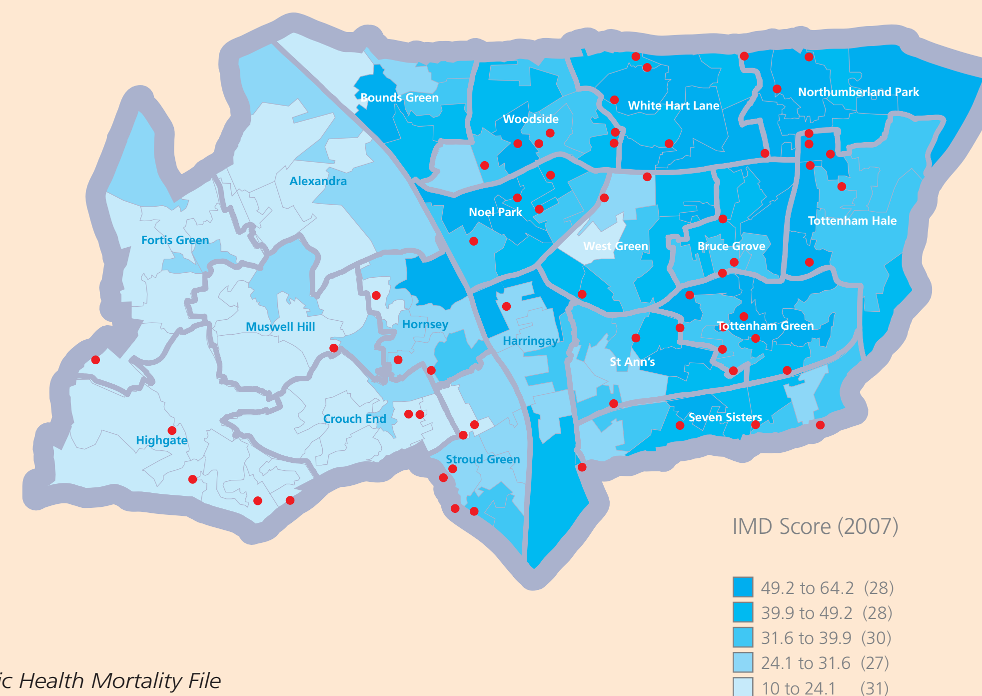
Source: National Centre for Health Outcomes Development (NCHOD)

The Department of Health Review of Health Inequalities in Infant Mortality highlighted inequalities in infant deaths among women in Black and Minority Ethnic groups.[24] This is because some Black and Minority Ethnic groups, including Pakistani, Bangladeshi, Black Caribbean and Black African families, are at particular risk of poverty and socio-economic disadvantage.

Clearly, ethnicity may be an important factor in infant mortality. However, numbers are too small at a local level to enable meaningful analysis. Nationally, the IMR in babies of mothers born in Pakistan was 10.2 per 1,000 live births in 2002–2004, double the overall IMR (4.9 per 1,000 live births in 2002–2004) for all babies born in England and Wales. The IMR in babies of mothers born in the Caribbean was 8.3 per 1,000 live births in 2002–2004, 63% higher than the national average. In London, deaths in the first year of life are more common among infants born to mothers who were born outside England and Wales, a rate of 5.9 per 1,000 in London, and as high as 10.9 in births to mothers born in West Africa.[25]

In Haringey between 2005 and 2007, local records based on Public Health Mortality Files identified 70 deaths, which are described in Figure 10.

Figure 10: Distribution of infant deaths in Haringey (under one year), 2005–2007



Source: Public Health Mortality File

4 Establishing a healthy start in life

The highest numbers of deaths were in Tottenham Green (10) and White Hart Lane (8). There were no reported deaths in Alexandra or Bounds Green wards. Analysis over a three-year period shows that the infant mortality rate is higher in wards in the east of Haringey. However, as the numbers are small it is not possible to ascertain a clear pattern across the borough. There was a higher proportion of male deaths, 61% (43), which is consistent with national figures. Prematurity-related conditions (57%) and congenital anomalies (16%) account for the highest numbers of deaths.

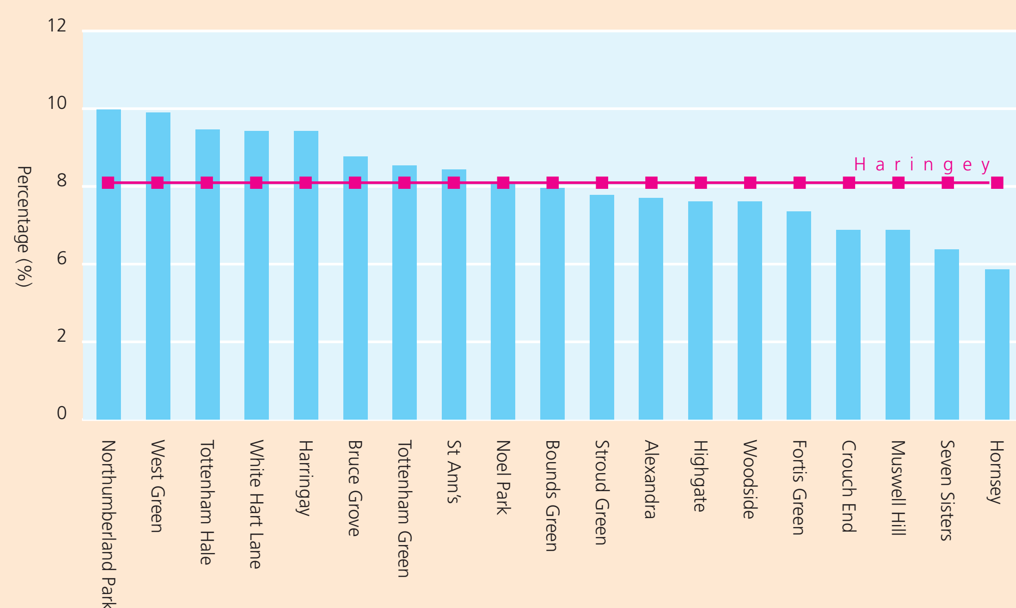
Between 2005 and 2007, there were 40 deaths in neonates (children under 7 days old) in Haringey, 13 between 7 and 28 days and 17 over 28 days. Compared to figures for England, Haringey has a slightly higher proportion of deaths under 7 days and between 7 and 28 days, but a lower proportion over 28 days.

The main cause of death for neonates (under 7 days) is prematurity-related conditions (68%) and congenital anomalies (15%). National data suggests that 75% of deaths among neonates are caused by prematurity-related conditions and congenital anomalies, suggesting that Haringey has a higher number of deaths from these causes than expected.

The main causes of death for those aged between 7 and 28 days is prematurity (62%). In those over 28 days, prematurity and infection are the main causes, both 29%.

It has been a legal requirement since April 2008 for the circumstances surrounding the death of any child resident in the borough to be reviewed. Haringey's Local Safeguarding Children Board established a Child Death Overview Panel in March 2008. The Child Death Overview Panel also considers the outcome of post-mortems and information gathered in Confidential Enquiry into Maternal and Child Health reports, in coming to a collective view as to whether or not a child's death might have been preventable.

Figure 11: Low birth weight by ward, 2005–2007



Source: Public Health Birth Files

The Annual Report of the Child Death Overview Panel identified that 25 Haringey children died between April 2008 and March 2009.[26] Of these, 19 were less than one year old and only six were older. Nine were less than one week old, 10 less than 28 days (40%). The overwhelming number of deaths were related to perinatal or congenital factors.

In the 2001 census, of the 0 to 15-year-olds in Haringey, 51.5% were White, 10.3% were Black Caribbean and 15.4% were Black African. This contrasts with the deaths reported, of which 8 out of 21 (38%) were Black African, 4 out of 21 (19%) were Black Caribbean and only 8 out of 21 (38%) were White.

Low birth weight

As numbers of infant deaths are small, there are fluctuations in the rate year on year which make it difficult to see longer-term patterns. Birth weight is, therefore, often used as a proxy measure for infant mortality. The graph given in Figure 11 describes the difference in low birth weight rates between wards. All of the wards in the east of the borough, with the exception of Seven Sisters, had the highest proportion of low birth weight babies born between 2005 and 2007.

4.4. Antenatal care

The importance of antenatal care

As more is known about foetal and infant development, the importance of booking early for antenatal care as an early intervention and prevention tool has become very clear. In addition, maternity services acknowledge the importance of addressing the needs of women and their partners before the woman becomes pregnant, as well as throughout pregnancy and childbirth.[28] Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies and on their future development.

However, around 16% of all pregnant women, including many of those under 18 years of age, delay seeking maternity care until they are five or more months pregnant, thus missing the crucial early days of maternity care. These women and their babies have worse outcomes than those who access maternity care at an earlier stage of their pregnancy.[29]

A new approach to health and well-being

In Haringey, wards with the highest numbers of low birth weight babies are being prioritised for local workshops for professionals who work directly with families. These meetings aim to raise awareness of the causes and risk factors for infant mortality and to develop practical strategies to address some of these issues with local families. This is in line with the Department of Health recommendation that local areas should raise awareness of the infant mortality target with local professionals.[27]

Haringey has also developed a local Infant Mortality Action Plan, which details specific actions to reduce infant mortality under the following headings:

- Strengthening local delivery.
- Teenage pregnancy.
- Smoking cessation.
- Antenatal care.
- Postnatal care.
- Improving housing quality and reducing overcrowding.
- Reducing child poverty.

4 Establishing a healthy start in life

The NHS has developed a target for early antenatal booking. This aims to have 80% of women presenting to maternity services receiving a full assessment by 12 weeks 6 days of pregnancy by the end of 2009/10 and 90% in 2010/11. Latest quarterly figures (January to March 2009) show that 53% of women in Haringey booked for antenatal care before 12 weeks 6 days. Achieving 80% by the end of 2009/10 is, therefore, a challenging target for Haringey.

Which groups tend to present late for antenatal care?

The London Health Observatory analysed the distribution of risk factors for infant mortality across North East London in 2004/05, identifying ethnic groups at higher risk of late booking. For North East London, the ethnic groups with the highest proportion of deliveries coded with gestational age who booked early (less than 12 weeks gestation at first antenatal booking) in 2004/05 were Bangladeshi, Irish White and White and Asian (mixed). The ethnic groups with the highest proportion of late booking (over 20 weeks) are predominately the Black ethnic groups, White and Black African (mixed) and African and Other Black, as well as the 'not known' category.

There is a much higher risk of infant death among babies born to women who were themselves born in high risk countries. In London, this means that women born in East or West Africa and the Caribbean make up the groups that tend to present late for antenatal care.[30] Therefore, influencing early access to effective antenatal care for these groups is vital.

In addition to the London Health Observatory analysis, national surveys indicate that, as a whole, women from Black and Minority Ethnic groups are more likely to book late for antenatal care, less likely to receive antenatal care regularly and therefore receive fewer antenatal check-ups. Evidence also suggests that some women from minority ethnic groups are less likely to have dating or anomaly scans and to be offered or to undertake screening.

Issues of mobility also impact on accessing antenatal care. In particular, Gypsy and Traveller women and recent migrants are often forced to move home during pregnancy or shortly after delivery, with potentially serious implications for their own and their babies' health.

The Confidential Enquiry into Maternal and Child Health Report[31] highlights that women who have recently arrived in the UK, whatever their immigration status, bring new challenges for maternity services. The key issues include poor overall health status and underlying and possible unrecognised medical conditions. Some women have also suffered the consequences of genital mutilation, while others experience the trauma of fleeing war-torn countries and pregnancy as a result of rape. Services therefore need to be flexible and sensitive to meet the needs of a mobile and potentially traumatised population.

Why some groups tend to present late for antenatal care

In order to understand the reasons why women book late for antenatal care, NHS Haringey commissioned a social marketing project to gather the evidence on this issue. The key barriers to early booking identified among local women are:

- A lack of understanding as to why early access to maternity services is important.
- Women not finding out they were pregnant until after 12 weeks 6 days.
- Limited capacity of services, resulting in booking in after 12 weeks 6 days.
- Communication difficulties between services – for example, between GP and hospital – resulting in delays.
- Previous negative views of health services.
- Language barriers.
- Transience of population – that is, moving between boroughs during pregnancy.

An action plan to address these barriers is in development. NHS Haringey has also recently recruited a Consultant Midwife in Public Health based at the North Middlesex Hospital to lead on promoting early access to maternity services.

Female genital cutting or mutilation

Women who have undergone female genital mutilation are significantly more likely to experience difficulties during childbirth and their babies are more likely to die as a result of the practice.[32] Complications include the need to have a caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalisation following the birth.

According to the World Health Organization, female genital mutilation is a common practice in a number of countries around the world, and over 100 million women and girls are estimated to have experienced female genital mutilation. It is illegal to perform female genital mutilation in the UK. However, due to increasing migration from countries where this practice is common, it is likely that the prevalence of female genital mutilation among the pregnant population in the UK is increasing. As female genital mutilation can affect women's pregnancies in a number of ways, it is important that maternity services respond with appropriate education and training for staff.

4.5. Childhood immunisation

A very effective medical intervention

Mass immunisation is widely acknowledged as being one of the most effective medical interventions to minimise infectious diseases.

A new approach to health and well-being

Developing maternity services in easily accessible and visible community facilities, such as Sure Start Children's Centres, is one way to engage with the most vulnerable families, especially in disadvantaged areas. By linking maternity services to the other types of care provided in children's centres, families will be able to access a whole range of other services that provide the valuable support and advice which both parents may need before and after their baby is born. Antenatal care is provided from most children's centres in Haringey ensuring easier access for vulnerable populations. Children's centre outreach workers are the key to reaching families that would not normally access mainstream services. Haringey is currently producing an outreach strategy that will embed outreach support in children's centres.

4 Establishing a healthy start in life

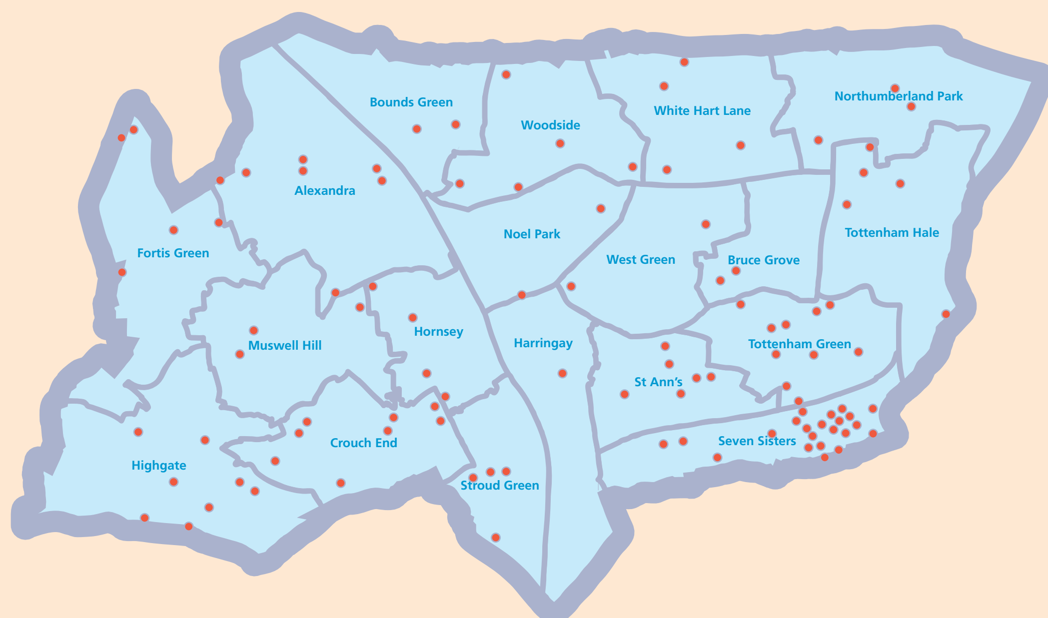
Immunisation works at two levels. Firstly, on the individual level the vaccine helps protects the person from the specific disease. Secondly, and possibly of more significance to public health, it reduces the incidence of the disease in the community. The latter relies on a high coverage of vaccine uptake across the population. The percentage of coverage required depends on the relative infectiousness of the particular disease and population mixing, but in general requires at least 90% or more of the population to receive the vaccine. Because of the importance of high coverage, every effort is made at the national and local level to ensure that the uptake is high and that immunisation services are equally accessible to all segments of the community.

But one that is not always used

There is some evidence to show that immunisation rates are lower in disadvantaged groups,[33] although the reasons for this are complex and due to a range of factors including large family size, cultural and religious beliefs and single parenthood.[34] However, children whose mothers are older and more highly educated have also been shown to be more likely to be unimmunised in comparison.[35]

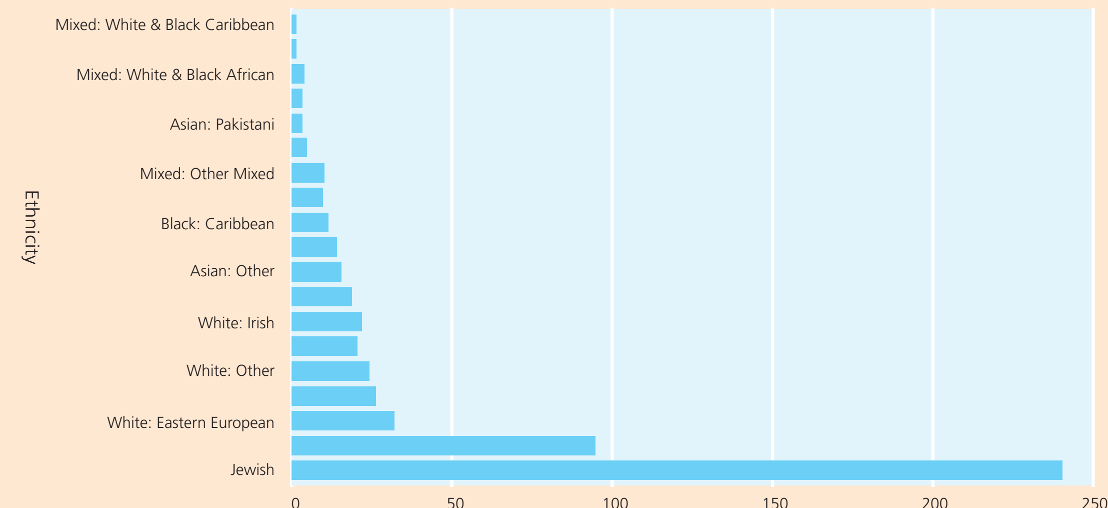
The relationship between ethnicity and vaccine uptake is complex in some cultures. It is possible that, where there are language barriers and therefore minimal access to mass media controversies, parents are more likely to trust health professionals and not be unduly influenced by outside pressure.[36] For other groups, media controversy can exacerbate fears, language barriers may mean that messages from health professionals are not fully understood and any beliefs about immunisation can prove difficult to change. The evidence suggests that different approaches are required to tackle immunisation uptake and ensure that services are provided to meet a wide range of needs.

Figure 12: Haringey measles cases from 21 May 2007 to 27 March 2009, by ward



Source: Health Protection Agency, April 2009

Figure 13: Measles cases in NE London from 21 May 2007 to 14 December 2008, by ethnicity



Source: Health Protection Agency, April 2009

In Haringey there have been ongoing problems collating data on immunisations due to the child health computer system that is currently being updated. Extensive work is underway to address this issue and preliminary immunisation data will be available for 2009/2010.

Measles vaccination

The number of measles cases is an indicator of whether vaccine coverage is sufficiently high. The rates of measles cases are fairly evenly spread across the borough as the map showing cases as red dots in Figure 12 indicates.

A small cluster of measles cases in the Seven Sisters area was predominantly within the orthodox Jewish community where there are well-recognised problems with access to services due to a range of cultural factors, large family size and close communities, with some distrust of wider healthcare provision.[37] This would mimic wider North East London data indicated in Figure 13, which shows that the Jewish communities have the highest incidence of measles cases that are most likely to be a result of low immunisation uptake.

Human Papilloma Virus vaccination

The new Human Papilloma Virus (HPV) vaccine was introduced in September 2008 to prevent development of cervical cancer. It has been offered in all Haringey schools to girls aged 12–13 years. Clinics were also held during evenings to offer immunisation to those who were not in school. For the routine cohort of girls aged 12–13 years, in school Year 8, the uptake is around 81%. This high uptake was achieved primarily due to the hard work of the school nursing service and the support of all the schools. The uptake of HPV immunisation has been examined according to the ethnic mix in each local school that participated in the programme. This suggests a slightly higher uptake among the White British population. However, the breakdown of the uptake figures for each school involves relatively small numbers and, therefore, does not allow for a robust analysis.

Although we know there are a number of factors that influence immunisation uptake, there is not much research analysing the uptake for HPV vaccine specifically. However, the initial trial for the vaccine implementation in Manchester suggested a lower uptake in schools with a higher proportion of girls from minority ethnic backgrounds.[38] Other factors, such as socio-demographic factors were also found to be important, as well as parents' beliefs on the safety, or otherwise, of the vaccine. Anecdotal reports from the local campaign would agree with this. It is therefore not possible to assume that the variation in the uptake is due to ethnicity alone.

4 Establishing a healthy start in life

Over 2009/10 and 2010/11 all those eligible under the national catch-up are being offered the vaccine either in school or at community clinics. Across London and nationally there is a drive to improve the data we have on immunisation and to ensure that we adopt a comprehensive approach to data collection. As part of this drive, NHS Haringey is moving all records to the new Rio system, which will greatly improve the way in which we can collect and analyse our immunisation uptake and the service we provide. This system may enable us to collect data systematically on ethnicity and other socio-demographic details.

4.6. Teenage pregnancy

Why teenage pregnancy rates matter

While individual young people can be good and competent parents, the evidence suggests that, generally, children born to teenagers are much more likely to experience a range of negative outcomes in later life. Having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Children born to teenage parents are also much more likely to become teenage parents themselves.

Women from some ethnic groups are more likely to become teenage mothers

There is evidence that suggests that young people from some ethnic groups are much more or less likely than others to experience teenage pregnancy, even after taking account of the effects of deprivation. For example, teenage pregnancy rates vary dramatically between London boroughs with a similar level of deprivation, but a different ethnic composition. In some instances, a borough's rate is double that of a similarly deprived borough with a different ethnic make-up.[39]

Data on mothers giving birth under the age of 19, identified from the 2001 census, show that rates of teenage motherhood are significantly higher among mothers of Mixed White and Black Caribbean, Other Black and Black Caribbean ethnicity. White British mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented.

Girls and young women of Black and Black British ethnicity are also over-represented among women aged under 18 undergoing abortions. In 2004, Black ethnic groups (which represent around 3% of all females aged 15–17) accounted for 9% of women aged under 18 undergoing abortions, and in London, which has high rates of repeat abortion, 43% of all women aged under 18 undergoing abortions following a previous pregnancy were young women from Black ethnic groups.

Variations between ethnic groups in sexual activity and contraceptive use suggest that the higher rates of teenage pregnancy among some ethnic groups are at least partly attributable to differences in behaviours and attitudes, and not simply a result of deprivation. A survey of adolescents in East London[40] showed the proportion having first sex aged under 16 was far higher among Black Caribbean men (56%), compared to 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, around 30% of both White and Black Caribbean groups had sex aged under 16, compared to 12% for Black African and less than 3% for Indian and Pakistani women.

Teenage pregnancies in Haringey

The conception rate among women aged under 18 in Haringey fell from 80.2 per 1,000 in 2002 to 63.7 per 1,000 in 2005. The annual rates for 2005 and 2006 were the same, with a small decrease in actual numbers of conceptions. The provisional annual rate for 2007 has seen a rise to 70 per 1,000 (an increase of 12 actual conceptions), but the most recent Office for National Statistics data for the first quarter of 2008 has shown a significant decrease to 52 per 1,000, with the lowest actual numbers of conceptions (45) since the national Teenage Pregnancy Strategy was published in 1999. The rolling quarterly average is now 67.8 per 1,000. Our 2007 rate also shows that 65% of conceptions among women aged under 18 led to abortion.

Teenage Pregnancy Monitoring

A teenage pregnancy conception data monitoring scorecard is being developed to support analysis using age, ethnicity, ward, etc. Initial analysis suggests 'hotspot' wards/postcodes, notably N17, N15 and N22. Ethnicity data sets suggest more clarity/breakdown is needed.

4.7. Childhood obesity

A growing health problem

There has been a steady rise in obesity rates among adults and children over the last two decades, with now one-third of children being either overweight or obese in England. Children who are obese are at greater risk of developing health problems in childhood as well as becoming obese adults, who are at greater risk of a lower life expectancy.

Obesity is associated with an increased risk of cardiovascular disease, diabetes, stroke and cancer, as well as psychological problems such as low self-esteem, lack of confidence, depression, stigma and discrimination. Causes of childhood overweight and obesity are linked to over-consumption of energy-dense food and drinks and reduced levels of physical activity.[41]

A new approach to health and well-being

NHS Haringey is working in partnership with other local organisations and young people themselves to undertake awareness-raising initiatives targeted at specific groups. These include:

- A Sex and Relationships Education (SRE) booklet for Turkish-speaking young men and women.
- A targeted publication made with and for Leaving Care and Asylum Team clients.
- A targeted fortnightly 4YP Nurse session at the Leaving Care and Asylum Team Compton Road Site, providing advice and guidance on sexual health and the full range of contraception and referrals to other relevant services. Targeted 4YP Youth Worker-led group sessions have also been run on sex and relationships for Afghani, Albanian and Turkish Sorani male clients.
- Accredited SRE/Speakeasy training has been provided for the Leaving Care and Asylum Team. This training is aimed at equipping parents and professionals with the skills to talk to young people about sex and relationships.

4 Establishing a healthy start in life

In view of the serious negative impact of obesity on health and well-being, the government has set an ambitious target to reduce the proportion of overweight and obese children to 2000 levels by 2020.[42] Haringey has also identified childhood obesity as a local public health priority in its Local Area Agreement.

Trends in childhood obesity in Haringey

In Haringey, results of the 2008 annual National Child Measurement Programme show high rates of children at risk of obesity (23.2%) in the 10–11 age group (Year 6). This is above both the London average (21.6%) and the England average (18.3%). The prevalence of children at risk of obesity in the 4–5 age group (Reception Year) was 10%, which is comparable to the London and England average.

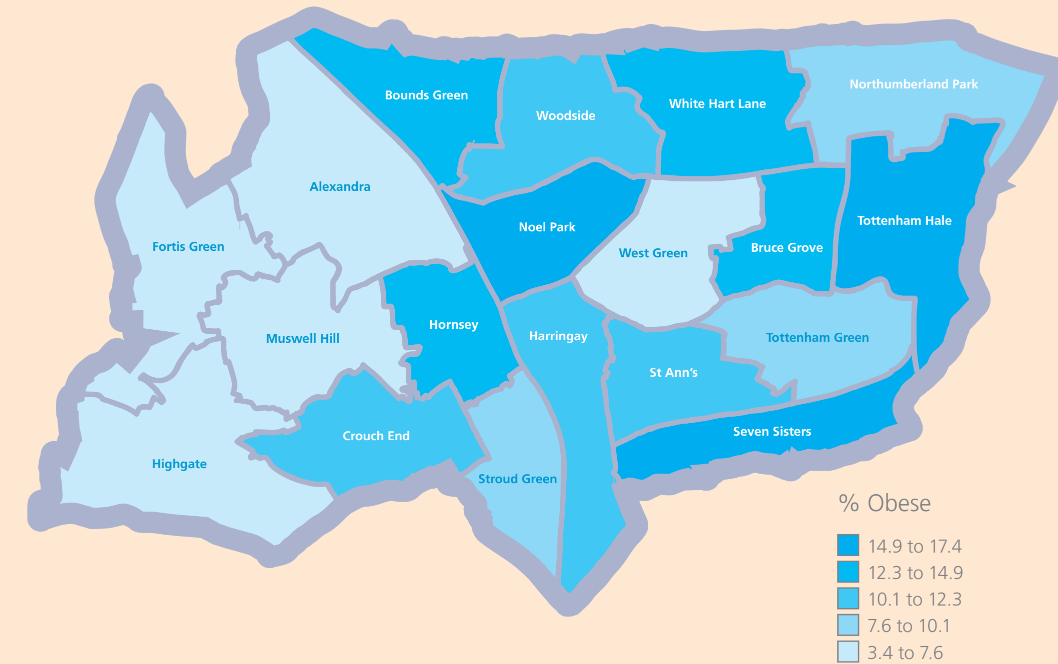
Further analysis of the child growth patterns across England and London revealed differences between ethnic groups. The largest prevalence of those at risk of obesity was found in the Black African and Caribbean and Other Black groups in addition to the mixed race White and Black groups. There was also a higher proportion of children at risk of obesity in the Bangladeshi, Pakistani, White Other and White Irish categories. Children in the White British, White and Asian, Indian and Chinese categories had significantly lower rates of risk of obesity.[43]

The overall prevalence of children at risk of obesity is significantly higher across London compared to England. This is linked to the far greater numbers of children of Black ethnic origin who were shown to have significantly higher Body Mass Index (BMI) than other ethnic groups. The reason for differences in child growth patterns between ethnic groups is unclear and may be due to biological differences or other confounding factors.[44] The weight status classifications of overweight and obese are based on the UK90 child growth reference chart, which in turn is based on a sample of White British children. Therefore, this does not account appropriately for differences in height and build in other ethnic groups. When accounting for other variables and differences in height between ethnic groups, it was found that children from Black African and Caribbean ethnic groups had no significant differences in the likelihood of being classified as overweight or obese from the White British group. Haringey has a high population of children of Black ethnic origin, which may disproportionately affect the rate of children defined as at risk of obesity. Further investigation of ethnicity as a factor in determination of child obesity is needed.

Deprivation is also strongly linked to prevalence of obesity. The risk of obesity in the most deprived group was almost double that of the least deprived group for reception age children in London, and for Year 6 children the risk was almost two-thirds greater in the most deprived compared to the least deprived groups. This relationship is also strongly linked to the high proportion of minority ethnic groups who live in areas of high deprivation. When these confounding influences were accounted for, it was revealed that deprivation is a stronger indicator of the risk of obesity, whereas ethnicity differences are more likely to do with body composition, in particular height.

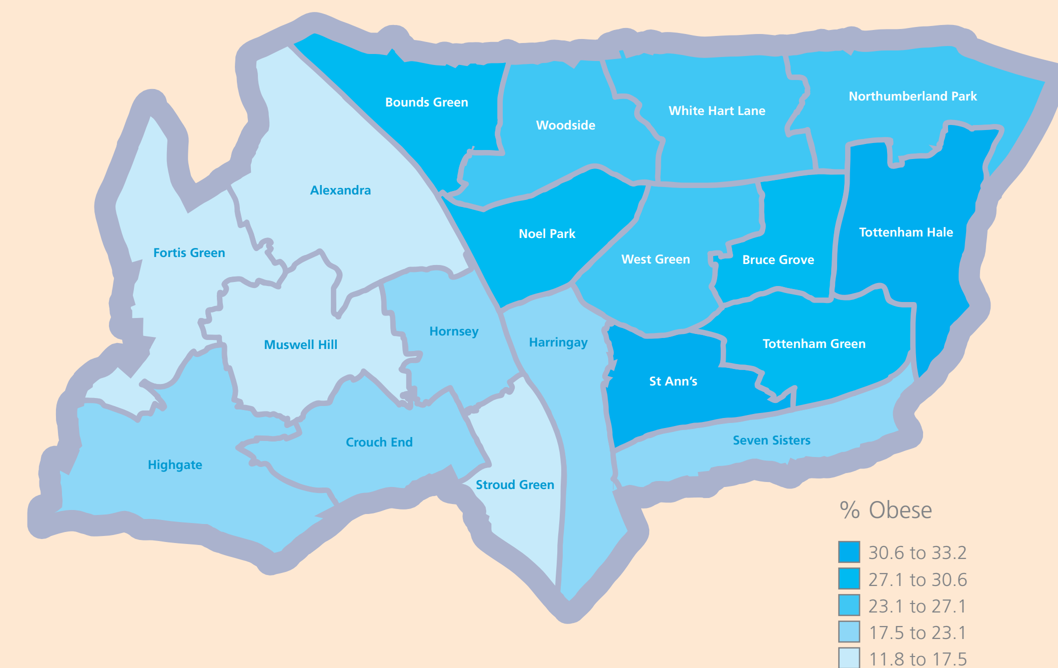
* The weight status classifications used in this data analysis are indicators only of the potential risk of obesity, overweight or underweight rather than a clinical defined diagnosis. The classification is based on calculation of BMI using the height and weight and then comparison against the UK90 child growth charts.

Figure 14: Obesity in Reception Year children, by ward, 2008



Source: National Child Measurement Programme

Figure 15: Obesity in Year 6 children, by ward, 2008



Source: National Child Measurement Programme

Therefore, for Haringey's migrant and Black and Minority Ethnic population there may be a greater risk of child obesity due to low socio-economic status and living in areas of deprivation. The maps given in Figures 14 and 15 show ward level data that reveals significantly higher rates of those at risk of obesity in the more deprived east of Haringey compared to the less deprived wards in the west.

NHS Haringey recently commissioned a social marketing research study, focusing on families in the east of Haringey, to provide insight into the social, psychological and environmental factors that may contribute to child obesity. The research revealed that families from minority ethnic groups tended to have more control over what their children ate and were generally more likely to prepare fresh home-cooked meals, although they had less awareness of dietary considerations, such as portion sizes and levels of fat, sugar and salt consumed. The assumption was that traditional home-cooking is always the healthy option regardless of amount and content of what is being eaten.

Some Black and Minority Ethnic families also placed less importance on sport and physical activity compared to study and religious practice, seeing it as an optional extra. Parents generally had low awareness of the need and importance of exercise for their children. Research also reveals that many parents/carers do not identify their children as being at risk of obesity or associate potential health problems of child overweight and obesity as applying to their children.[45]
There is a misconception, particularly among some minority ethnic groups, that parents perceive overweight as desirable, being an indication of health and prosperity.[46]

4.8. Children's centres

An integrated approach to service delivery

Children's centres provide multi-agency services that are flexible and meet the needs of young children and their families. Children's centres offer integrated early learning, care, family support, health services, outreach services to children and families not attending the centre and access to training and employment advice. High quality learning and childcare are central to the role of children's centres.

Children's centres play a crucial role in improving outcomes for all young children and in reducing inequalities in outcomes between the most disadvantaged children and the rest. Children's centres also have a key role in promoting social cohesion and fostering positive relationships within their community.

Parents from minority ethnic groups generally want the same range of services from children's centres as other parents, but may require a different model of support or delivery in order to access them.

Sure Start Children's Centre Practice Guidance[47] states that in order to ensure that services are responsive, the manner in which services are delivered in children's centres should be tailored to families' particular needs, in terms of timing, venue, language, faith and culture.
Play equipment, resources, books and activities should reflect the background of different communities, and positive images of minority ethnic groups should be displayed prominently.

Evaluations suggest that the greatest barrier towards inclusion in children's centre services for Black and Minority Ethnic and migrant communities is the lack of English proficiency. Children's centres try to overcome this by employing a greater number of multi-lingual staff or outreach workers, in order to enable effective targeting and to support initial contact with families.

Children's centres seek to build a relationship of trust with minority ethnic communities so that families feel that they know about and can access services. An outreach strategy is currently in development in Haringey, which will embed outreach provision within children's centres.

Where are we now?

There are 17 children's centres in Haringey, offering a range of services to families with young children, including stay and play sessions, workshops on parenting, healthcare support and information on childcare.
Further information for families can be found at www.haringey.gov.uk/fisd.

A new approach to health and well-being

Broadwater Farm Children's Centre runs a successful Polish Group. The group was initiated by the Polish family support worker. The Polish parents then asked whether they could continue to run the group by themselves with the help of Centre staff. The group started with six parents and has since doubled due to effective communication within the Polish community, many of whom are now accessing other Children's Centre services. The group meets to discuss particular topics, ranging from safety in the home to nutrition. For further information contact: Salma Douik, Information Officer, on 020 8885 8800.

Park Lane Children's Centre has, over the last two years, seen an increase in the number of Polish, Somalian and Romanian women accessing services. This increase is due largely to the provision of antenatal and postnatal services at the Centre, run by the Community Midwives from North Middlesex and Whittington Hospitals. For further information, contact Marlene D'Aguilar, Deputy Head of Centre, on 020 8489 4945.

Sonia Blake, Midwife Team Leader, North Middlesex Hospital, says:

"Working within Park Lane Children's Centre has made a difference in our approach and the means of delivering antenatal and postnatal care to our women. Our aim is to be able to reach families that we may not otherwise reach and reduce our waiting time at appointments."

5 Accessing health services

5.1. Mental health

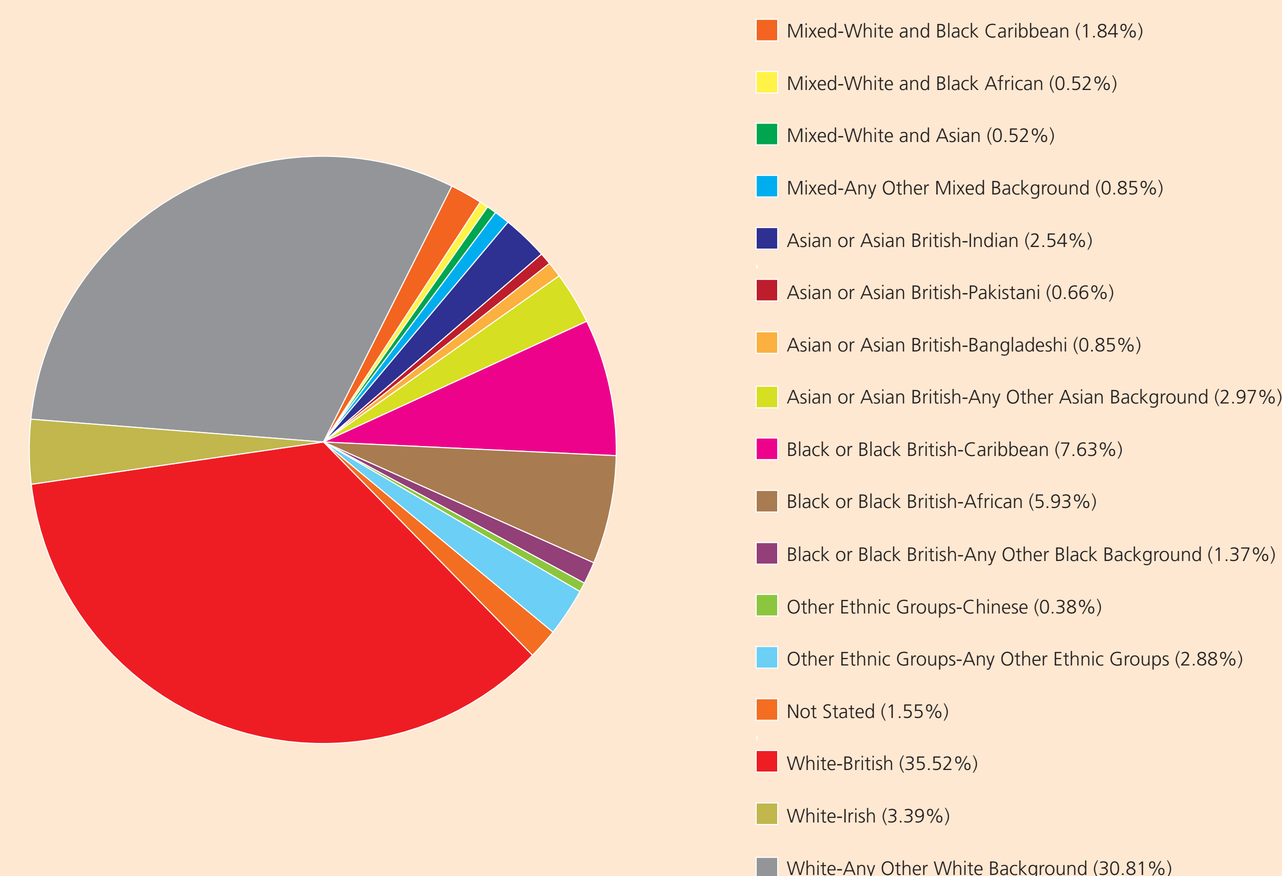
The scale of the problem

Mental health needs are high in Haringey. It is estimated that 28,757 people aged between 16 and 74 years are living with common mental health conditions in the borough.[48] This number is probably significantly underestimated because some people suffering mental health problems do not seek help. Many of the factors that can increase mental health problems, such as high levels of deprivation, unemployment, poor housing and homelessness, are prevalent among our population and in particular among migrants and Black and Minority Ethnic groups.

Some groups have higher rates of mental health problems than others

People from some Black and Minority Ethnic groups are more likely than others to suffer from mental health problems. An estimated 22% of people committing suicide in Haringey in 2006–07 were from Black and Minority Ethnic groups, although this proportion is likely to be even higher as ethnicity was identified only for half of those committing suicide.

Figure 16: The variety of nationalities accessing IAPT therapy in Haringey



Source: Haringey IAPT Service

Key messages:

- Mental health needs are high in Haringey and people from some Black and Minority Ethnic groups are more likely than others to suffer from mental health problems.
- Screening for breast and cervical cancers reduces mortality, but women from some ethnic groups are less likely than others to use screening services.
- The majority of people suffering from tuberculosis come from Black and Minority Ethnic communities. Rates of tuberculosis have fallen over the last five years.
- Black Africans made up the highest number of new diagnoses of HIV in Haringey between 2004 and 2008. More White men and women were newly diagnosed with HIV between 2004 and 2008 than Black Caribbean, despite this ethnic group having higher estimated prevalence.

The patterns of mental ill health vary across different ethnic communities. It is estimated that between 25,000 and 30,000 refugees and asylum seekers live in Haringey. Refugees and asylum seekers are likely to have more mental health problems than native populations.[49 50] This group also has more complex mental health needs as a result of language and cultural issues and reasons for seeking asylum. Men from African and Caribbean backgrounds also have high levels of mental illness.[51]

Furthermore, mental health services are significantly under-used by Black and Minority Ethnic groups. Not only does this group of patients have difficulty accessing all health services, but there are particular issues related to stigma of mental health conditions that prevent them from seeking adequate treatment.
In a recent Haringey project among the Turkish and Kurdish communities, a healthcare worker stated: 'We have a large number of clients that complain of back aches, headaches, and digestion problems which have no physical causes'.[52] These patients are probably suffering from mixed anxiety and depressive disorder, or a generalised anxiety disorder, but often only recognise the physical symptoms.

Removing barriers to accessing mental health services

Improving Access to Psychological Therapies (IAPT) is a government initiative that has now been mainstreamed into primary care services in Haringey. It gives sufferers of mild mental health problems direct access to a mental health counsellor based in local GP practices in Haringey. This treatment is particularly good for mild anxiety and depression.

In Haringey a team of therapists provides face-to-face counselling. Figure 16 shows the variety of ethnic groups accessing the IAPT service through primary care. Sixty-five percent of the patients accessing the service are defined as 'White', which is broadly reflective of the population of Haringey. However, it does not reflect usage by people from Black and Minority Ethnic communities in line with the higher levels of mental health need. This indicates an ongoing level of unmet needs for mental health services among some ethnic groups.

Figure 17 shows the country of origin of those patients who access IAPT services. As can be seen from the figure, IAPT services are accessed by diverse local populations, suggesting that the provision of these services is equitable and culturally acceptable to local diverse communities.

Over 65% of patients access the IAPT service after discussing their mental health problems with

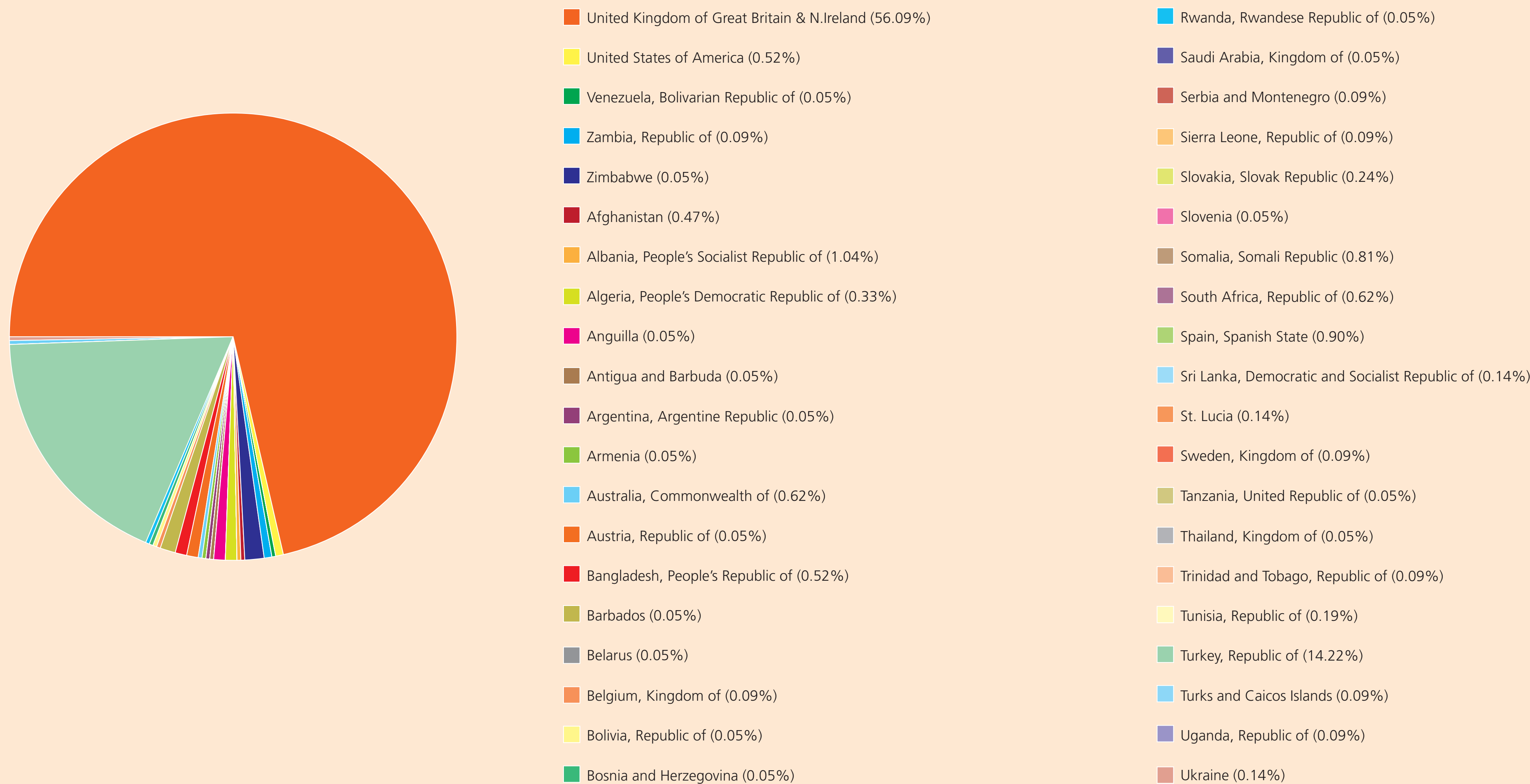
5 Accessing health services

their GP. However, there is a variety of other ways in which patients can access the service, including self-referral (25%) and referrals from hospitals and social care services, as shown by Figure 18.

Patients accessing the IAPT service come from all over Haringey. There is a slightly greater concentration of patients in the east of Haringey, which could be predicted as East Haringey has greater levels of deprivation and a more varied minority ethnic population, factors that are known to be associated with increased mental ill health.

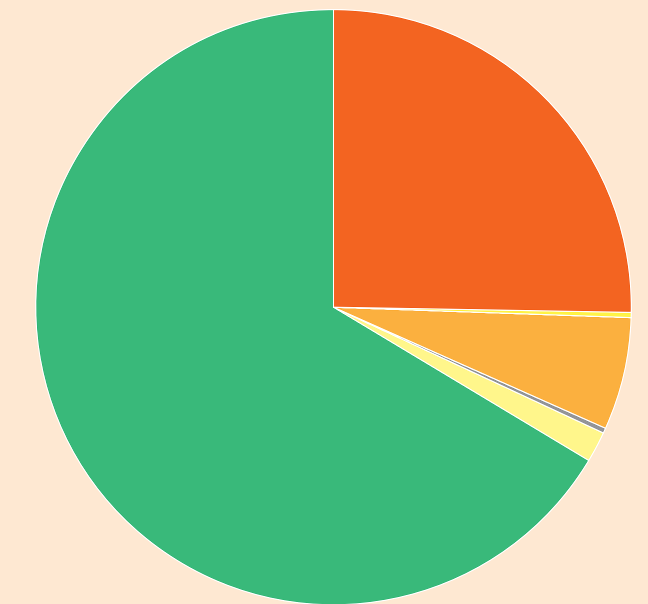
The Haringey IAPT service is accessible to and used by people from many different Black and Minority Ethnic groups. However, it is not clear that access to this service is sufficient to meet the existing unmet needs of the local population. The challenge for the coming year is to identify individuals and communities that either do not recognise their mental health problems or do not access the service due to stigma or other cultural barriers.

Figure 17: The countries of origin of patients accessing IAPT



Source: Haringey IAPT Service

Figure 18: Referral methods to IAPT services



Source: Haringey IAPT Service

- Self (25.20%)
- Local Authority Social Service (0.23%)
- A&E Department (0.09%)
- Employer (0%)
- Educational Service (0%)
- Police (0.03%)
- Other Clinical Speciality (6.04%)
- Carer (0.06%)
- Courts (0.03%)
- Probation Service (0%)
- High Security (0%)
- MediumSecurity (0%)
- Temporary Transfer from Mental Health Unit (0%)
- Permanent Transfer from Mental Health Unit (0.18%)
- Voluntary Sector Organisation (0%)
- Transfer by Graduation from Local Child and Adolescent MH Services (0%)
- Community/Practice Nurse/Health Visitor (0.91%)
- Job Centre Plus Manager (0%)
- Other (1.70%)
- General Medical Practitioner (65.54%)

5 Accessing health services

NHS Haringey

> “Once you retire from a professional job you need something to stimulate the brain, I am stretched! It keeps me fit and away from the doctor!”
>
> Time bank participant

CASE STUDY

A new approach to health and well-being

Case study: Demonstrating the impact of Time Bank on users and the community

Northumberland Park Time Bank rewards local people for helping others. For every hour a member spends helping someone else, they acquire an hour of ‘time credit’ in return, which they can ‘spend’ by asking for help themselves: for example, ironing, gardening, dog walking, washing a car, shopping, DIY, and so on. The principles behind Time Bank include recognition that everyone has assets and skills to share, encouraging reciprocity and exchange rather than dependency.

The Time Bank is open to all members of the Haringey community, irrespective of their age, gender, religion, or mental or physical disabilities. It has 73 individual members, comprising 51 women and 22 men. Of these members, about 77% are from Black and Minority Ethnic and other Non-British White groups.

The Time Bank is being managed by one part-time member of staff and a line manager. The organisation Groundwork is delivering the project with funding from Communities for Health.

In 2008 over 2000 hours were exchanged for activities such as caring, IT lessons, gardening, dog walking, hospital visiting, shopping and reflexology. Requests for help from Time Bank are growing and are becoming more diverse. Members are increasingly asking for help with transport for hospital appointments, shopping, gardening, DIY and simple decorating, simple home hairdressing, basic knowledge of domestic electrical equipment, IT skills, dance and exercise classes and massage and relaxation.

There is evidence that Time banks have beneficial effects on economic, social and human capital. They are known to be effective in moving people into training or employment; achieving something useful and doing more volunteering;[53] and attracting participation among the most deprived neighbourhoods and those least likely to be involved in traditional volunteering.[54] Other benefits that have been demonstrated include: increased self-esteem and confidence; the gaining of skills; growing social networks and building friendships; greater involvement in the community; meeting needs; overcoming social exclusion; and enabling active citizenship.

A recent assessment of the impacts of Northumberland Park Time Bank on the well-being of its members was reassuring. Northumberland Park Time Bank members reported that the service has improved their skills and attributes, as well as opportunities for self-help. It has positive impacts on their sense of belonging and it decreases isolation and improves communication.[55]

Other benefits identified by members include: building networks and trust in the community; increasing relaxation and enabling inter-generations of cultures; increasing feeling of involvement, confidence and inspiration; improving trust between members and the community. Members are feeling safer at home, and their isolation and anxiety has reduced.

> “I have been involved since the beginning in August 2008, it’s giving your own talents to those less fortunate. You need to use your own talents or you become miserable and it affects your own health.”
>
> Time bank participant

5.2. Screening

Why screening matters

Screening for cervical and breast cancer have been shown to be effective in reducing mortality. Cervical screening is one of the best ways of preventing cervical cancer as regular cervical screening can detect abnormalities in the cells of the cervix before cancer develops.[56] Women aged 25–64 are eligible for screening. All women from the age of 50 years are eligible for breast screening. Breast screening allows abnormalities in breast tissue to be detected before they are palpable by hand, therefore screening allows breast cancer to be diagnosed at an early stage and early detection improves the outcome for individuals.[57]

Who are not using screening services, and why

Although screening is very effective, some women do not use these services. NHS Haringey recognised the need to understand why.
We therefore started two projects to explore the factors that contribute to non-attendance for screening appointments so that an intervention could be developed to motivate those women to

5 Accessing health services

access screening. A social marketing approach was used for both projects.[58] This approach has been defined as 'the systematic application of marketing concepts and techniques to achieve specific behavioural goals relevant to a social good'. Behaviour change is a complex process. Social marketing seeks to understand what 'moves and motivates' people to change.

Various sources of data including census; NHS screening service data; profiles of Haringey's population's household make-up and socio-demographics, lifestyle, culture and behaviour; and ward maps were used to identify those women who had never attended screening or had not been screened in the previous five years. The research found that women who did not attend breast and cervical screening were resident predominantly in the more deprived wards of East Haringey. The results of the analysis according to group and ethnicity are outlined in Table 6. Barriers and motivations to attend screening were explored with women from the ethnic groups described in the table below and data obtained were analysed to identify any key differences in knowledge, attitudes and beliefs that might influence non-attendance.

Those women eligible, who had never attended or had not attended breast screening in the previous five years, reported the following range of views:[60]

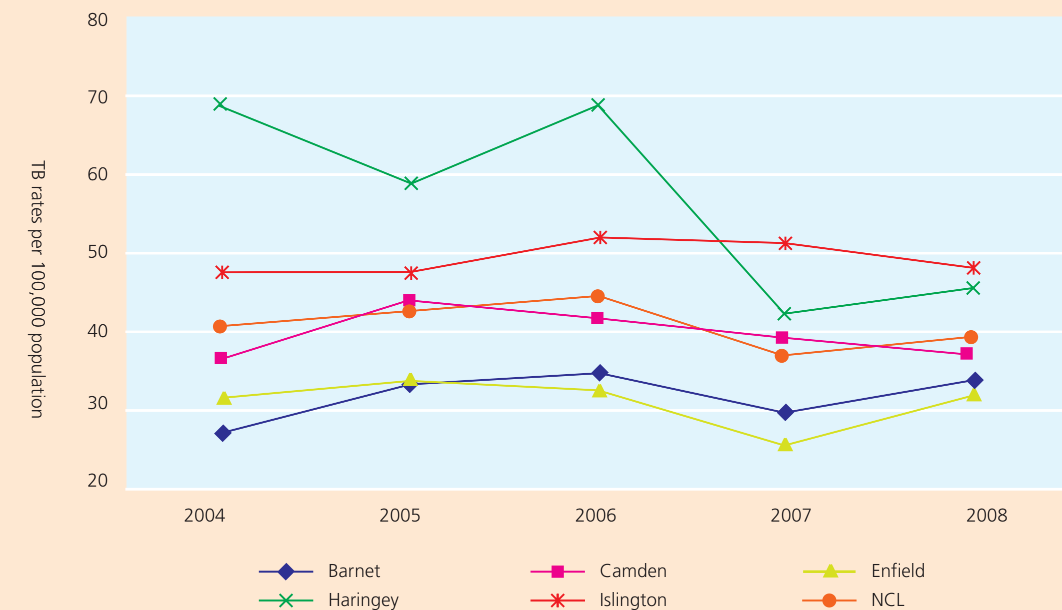
- Felt only those at risk of breast cancers would need screening, but did not know the factors that place an individual at risk.
- Fear of detecting cancer, undergoing mastectomy and possible death was a barrier.
- Prefer not to know that they have cancer and did not see an association between breast screening and improved survival chances.
- Perception that the procedure was painful and embarrassing.
- Myths and misconceptions about breast cancer and breast screening existed, including the belief that breast cancer is a White person's disease and could be caused by physical trauma.
- Some groups did not know who was eligible for screening and never received an invitation to attend.
- Some groups felt that breast self-examination was 'wrong'.
- Some participants expressed embarrassment using the Mobile Breast Screening Unit, which clearly displays its title.

Table 6: Women who have never been screened or have not been screened in the last five years, by mosaic group type

Group Type	Ethnicity	% DNA Breast Screening (women 50-69 years)	% DNA Cervical Screening (Women 25-64 years)
Settled Minorities-economically deprived	Mix of Caribbean, African, Cypriot and Pakistani origin	45%	35.7%
Metro Multicultural-modest income, low educational attainment, high unemployment	Multi-ethnic mix, particularly Black Africans and those of Asian origin	22%	17.8%
Counter Cultural Mix-No defined ethnic breakdown		14%	15.9%

Source: Barkers Social Marketing; NHS Haringey Increase Uptake of Breast Cancer and Cervical Screening Scoping Reports, 2009 [59]

Figure 19: TB rates per 100,000 population, North Central London, 2004–2008



Source: London TB Register, Health Protection Agency London

- The opening hours of the screening unit were also perceived as barriers.
- Haringey's mobile population results in inaccurate patient lists for inviting eligible women.

Those women eligible for cervical screening who had never attended or had not attended in the previous five years reported the following range of views:[61]

- Knowledge and awareness of cervical cancer was very low.
- Lack of knowledge and awareness of the risk factors associated with cervical cancer was found across all groups. Some thought it was hereditary; others linked it to promiscuity and on that basis excluded themselves from at-risk groups.
- There was a lack of understanding of the purpose of cervical screening, eligibility and frequency of screening.
- Anxiety and stress associated with receiving positive results for cancer and pain and embarrassment associated with procedure reduced motivation to attend.
- Some women would not feel comfortable discussing cervical screening with male GPs.
- Health professionals do not do enough to ensure that women receive the correct information. Language issues are also a factor.
- There is a perception that cervical cancer is detectable to 'the naked eye'.

This insight enabled specific messages to be developed to target those groups of women who never attended screening or who had not attended in the previous five years, with the aim of motivating them to attend screening in the future.

5.3. Communicable diseases

Tuberculosis (TB)

Action to combat tuberculosis

Effectively diagnosing, treating and stopping the spread of tuberculosis (TB) has been a priority in Haringey for the last five years, during which Haringey has provided additional resources to TB services. The borough has seen a decrease in TB rates from nearly 70 per 100,000 population in 2004 to 46 per 100,000 population in 2008, very close to the London average (see figure 19).

This significant decrease in TB rates in recent years compares well with the other North Central London (NCL) PCTs, but Haringey still has a disproportionate share of TB notifications (21.2%) in North Central London compared to its share of the North Central London general population (17.6%).

5 Accessing health services

The success in rate reduction is a result of proactive action over the last five years, which included the development and implementation of the Enfield and Haringey TB Strategy and the North Central London TB Strategy. This work was been guided by the National TB Action Plan and National TB Commissioning Toolkit and included rationalisation of services with additional investment to increase the multi-disciplinary staffing levels, better meeting the needs of TB patients.

Fifty-eight percent of TB cases in 2008 were in males. The majority (64%) of TB cases (male and female) were aged 20–49 years. No children under the age of 10 years were notified with TB in 2008 and, since children with TB are usually indicative of community transmission, this is a positive outcome probably due to the Haringey universal neonatal BCG (Bacillus Calmette-Guerin) vaccine programme and decreases in TB notifications from Black African communities.

TB and ethnicity

There have been significant changes to the ethnicity of TB cases in Haringey over the last five years, as described in Figure 20. TB notifications from Black African communities have shown the single biggest decrease, from over 50% of total TB notifications in 2003 to 35% in 2008. The exception to this is TB notifications from the Somali community, which are showing a different pattern to Somali TB notifications across North Central London.

Figure 21 shows how TB notifications by country of birth have changed over the last five years. Cases according to country of birth show substantial decreases in new cases in people born in individual sub-Saharan African countries, such as the Congo and Nigeria, in contrast to people born in Somalia, Turkey, India, Pakistan and the UK, which have shown marked increases. The most significant increase was in people born in the UK. Half of the TB notifications in UK born people were from non-White ethnic backgrounds and the majority of notifications were in those over 50 years of age.

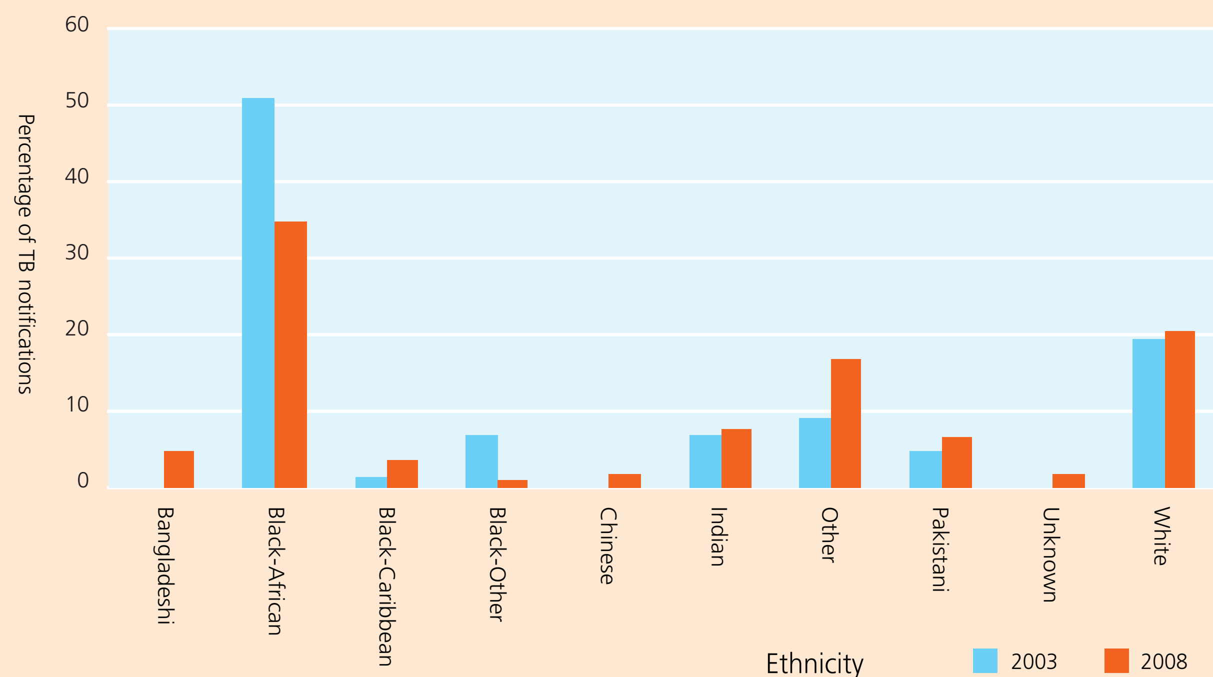
Of those notifications where year of entry to the UK was known, 65% had been in the UK for 10 years or less, and a further 38.5% had been here for five years or less. Of those patients with TB who were in the UK for 10 years or less, 30% were from the Somali community. TB notifications from the Somalian community live exclusively in the N15, N17 and N22 areas of Haringey and members of the Turkish community with TB live in N15 and N17.

There was one death known to be associated with TB in Haringey in 2008.

New entrants or migrants may have difficultly engaging with UK health services to seek treatment for TB for a number of reasons. These reasons include illegal entry, lack of understanding of UK healthcare processes and lack of knowledge of the English language. The impact on people who suffer from TB, and on their families, is often underestimated. Time spent in hospital, being unwell or being on treatment, and therefore having frequent visits to hospital, results in time spent away from school and college and has an impact on ability to take examinations, employment and caring for children and other family members. Stigmatisation by the community also affects a person's ability to lead a 'normal' life for the duration of the illness and treatment. This can impact on life after TB through lack of education, poor examination results, employment continuity and exclusion from their community.

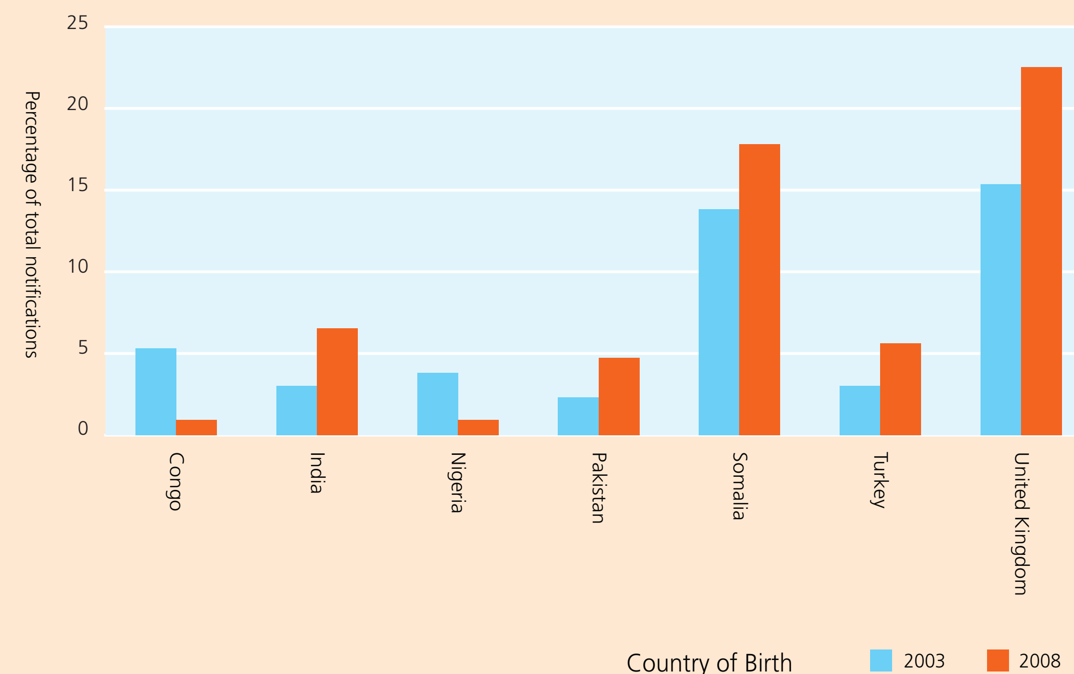
A London-wide strategy for TB service provision is being developed and will include a needs assessment encompassing service provision and service users' and population needs, leading to the implementation of a London-wide TB control programme. Haringey will benefit from a pan-London approach that ensures public and patient engagement.

Figure 20: TB notifications, by ethnicity, in Haringey, 2003 and 2008



Source: London TB Register, Health Protection Agency London

Figure 21: TB notifications by country of birth, UK, 2003 and 2008



Source: London TB Register, Health Protection Agency London

5 Accessing health services

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS), is transmitted through unprotected sexual intercourse, sharing contaminated needles and syringes, and contaminated blood products. As there is still no vaccine to prevent the onward transmission of HIV, prevention interventions focus mainly on behavioural change and provision of good information.

Haringey has the ninth highest number of HIV-diagnosed people of all local authorities in London.

In 2008, 1,133 people with HIV accessed HIV treatment and care in Haringey.[62] The most prevalent route of HIV infection is sex between men (see figure 22). However, trends suggest that 'women who have sex with men' is becoming the second most common route of HIV infection.[62]

HIV and ethnicity

HIV infection has an unequal impact on some ethnic and minority groups. Britain's African communities have been particularly adversely affected by HIV/AIDS, with high levels of new infections reported among both adults and children. Haringey has a large population of Black and Minority Ethnic communities, of which Black Caribbean, Black African and Black British represent the largest Black and Minority Ethnic groups within the borough.

In the UK the estimated prevalence of HIV in Black Africans is 3.7% and 0.4% in Black Caribbeans, which is significantly higher than the estimated HIV prevalence of the White population (0.09%).[63] In line with these figures, Black Africans made up the highest number of new diagnoses in Haringey between 2004 and 2008. However, more White men and women were newly diagnosed with HIV between 2004 and 2008 than those who were Black Caribbean, despite their ethnic group having higher estimated prevalence (0.4% compared to 0.09%).

Figure 22: Number of Haringey residents with HIV infection receiving treatment, by gender, 2004–2008

Source: The Survey of Prevalent HIV Infection Diagnosed (SOPHID)

5.4. Health protection in Haringey

Roles and responsibilities in health protection

The Health Protection Agency, and locally the North East and North Central London Health Protection Unit, holds shared responsibility for the protection of the local population's health with NHS Haringey and the local authority. This is achieved through robust partnership arrangements and an overall Framework Agreement. This includes:

- Expert health protection advice, 24 hours a day, 7 days a week and Proper Officer arrangements (Public Health Acts).
- Joint business planning.
- Support on emergency preparedness.
- Robust outbreak/incident plans and exercises.
- A growing emphasis on supporting the Primary Care Trust to commission the most effective health protection services.
- Joint communications approaches.
- Environmental public health.

There is a statutory requirement for the notification of certain infectious diseases, organisms or non-infectious environmental hazards, such as land contamination, water incidents, fire or carbon monoxide poisoning. On the whole, GPs or hospital clinicians will notify either a suspected or confirmed case depending on the urgency of the public health action required. However, anyone can notify a health protection concern to the Health Protection Unit. The Health Protection Unit will then provide expert advice, guidance and often leadership in incidents and outbreaks.

The Health Protection Unit works alongside other organisations and stakeholders with health protection responsibilities, such as Environmental Health Officers, acute and mental health NHS trusts, police, London Ambulance Service, London Fire Brigade and local authorities. The Health Protection Unit also supports other organisations, including colleges, schools, care homes and businesses, among others.

5 Accessing health services

NHS Haringey

Infectious diseases in Haringey

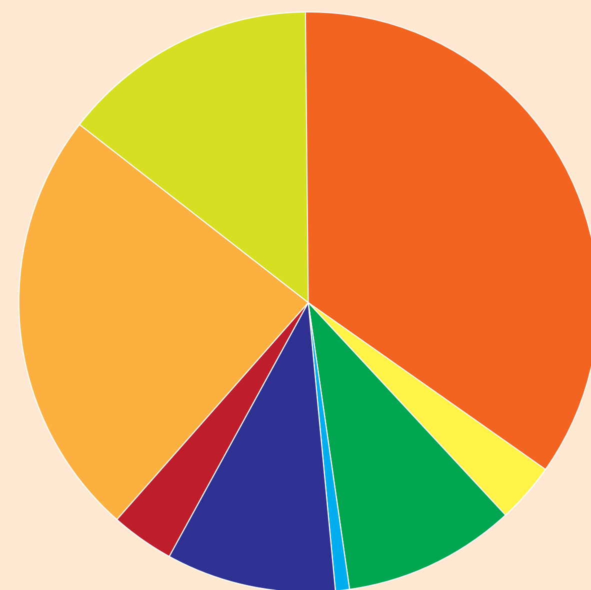
Between April 2008 and March 2009, a total of 390 notifications of infectious diseases in Haringey's residents were reported to North East and North Central London Health Protection Unit. Fifty-six percent of the notifications were in males and 46% in females. Ninety-nine percent of notified cases were registered with a GP. This is very encouraging due to the high mobility of the population in Haringey and London overall.

The main diagnoses were gastrointestinal illness, which included norovirus (winter vomiting bug), unspecified food poisoning, salmonella (19%), campylobacter (50%), shigella, paratyphoid and hepatitis A. The most common cause of gastrointestinal illness in the UK is campylobacter. In 2008, there were 49,880 laboratory reports in England and Wales.[64] Hepatitis A is usually associated with travel abroad and is investigated thoroughly due to its high infectivity rate, especially among children. A breakdown is shown in Figure 23.

Twenty-eight outbreaks or incidents were reported between April 2008 and March 2009. See Figure 24 for a breakdown of the main causes of local outbreaks.

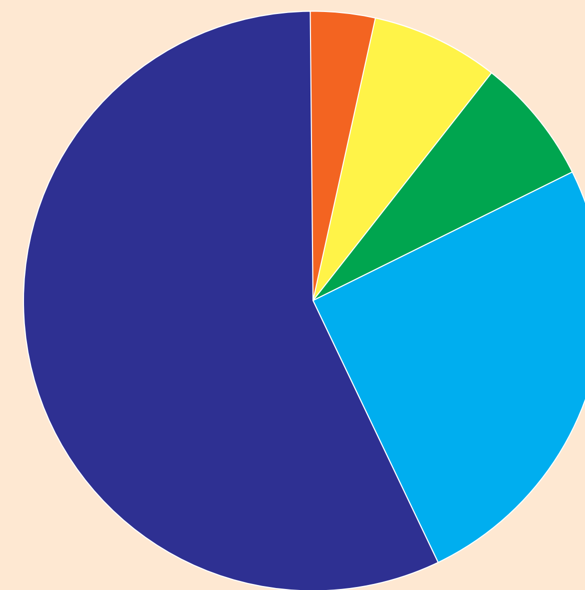
The Health Protection Unit investigates all cases of vaccine-preventable diseases to ensure that both the case and wider contacts are protected where possible. Developing clusters of disease can often be interrupted by mass vaccination campaigns and education.

Figure 23: Main diagnosis of notifications of infectious diseases in Haringey (April 2008 - March 2009)



Source: North East and North Central London Health Protection Unit

Figure 24: Outbreaks and incidents in Haringey, April 2008 to March 2009

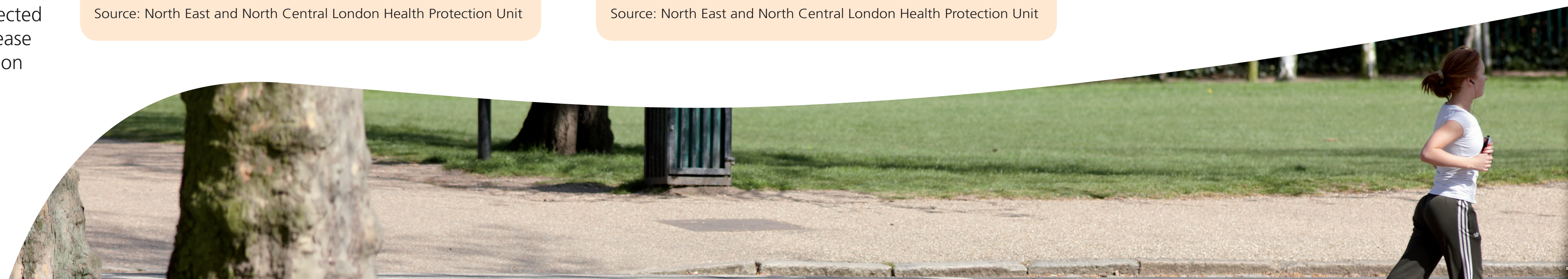


Source: North East and North Central London Health Protection Unit

Health protection and ethnicity

Inadequate data collection and analysis on ethnicity remains an issue for notifiable diseases. This is an ongoing concern which the Health Protection Agency is attempting to address. It is often very difficult to ascertain the ethnicity of an individual, and although the NHS collects this data where possible, it is not always feasible to ascertain ethnic background at the time of the investigation. A new Health Protection Agency database, currently in development, will place ethnic recording at the forefront of risk assessment.

Please see www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1219908762203 for further information on the work of Health Protection Units, and www.hpa.org.uk for more details of the Health Protection Agency.



6 Improving lifestyles

Key messages:

- Alcohol misuse is costly both for the individual and for society and has risen significantly in Haringey over the last five years.
- In Haringey drug use problems are concentrated in the east of the borough. Local evidence shows that Haringey drug treatment agencies are successful in reaching a large number of clients from Black and Minority Ethnic groups.
- Smoking is currently the principal avoidable cause of premature death in the UK. There are marked inequalities in smoking between ethnic groups, with major gender differences within the groups.
- Participation in regular physical activity can help to prevent and treat over 20 long-term conditions or disorders. Participation in physical activity is less likely in some Black and Minority Ethnic groups.

6.1. Alcohol

Alcohol misuse: the scale of the problem

Almost one-third of the adult male population and one-fifth of the adult female population regularly drink more alcoholic drinks than the government recommends. For almost 3 million people in England, alcohol consumption is a major cause of ill health and over 1 million people are dependent on alcohol.[65] There were 8,758 deaths due to alcohol in the UK in 2006.

Recently, alcohol use and misuse have received a great deal of coverage in the media. The Chief Medical Officer highlighted the issue of young people drinking alcohol. He suggested that under-16s should not be allowed to drink alcohol and that a minimum price should be set for alcoholic drinks, based on a price per unit.[66] These public health measures are designed to address the problem of alcohol misuse in society.

Alcohol misuse is costly both for the individual and for society. Alcohol can also have a detrimental effect on health if used to excess. Some common diseases associated with alcohol are cirrhosis of the liver, cancers and heart disease.

Society bears the direct costs of alcohol misuse via the NHS. This cost is estimated at almost £3 billion per year. The wider costs of alcohol misuse are due to the effects on crime and disorder and sickness from work. The total annual cost of alcohol misuse has been estimated to be up to £25 billion.[67] Haringey Drug and Alcohol Action Team take the lead for the local Alcohol Harm Reduction Strategy. This document, available from www.haringey.gov.uk, outlines activities to reduce alcohol problems in Haringey.

Local analysis for 2002-2008 shows that across all ethnic groups the main cause of alcohol related hospital admissions was hypertensive disease. It is well documented that the prevalence of hypertension is very high among black people compared to Caucasians . This is significant bearing in mind the diverse make up of Haringey which could contribute to the high rates of hospital admissions for hypertension.

Alcohol misuse in Haringey

In 2007/08 the directly standardised rate of deaths due to alcohol in Haringey was 3.5 per 100,000 population for females and 15.8 per 100,000 for males. These are both below the London average. There were 1,820 alcohol-related ambulance calls in Haringey in 2008 and the rate of admission for alcohol-related harm was 1,404 per 100,000 population (directly age and sex standardised) in 2007/08.[68]

Table 7: Alcohol units

Type of alcoholic drink	Volume containing 1 unit
Beer	½ pint (285ml)
Wine	1 small glass (125ml)
Spirits	1 measure (25ml)
Sherry	1 glass (50ml)

Table 8: The detrimental effects of alcohol

Condition	Men (increased risk)	Women (increased risk)
Hypertension	4 times	2 times
Stroke	2 times	4 times
Coronary heart disease	1.7 times	1.3 times
Pancreatitis	3 times	2 times
Liver disease	13 times	13 times

Although below the London average, there is cause for concern about the level of alcohol misuse in Haringey. As Figure 25 shows, the rate of wholly alcohol-attributable hospital admissions in Haringey has risen sharply over the last five years.

Barriers to getting help with alcohol misuse

In an ethnically diverse borough like Haringey there are potentially numerous barriers to accessing support for alcohol related issues. These barriers can include language, stigma, childcare issues, concerns over confidentiality and lack of gender specific services. Some communities, such as asylum seekers or refugees may find it difficult to trust government-funded services.

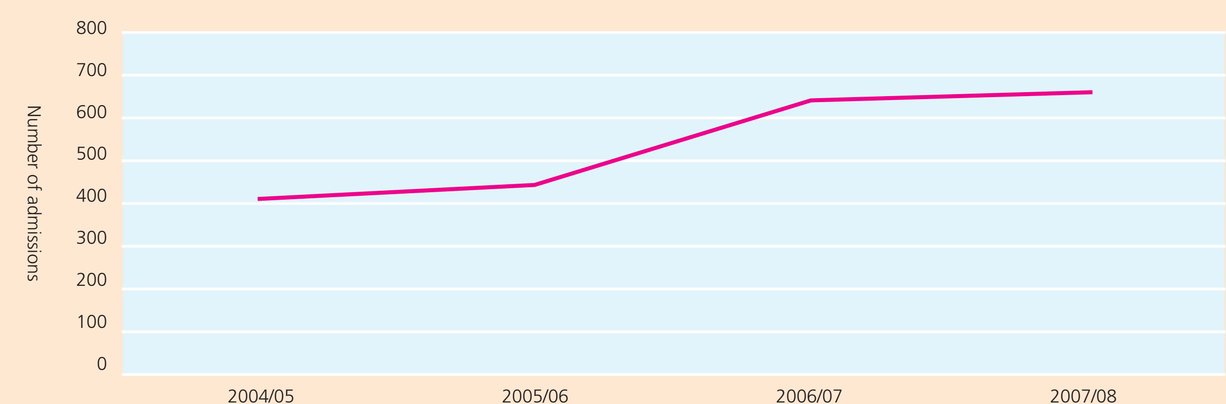
Haringey DAAT continue to attempt to reduce and/or remove these issues in a number of ways. For example, creating woman only sessions in treatment services and providing translation services. Haringey DAAT have recently received funding from the Migration Impact Fund (Government Office for London) to research the needs of street drinkers in Haringey.

However it is difficult to establish which groups are more affected by alcohol misuse and the extent they access services. The definitions of different ethnic groups are very broad, for example, the term 'white other' could refer to someone from Iran as easily as it could refer to someone from Slovenia.

Alcohol services

There are many different treatments available for people concerned with their levels of alcohol consumption. These include services concentrating on medication and counselling. People worried about their drinking or that of anyone close to them, can contact their GP or the Haringey Advisory Group on Alcohol (HAGA), 590 Seven Sisters Road, Tottenham, N15 6HR. Tel. 020 8800 6999; web: www.haga.co.uk.

Figure 25: The rate of wholly alcohol-attributable hospital admissions in Haringey, 2004/05–2007/08



Source: Hospital episode Statistics, 2004–2008

6 Improving lifestyles

6.2. Substance misuse

The extent of problem drug use in Haringey

There are approximately 2,700 problem drug users in Haringey.[69] Problem drug use can impact on many areas of an individual's health and social functioning. Links have been shown between problem drug use and mental health, unemployment, crime, family breakdown and homelessness.

In Haringey, drug use problems are concentrated in the east of the borough, with crack use being most prevalent in the north-east. This may be a reflection of the fact that the east of the borough is more densely populated and more deprived.

Drug use and ethnicity

Although the current prevalence data does not specify ethnic group, local evidence shows that Haringey drug treatment agencies are successful in reaching a large number of clients from Black and Minority Ethnic groups.[70] In 2008, there were 1,028 problem drug users in treatment in Haringey.[71] Nearly half (41%) of these individuals classed their ethnic group as non-White. The London average is 33% (see Table 9). Some Black and Minority Ethnic groups are over-represented both in drug treatment statistics and in the criminal justice system for drug-related offences.[72]

Local data shows that during the 2007/08 financial year White British, Black Caribbean and White Other were the largest ethnicity groups (37%, 15% and 15% respectively)[74] that presented for treatment at drug services. Black Caribbean, Other Black and any other ethnic categories were over-represented in the treatment population in comparison to the total Haringey population.[75] Over 50 different nationalities were represented in treatment in 2007/08.[76] This is a reflection of the diversity within the borough.

In order to avoid stigmatising certain ethnic groups, care needs to be taken when drawing conclusions about illicit drug use or type of crime on the basis of ethnicity or nationality information in isolation. For any intervention to be effective with problem drug use, the focus should be on using a multi-agency approach to tackle the complex issues that surround an individual's use of drugs.

Table 9: Treatment population and ethnicity breakdown by region, 2008 [73]

Overall ethnic group	Mixed %	Asian %	Black %	White %	Other %
Haringey	7%	5%	25%	56%	4%
London	6%	9%	15%	64%	3%
National	3%	4%	4%	83%	1%

Source: National Treatment Agency for Substance Misuse

Drug misuse services in Haringey

In 2007/08 the Healthcare Commission reviewed drug misuse services in Haringey with a specific focus on diversity. Haringey Drug and Alcohol Action Team* (DAAT) and our local drug treatment agencies were awarded a score of 4, which means services were rated as excellent. The Healthcare Commission concluded that Haringey did especially well on:

- Needs assessment and planning that identifies and responds to the needs of diverse populations
- Ensuring that services are planned and provided with consideration and respect for the views of service users and other services.

Haringey DAAT also continues to commission culturally competent agencies such as BUBIC (Bringing Unity into the Community) and Eban. BUBIC is a community support service run by former drug users, most of whom are non-White British. Eban offers specialist treatment for crack and other stimulant users. We plan to continue to develop our drug misuse services with improvements, including:

- Ensuring that better translation services are available to all drug treatment and support agencies by facilitating a skills audit and skills exchange
- Commissioning trainees from diverse communities to develop the workforce
- Facilitating training for staff on cultural competence with the aim of diversifying the workforce when recruiting, for example, by a volunteer scheme.

6.3. Smoking

Smoking as the principal avoidable cause of premature death

Smoking is a major cause of illness and premature death in England, and also contributes substantially to the inequality in health across the country. It is currently the principal avoidable cause of premature death and ill health in England. Hence, reducing the number of smokers is a key priority in improving the health of the population in Haringey and other deprived boroughs where smoking rates tend to be higher.

Smoking rates in Haringey

Currently there is no data on tobacco prevalence across the borough at ward level and among different population groups. However, modelled prevalence suggests that current smoking prevalence in Haringey is about 28.3% compared to 23.3% in London and 24.1% in England as a whole. Highest smoking prevalence of between 29 and 33% was estimated in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.[77]

Every year in Haringey, there are 260 deaths related to smoking, which represents about 19% of total deaths in borough and 1,120 hospital admissions, at a cost of over £2.5 million in at 2004.[78]

* The DAAT represents and delivers the work of the Drug and Alcohol Partnership in Haringey.

6 Improving lifestyles

Smoking and ethnicity

Available data suggests that there are marked inequalities in smoking between ethnic groups with major gender differences within the groups. In general, the gap between the smoking rate of the general population and that of minority groups in each sex has closed between 1999 and 2004. The rates of smoking in groups with rates above that of the general population, such as Bangladeshi men, Irish men, Black Caribbean men and Irish women, are falling and those with rates below the general population, namely Chinese men, Indian men, Bangladeshi women, Pakistani women, Indian women and Chinese women, are rising.[79]

A national survey published in 2004 found that Bangladeshi men were 43% more likely to smoke compared to the general population. Other groups with higher smoking rates were Irish, Pakistani and Black Caribbean men who were 30%, 8% and 2% respectively more likely to smoke than the general male population. Smoking prevalence was found to be lower in Chinese men and Indian men than the general male population.

Smoking prevalence is lower among women in most minority ethnic groups than the general female population when age was taken into consideration. Compared to the general female population, Bangladeshi, Pakistani, Indian, Chinese, Irish and Black Caribbean women were found to be more likely to smoke. A quarter of Bangladeshi women also chew tobacco.

A report of prevalence of current smoking for major ethnic groups found that respondents from the Black African, Indian, Pakistani, Bangladeshi and Chinese Minority Ethnic groups were less likely to be current smokers than England as a whole, whereas Irish respondents were more likely to be current smokers.

Tobacco control activities

In 2007, NHS Haringey commissioned research on tobacco control activities in Haringey. Data on deprivation, ethnicity, housing condition, health status, income and employment were aggregated to identify postcodes and wards that are likely to have the highest smoking prevalence. These areas were matched against numbers of residents who accessed quit smoking services and were successful quitters at four weeks post attempt. The results suggest that in general the best quitting performance is being achieved in areas and ethnic groups for which the problems are generally not the worst.[80]

6.4. Physical activity

The importance of physical activity to health

Participation in regular physical activity can help to prevent and treat over 20 long-term conditions or disorders, including coronary heart disease stroke, obesity, some cancers, mental health and type II diabetes. The risk of premature death among physically active adults is reduced by 20–30%, and the risk of developing major long-term conditions, such as coronary heart disease, stroke, diabetes and cancers, is reduced by up to 50%.[81]

The vast majority of the adult population in the UK are not active at levels to confer health benefits. The current recommendations for adults for general health are that every adult should achieve a total of a minimum of 30 minutes a day of at least moderate intensity physical activity on five or more days of the week. Children and young people should be physically active to at least a moderate intensity for a total of at least 60 minutes every day.[82]

Haringey recognises the important role of physical activity for improving health and has identified physical activity as a local priority in its overall plan, known as the Local Area Agreement. The Local Area Agreement target is to increase physical activity participation from 22.9% to 26.9% over a three-year period by 2010. No single approach and no single organisation will be able to solve the issue of physical inactivity in Haringey. A multi-pronged approach is needed, which will involve a range of partners, including schools, the NHS, leisure and sports services, the media, and town and transport planners.

National and local data

The national results of the Active People Survey 2007/08 revealed that 21.3% of adults (aged 16 and over) participate in physical activity three times a week for 30 minutes at a moderate intensity, indicating an increase of 0.32% over the past two years.[83] However, London rates fall below these figures at 20.2%, indicating a decrease of 1.1% over the past two years.

A new approach to health and well-being

In January 2009, Haringey formed a Community Sport and Physical Activity Network as part of Sport England's delivery system for sport and physical activity. The core aim of this network is to facilitate the effective strategic co-ordination of sports and physical activity planning and provision to enable all people to have the opportunity to participate in high quality sport and physical activity and therefore reduce health inequalities. The work of this network has a specific focus on improving participation rates among people from ethnically diverse backgrounds.

A similar trend is evident in Haringey, where participation rates have decreased from 22.9% in 2006/07 to 19.8% in 2007/08, although this decrease does not represent a statistically significant change.

Physical activity and ethnicity

Participation in physical activity is less likely in some Black and Minority Ethnic groups. National participation rates among White adults have increased over the past two years from 21.2% to 21.7%%, while participation among non-White adults has decreased from 18.6% to 17.6%.[84]

7 A snap shot of Haringey's health

7.1. Background

The purpose of this chapter is to provide some key facts and figures about health and well-being outcomes in Haringey as they compare to the country as a whole. As such, it provides a snapshot of the health and well-being of Haringey's population.

More detailed information is provided in the Joint Strategic Needs Assessment (JSNA). The production of a JSNA is a legal requirement from 1 April 2008 for organisations with formal responsibility for planning and arranging publicly funded provision of health and social care services. The JSNA is now the main mechanism for analysing and reporting need across the partnership in Haringey.[85] A JSNA is a method of gathering information about the current and future health, care and well-being needs of the population. This information will then be used for service planning and commissioning strategies. The JSNA is available at: www.haringey.gov.uk/jsna_executive_summary_and_chapter_1_introduction.pdf.

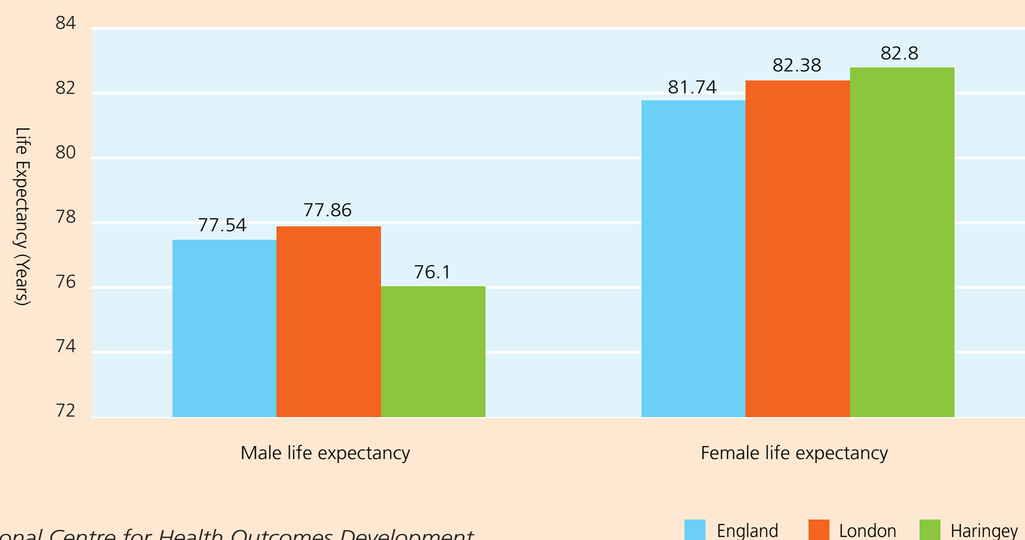
7.2. Life expectancy and major causes of death

Life expectancy in Haringey

Life expectancy in Haringey using 2005–2007 data is 76.1 years and 82.8 years for males and females respectively. Haringey has a slightly lower male life expectancy than England as a whole, with male life expectancy 1.4 years lower than the national average. Female life expectancy in Haringey is slightly higher (1.06 years) than the national average.

Consistent with national trends, life expectancy in Haringey for men and women has improved steadily over the past decade. The gap between Haringey and England is narrowing slightly for males. Between 2001–2003 and 2005–2007, life expectancy in Haringey increased 1.5 years for men and 3 years for women.

Figure 26: Male and female life expectancy in England, London and Haringey, 2005–2007

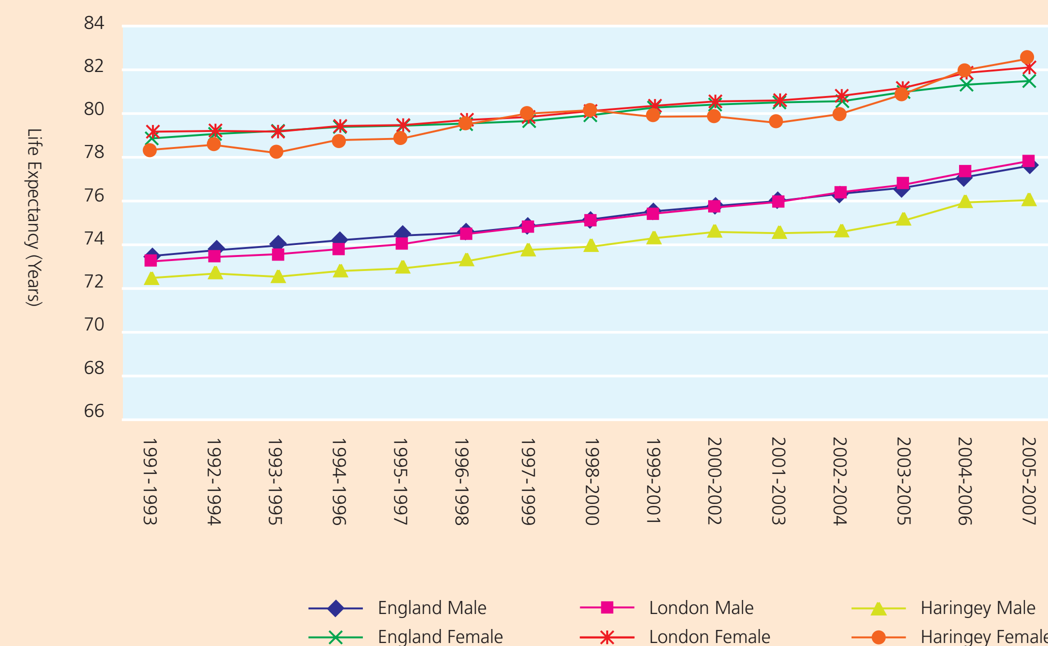


Source: National Centre for Health Outcomes Development

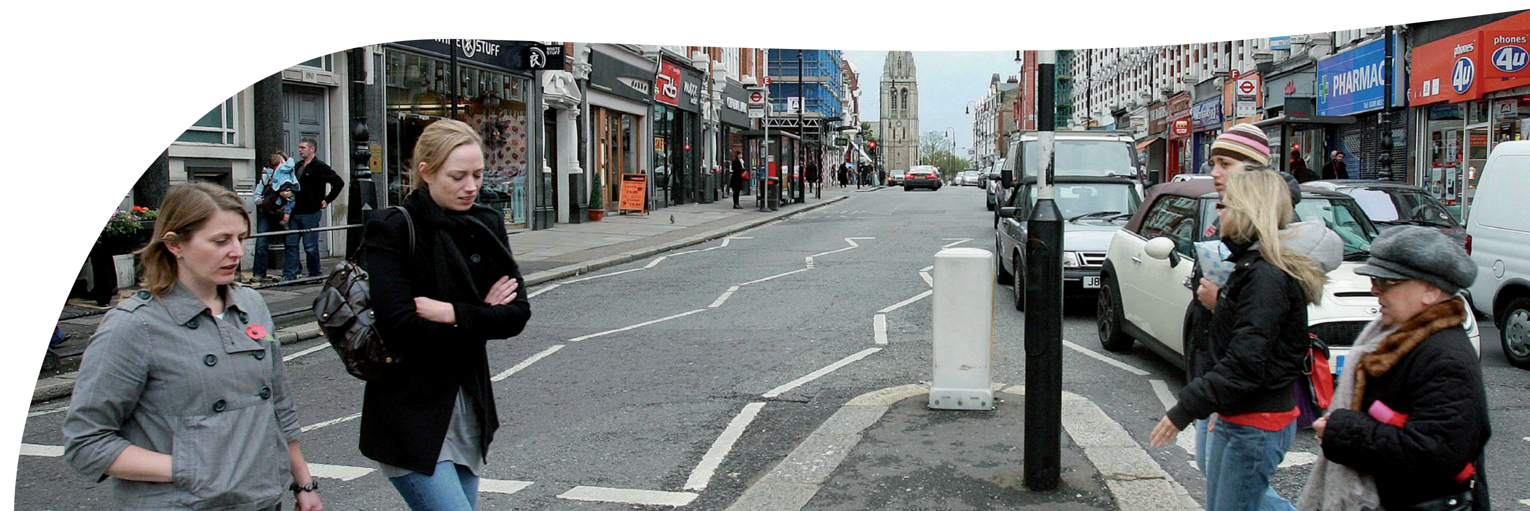
Key messages:

- Male life expectancy using data from 2005–2007 in Haringey is 1.4 years lower than in England as a whole. Female life expectancy is 1.1 years higher than in England.
- Life expectancy is not evenly distributed in Haringey. At the two extremes, male life expectancy in Tottenham Green is eight years lower than male life expectancy in Alexandra.
- Cancer and heart and circulatory diseases together account for most deaths in Haringey residents under the age of 75 years. This division is similar to that seen nationally.
- Lung cancer followed by breast, colorectal, bladder and prostate cancers were the most common causes of death from cancer in Haringey (and nationally) between 1996 and 2005.
- Understanding the prevalence and distribution of behavioural risk factors for chronic diseases, particularly smoking, diet and physical inactivity, continues to be a challenge in Haringey, as it is across England. Prevention of these risk factors will be key to reducing premature mortality in the medium and longer term.

Figure 27: Trends in male and female life expectancy, Haringey, London and England, by sex, 1991–1993 to 2005–2007



Source: National Centre for Health Outcomes Development



7 A snap shot of Haringey's health

How does life expectancy vary within Haringey?

Within Haringey, life expectancy varies significantly between wards. Generally, the more deprived wards (as measured by the Index of Multiple Deprivation) have a lower male life expectancy than the more affluent wards. At the two extremes, male life expectancy in Tottenham Green (70.6 years) is 8 years lower than male life expectancy in Alexandra (78.9 years). These figures are based on 2002–2006 data. The gap in male life expectancy between wards with the highest and lowest life expectancy does not appear to be narrowing, as improvements in life expectancy in the wards with the highest life expectancy is increasing in line with improvements in wards with the lowest.

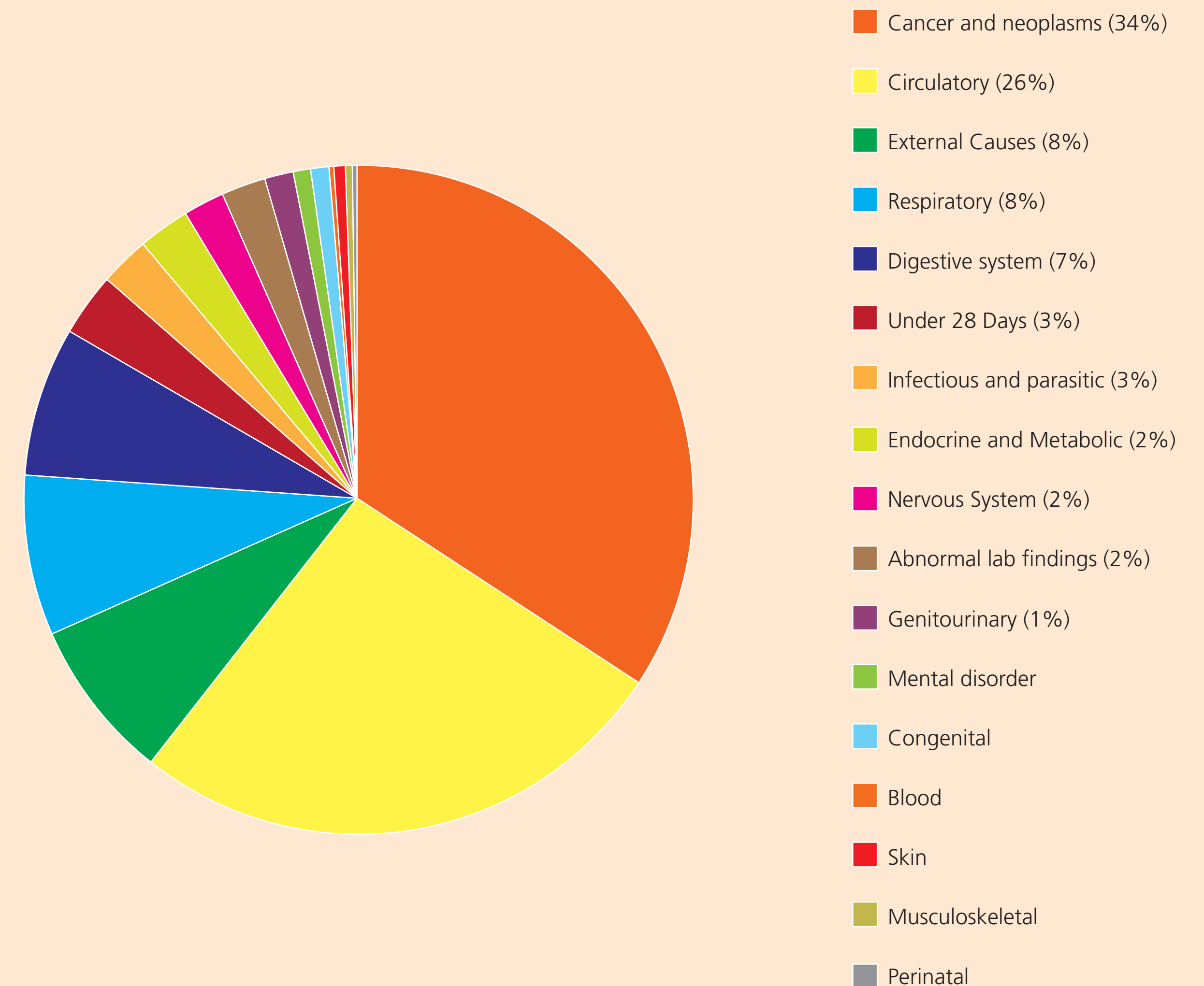
Table 10: Male and female life expectancy by ward in Haringey, 2002–2006

Region	Male life expectancy	Lower 95% confidence limit	Upper 95% confidence limit	Female life expectancy	Lower 95% confidence limit	Upper 95% confidence limit
Tottenham Green	*70.6	68.9	72.4	79.6	77.3	81.9
Northumberland Park	*70.7	68.8	72.7	79.4	77.5	81.3
White Hart Lane	*72.5	70.7	74.4	*76.9	75.2	78.6
Bruce Grove	*72.8	71.1	74.6	79.9	78.2	81.7
Hornsey	73.0	71.0	75.1	80.8	78.8	82.9
Noel Park	73.5	71.1	75.8	80.2	78.1	82.3
Tottenham Hale	73.7	72.0	75.3	*78.0	76.3	79.6
Bounds Green	75.0	73.1	76.9	81.2	79.4	83.1
Seven Sisters	75.2	73.4	77.0	81.6	79.4	83.7
Stroud Green	75.3	73.0	77.7	#85.3	82.2	88.4
West Green	75.3	73.7	77.0	82.8	80.8	84.9
Woodside	75.3	73.5	77.2	#83.7	82.0	85.4
St Ann's	76.3	74.2	78.4	82.4	80.2	84.6
Haringey	76.4	74.0	78.8	81.6	79.4	83.8
Fortis Green	77.3	75.5	79.0	#83.6	82.0	85.3
Crouch End	77.4	75.5	79.3	82.3	80.4	84.1
Muswell Hill	77.6	76.0	79.3	80.6	78.9	82.3
Highgate	78.0	75.9	80.1	82.1	80.4	83.8
Alexandra	#78.9	77.1	80.6	80.6	79.0	82.1
Haringey	75.0	74.6	75.4	81.0	80.6	81.4

** Statistically significantly lower ward life expectancy than Haringey as a whole*
 # Statistically significantly higher ward life expectancy than Haringey as a whole

Source: London Health Observatory, 2002–2006 data

Figure 28: Major causes of death in people aged less than 75 years, Haringey, 2005–2007



Source: National Centre for Health Outcomes Development

The gap in female life expectancy between the wards with the highest and lowest life expectancy (White Hart Lane and Stroud Green respectively) is 8.4 years.

Which illnesses impact most on life expectancy in Haringey?

Figure 28 shows the main causes of premature death, defined as deaths under the age of 75 years, in Haringey over the period from 2005–2007. Heart and circulatory diseases and cancer together account for 60% of all premature deaths in Haringey and thus represent the greatest opportunity for interventions to reduce premature mortality. These proportions are similar to those observed in the country as a whole.

7 A snap shot of Haringey's health

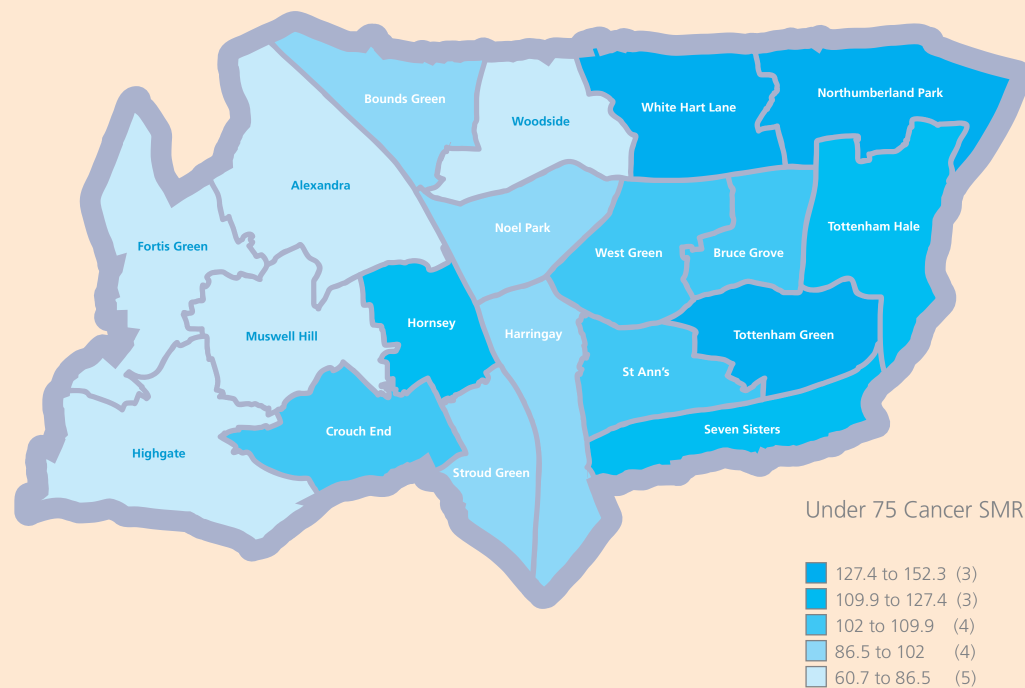
Cancers

Cancers are a major cause of mortality in the UK and contribute much to morbidity and disability. Cancer was the leading cause of premature mortality (defined as deaths in residents under 75 years) in Haringey in 2005–2007, accounting for 34% of all deaths. In 2006, there were 129.7 deaths per 100,000 of population from cancers in residents aged under 75 years in Haringey, compared to 109.0 in London and 114.7 in England and Wales. Figure 29 shows the Standardised Mortality Ratio for cancer for persons aged less than 75 years by ward.

Cancer mortality is not evenly distributed across the borough. Between 2002 and 2006, it was highest in Northumberland Park, Tottenham Green and White Hart Lane wards.

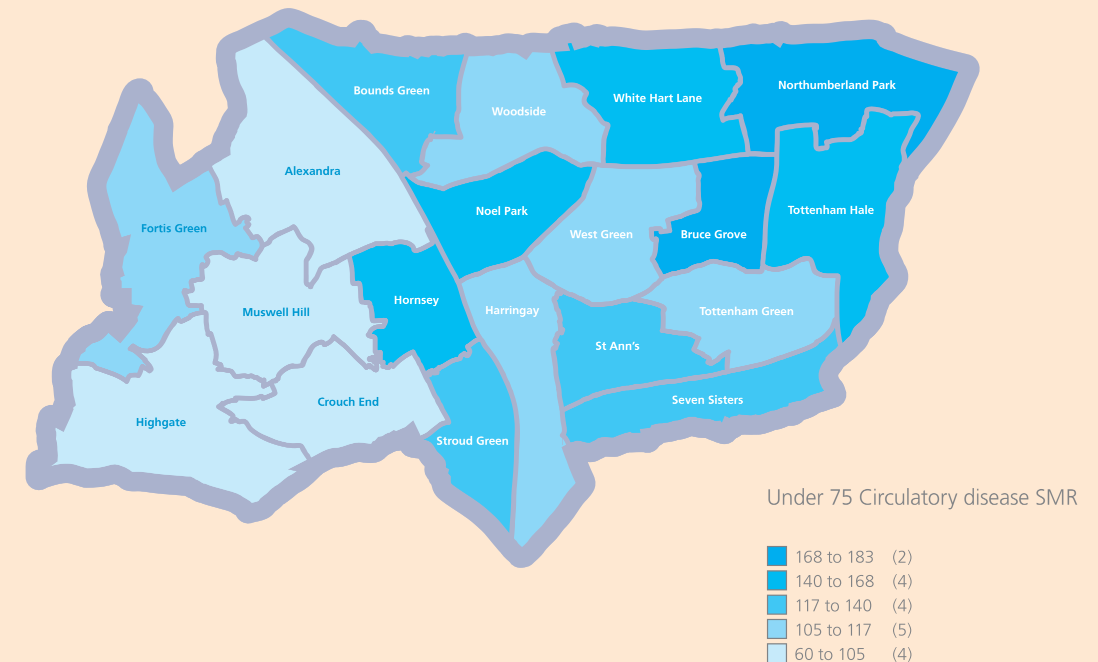
Lung cancer was the most common cause of death from cancer in Haringey between 1996 and 2005, followed by breast cancer, colorectal cancer, prostate cancer and bladder cancer. This trend is similar to that observed in England as a whole and underlines the importance of reducing smoking prevalence to reduce premature mortality, particularly among disadvantaged groups.

Figure 29: Standardised Mortality Ratio for cancer by ward, persons under 75 years of age, Haringey, 2002–2006



Source: London Health Observatory

Figure 30: Standardised Mortality Ratio for all circulatory diseases by ward, persons under 75 years of age, Haringey, 2002–2006



Source: London Health Observatory

Circulatory diseases

Circulatory diseases include heart diseases and stroke. Circulatory diseases account for 26% of deaths in people aged less than 75 years in Haringey. Deaths from circulatory diseases are not evenly distributed across Haringey. Deaths are highest in Northumberland Park and Bruce Grove and lowest in Highgate, Crouch End, Alexandra and Muswell Hill, suggesting that there are differences in prevalence of disease and disease risk factors as well as management of circulatory diseases in different areas of the borough.

7.3. Risk factors for disease and determinants of health

Organisational, economic and environmental factors have major impacts on the health of individuals. However, health-related behaviours also contribute significantly to cardiovascular and respiratory diseases, cancer and other conditions that account for much of the burden of morbidity and mortality in later life.

Smoking

Every year in Tottenham there are approximately 130 deaths and 600 hospital admissions related to smoking, at a cost of nearly £1.4 million (as at 2004).[86] Modelled smoking prevalence data, derived from the Health Survey for England (2003–2005),[87] predicts that Haringey has a prevalence of current smoking of 23.5% compared to 23.3% in London and 24.1% in England. This data was released to small geographical areas known as Middle Super Output Area (MSOA) level. Highest smoking prevalence of between 29 and 33% was predicted for MSOAs in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

7 A snap shot of Haringey's health

NHS Haringey

Eating habits

Fruit and vegetable consumption by adults is recorded in the Health Survey for England.[88] The most recent prevalence data modelled from the Health Survey for England suggests that 27.8% of adults in Haringey consume adequate amounts of fruit and vegetables in their diet, compared to 26.3% in England and 29.7% in London. This data was released to Middle Super Output Area (MSOA) level. MSOAs that are predicted to have adequate fruit and vegetable consumption of less than 25% include those in Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

Obesity

Obesity in adults was estimated using the Health Survey for England (2003–2005). 17.9 percent of adults are predicted to be obese, compared to 18.4% in London and 23.6% in England. The estimates for obesity vary considerably across the borough, ranging from less than -10% in an MSOA in Highgate to greater than 25% in MSOAs in Tottenham Hale, West Green, White Hart Lane, Bruce Grove and Northumberland Park.

In 2008, 17% of Haringey school children weighed were considered to be obese, and a further 14% were overweight. This varied by age. Twenty three percent of Year 6 children were obese compared to 10% in Reception Year. These figures are currently above the national predicted levels for 2010.

Physical activity

The Active People Survey is now conducted annually and identifies the ways in which participation varies from place to place and between different groups in the population. The survey measures the proportion of the adult population who volunteer in sport on a weekly basis; club membership; involvement in organised sport/competition; receipt of tuition or coaching; and overall satisfaction with levels of sporting provision in the local community. In the 2006/07 survey, 19.8% of Haringey adults reported taking part in moderate intensity sport and active recreation on at least three days a week (at least 12 days in the last four weeks) for at least 30 minutes continuously in any one session. This shows a reduction in participation from 22.9% in 2005/06, although this does not represent a statistically significant change.

Teenage conceptions

Sixteen of Haringey's 19 wards have teenage conception rates over 54.3 per 1,000 (conceptions in females less than 18 years of age). Haringey's teenage conception rate, however, is beginning to fall. It was down from 79.3 girls in every 1,000 in 2002 to 63.7 in 2005. High rates correlate closely within the wards with the highest levels of poverty and deprivation. Between 2001 and 2003, the rate of teenage conception varied from 11.8 per 1,000 in Muswell Hill to 120.9 per 1,000 in Bruce Grove.

8 Conclusions and recommendations

8.1. Conclusions

Haringey has one of the most ethnically diverse populations in the country. It also has one of the largest populations from Black and Minority Ethnic communities. In 2001, 45% of the population were of White British background compared to 60% for London and 85% for England. Because the young population of Haringey is more ethnically diverse than the older population, it is likely that the percentage of the population from Black and Minority Ethnic groups may increase over the next generation.

It is essential that services to promote and sustain health and well-being meet the needs of all Haringey's people equally. The relationship between health, ethnicity and migration is complicated. However, we know that many minority ethnic groups are more likely to experience poorer health outcomes than the general population. But data collection and analysis on health, ethnicity and migration need to be improved so that we can better understand the extent of unmet need and how best to meet this.

Experiences in early childhood are crucial to health outcomes in later life. Prenatal and antenatal care is an important first step in health. However, some Black and Minority Ethnic groups are more likely to present late for antenatal care. There is also a strong link between deprivation and poor child health, leading to worse health in adulthood. For example, the number of low birth weight babies, a proxy indicator for infant mortality, is higher in the deprived wards in the east of the borough. There is also a strong link between educational achievement and health. Pupils from some Black and Minority Ethnic groups continue to have lower educational attainment than White British pupils. New integrated service models, such as children's centres, are proving effective at offering services to hard-to-reach communities. More needs to be done to ensure that all children have the healthy start they need to build the foundations for a healthy adulthood.

Some Black and Minority Ethnic communities have higher levels of health needs than others. But data suggests that they are not always accessing the services they need. Mental health needs are high in Haringey and people from some Black and Minority Ethnic groups are more likely than others to suffer from mental health problems. Screening for breast and cervical cancers reduces mortality, but women from some ethnic groups are less likely than others to use screening services. Cultural issues such as stigma and language can act as barriers to health services. More work is needed to understand the extent of unmet health need and to ensure that our services are accessible to everyone.

Lifestyle risk factors are a major determinant of health. Alcohol misuse is damaging to the health of both the individual and society. Smoking is the single biggest cause of preventable death. Participation in regular physical activity can help to prevent and treat over 20 long-term conditions or disorders, but too few people in Haringey do enough physical activity. It is important to avoid generalisations about unhealthy lifestyles and ethnicity that can result in stigmatisation, but we know that some minority ethnic groups and migrants are more likely to experience the stress that contributes to unhealthy behaviours. This includes stress resulting from deprivation. Understanding the prevalence and distribution of lifestyle risk factors for chronic diseases, particularly smoking, diet and physical inactivity, continues to be a challenge in Haringey, as it is across England. Prevention of these risk factors will be key to reducing premature mortality in the medium and longer term.

Although data on migration status is inadequate, we know that asylum seekers and refugees experience worse health outcomes than the general population. Their health may be affected by the trauma they have suffered in their home countries, pre-existing health conditions, a sense of alienation and loss, poverty, homelessness and the uncertainties of their legal status in the UK. They are more likely to have unhealthy lifestyles and less likely to use health services. We need to better understand the health needs of this group and develop more targeted services.

Improving health and well-being cannot be done by NHS Haringey acting alone. Effective action requires a partnership approach involving all organisations with a role in service delivery. Most importantly, communities themselves need to be empowered to define their own needs and to develop community-based approaches to meeting these needs with support from statutory agencies. Although there have been some successful examples of this approach, more needs to be done. This will involve a radical shift in the way in which service providers, including NHS Haringey, work.

8 Conclusions and recommendations

NHS Haringey

8.2. Recommendations

Based on the conclusions above, a number of recommendations for NHS Haringey and other organisations have been developed.
These recommendations build on the evidence of successful new approaches to health and well-being that this report has highlighted, and on broader evidence-based research.
They recognise the progress that has already been achieved in many areas and are intended to highlight priorities where further effort is now needed.

Improving understanding:

- Improve the collection and analysis of information on migration status with a view to understanding how this impacts on health outcomes and needs.
- Undertake further investigation of ethnicity as a factor in determination of child obesity, particularly how ethnicity may affect growth patterns.
- Improve the collection and analysis of data on immunisation rates.
- Identify Black and Minority Ethnic groups with the highest infant mortality rates.
- Utilise information from the Child Death Overview Panel to identify any wider public health or safety concerns arising from a particular death or pattern of deaths in the area.

Overcoming language and cultural barriers:

- Remove the language barrier that prevents many people from accessing services. It is important to have a culturally competent workforce with language skills to match the diversity of Haringey's population.
- Provide health services in a culturally sensitive and welcoming way. Services that have been identified in this report as needing particular consideration to ensure cultural sensitivity include antenatal services, screening services, mental health services, drug and alcohol services, immunisation and teenage pregnancy services.
- Engage sensitively with women from countries where female genital mutilation or cutting is prevalent during pregnancy and develop management plans for delivery agreed during the antenatal period.
- Ensure that schools provide a welcoming and safe environment, and a positive school ethos.
- Engage positively with service provider partners, including the local authority, to improve the patient's whole experience during the period of care.
- Be mindful of the variety of factors that affect immunisation uptake and be able to act on these for local client groups.

Engaging with local communities:

- Ensure that services are culturally appropriate by engaging with recently arrived and Black and Minority Ethnic communities as key partners in promoting access to services.
- Develop a communications strategy to promote early access to antenatal services – for example, information at key venues in Haringey.
- Promote the use of self-referral forms in maternity services and promote direct access to a midwife via children's centres.

Empowering people to improve their own health:

- Develop information resources to challenge attitudes and misconceptions about nutritional value of foods, portion sizes for children and the importance of exercise.
- Ensure that behaviour change interventions are a key component of the strategic commissioning priorities for screening services.
- Raise awareness of TB in communities and within primary and secondary healthcare in order to destigmatise TB.
- Work with local communities to raise awareness of the benefits of physical activity and to better promote opportunities for physical activity across the borough.

Integrating service delivery across agencies:

- Engage positively with service provider partners, including the local authority, to improve the patient's whole experience during the period of care for TB.
- Continue to build on the children's centre model.

9 References

[1] www.lse.ac.uk/collections/LSELondon/pdf/theImpactofRecentImmigrationOnTheLondonEconomy.pdf

[2] Office for National Statistics (ONS) 2008 mid-year population estimates.

[3] Based on applying 2001 census percentage of 55% non-White British to 2008 figures.

[4] 2001 Census.

[5] Bhugra D (2004). Migration, distress and cultural identity. British Medical Bulletin, 69: 129–141.

[6] Dobson J, Koser K, McLaughlan G, Salt J (2001). International Migration and the United Kingdom: Recent Patterns and Trends, RDS Occasional Paper 75, Home Office, London, 280pp.

[7] UNHCR 1951 Convention and its 1967 Protocol.

[8] Office of the United Nations High Commissioner for Refugees, 1951.

[9] Health Protection Agency (2006). Migrant Health. Infectious Diseases in Non-UK Born Populations in England, Wales and Northern Ireland: A Baseline Report.

[10] Jones J. (March 2008). Travelling and Migration – Infectious Diseases in Migrant Population. Health Protection Agency London, Health Protection Forum.

[11] Kristiansen M, Mygind A, Krasnik A (2007). Health effects of migration. Danish Medical Bulletin, 54 (1): 46–47.

[12] Nazroo J (1997). The Health of Britain's Ethnic Minorities. Policy Studies Institute, London.

[13] McKeigue P, Chaturvedi N (1996). Part 2, Epidemiology and Control of Cardiovascular Disease in South Asians and Afro-Caribbeans in Ethnicity and Health. NHS Centre for Reviews and Dissemination, University of York.

[14] Burnett A, Peel M (2001). Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. British Medical Journal, 322: 544–547.

[15] Department of Health (2000). The NHS Plan: a plan for investment, a plan for reform

[16] Kristiansen M, Mygind A, Krasnik A (2007). Health effects of migration. Danish Medical Bulletin, 54 (1): 46–47.

[17] Carballo M, Mboup M (2005). International Migration and Health. Global Commission on International Migration. www.gcim.org.

[18] www.neweconomics.org/sites/neweconomics.org/files/Five_Ways_to_Well-being_Evidence_1.pdf.

[19] www.youngfoundation.org/our-work/local-innovation/strands/wellbeing/the-local-wellbeing-project/local-wellbeing-project.

[20] Department of Health (2004). Choosing Health: Making healthy choices easier

[21] DCSF (2007). New Arrivals Excellence Programme Guidance, Primary and Secondary National Strategies.

[22] Bhattacharyya G (2003). Minority Ethnic Attainment and Participation in Education and Training: The Evidence. University of Birmingham and Department for Education and Skills.

[23] Haringey Children and Young People's Service (2009). Analysis of the Results at the End of Foundation Stage, Key Stage 1, 2, 3, 4 and Post 16 for 2008.

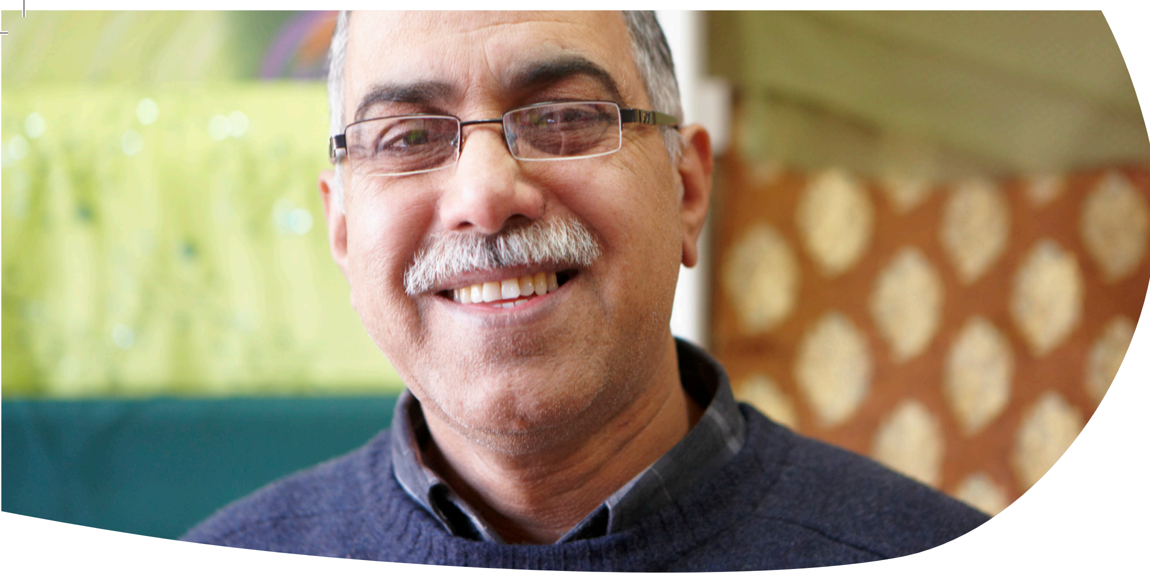
[24] Health Inequalities Unit, Department of Health (February 2007). Review of the Health Inequalities Infant Mortality PSA Target. Department of Health, London.

[25] London Health Observatory (July 2007). Born Equal? A Biefing on Inequalities in Infant Mortality in London.

[26] Haringey Local Safeguarding Children Board (2009). Child Death Overview Panel Annual Report 2008/2009.

[27] Department of Health (2007): Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide.

[28] Department of Health (2004). National Service Framework for Children, Young People and Maternity Services. London.



[29] Department of Health (2007). Maternity Matters: Choice, Access and Continuity of Care in a Safe Service.

[30] London Health Observatory (July 2007). Born Equal. A Briefing on Inequalities in Infant Mortality in London.

[31] Lewis G (Ed.) (2007). Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mother's Lives: Reviewing Maternal Deaths to Make Motherhood Safer – 2003–2005. CEMACH, London.

[32] WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet, 367: 1835–1841.

[33] Department of Health (2005). Vaccination Services – Reducing Inequalities in Uptake. DH gateway reference: 4659.

[34] Smailbergovic M S, Laing G, Bedford H. (2003). Why do parents decide against immunization? The effect of health beliefs and health professionals. Child: Care, Health and Development, 29(4): 303–311.

[35] Samad L, Tate R, Dezateux C, Peckham C, Butler N, Bedford H. (2006). Differences in risk factors for partial and no immunisation in the first year of life: prospective cohort study. British Medical Journal, 332: 1312–1313 (bmj.com).

[36] Vernon J G (2003). Immunisation policy: from compliance to concordance? British Journal of General Practice, May: 399–404.

[37] Henderson L, Millet C, Thorogood N. (2008). Perceptions of childhood immunization in a minority community study. Journal of the Royal Society of Medicine. 101: 244–251.

[38] Brabin L, Roberts S, Stretch R, Baxter D, Chambers G, McCann R (2008). Uptake of first two doses of human papilloma virus vaccine by adolescent school girls in Manchester: prospective study. British Medical Journal, 336: 1056–1058.

[39] Department for Education and Skills (2006). Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies, pp18–19.

[40] Viner R, Roberts H (2004). Starting Sex in East London: Protective and Risk Factors for Early Sexual Activity and Contraception Use Amongst Black and Minority Ethnicity Adolescents in East London. University College London, City University and Queen Mary, University of London.

[41] NICE (2006). Obesity Guidance on the Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children. National Institute for Health and Clinical Excellence.

[42] Cross-Government Obesity Unit (2008). Healthy Weight, Healthy Lives: A Cross-government Strategy for England. HM Government.

[43] Munro-Wild H, Fellows C (2009). Weighty Matters: The London Findings of the National Child Measurement Programme 2006 to 2008. London Health Observatory.

[44] Ridler C et al. (2009). National Child Measurement Programme: Detailed Analysis of the 2007/08 Dataset. National Obesity Observatory, HM Government.

[45] BMRB Social Research (2007). Research into Parent Attitudes Towards the Routine Measurement of Children's Height and Weight, Department of Children, Schools and Families.

[46] Ipsos MORI (2009). Reducing Childhood Obesity in Haringey, Final report for NHS Haringey.

[47] DCSF/DH (2006).Sure Start Children's Centres Practice Guidance.

[48] Using the Care Services Improvement Partnership tool.

[49] Burnett A, Peel M.(2001). Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. British Medical Journal, 322: 544–547 .

[50] Palmer,D, Ward K. 'Unheard voices': Listening to Refugees and Asylum Seekers in the Planning and Delivery of Mental Health Service Provision in London. Commission for Patient and Public Involvement in Health London. Available at: www.irr.org.uk/pdf/Unheard_Voices.pdf.

[51] Keating F (2007). Race Equality Foundation and Great Britain: Department for Communities and Local Government. African and Caribbean Men and Mental Health. Race Equality Foundation, London. Better Health Briefing 5. Available at: www.reu.org.uk/health/files/health-brief5.pdf.

[52] Mental Health Need in Turkish and Kurdish Communities in Haringey. Haringey Primary Care Trust.

[53] C Reilly,T Cassidy (August 2008). Volunteer Development Scotland.

[54] Seyfang G (2006). Time Banks and the Social Economy: Exploring the UK Policy Context. Centre for Social and Economic Research on the Global Environment, School Environmental Sciences, University of East Anglia, Norwich.

[55] Atkinson G, Clark J, Risheq E, Alli L, Suleman A, Woodruff J. (December 2008). Northumberland Park Time Bank. Mental Well-being Impact Assessment. Well London.

[56] NHS Cervical Screening Programme Available at: www.cancerscreening.nhs.uk/cervical/index.html#eligible.

[57] NHS Breast Screening Programme Available at: www.cancerscreening.nhs.uk/breastscreen/index.html#whatis.

[58] What is Social Marketing? Available at: www.nsms.org.uk/public/default.aspx?PageID=10.

[59] Barkers Social Marketing (2009). NHS Haringey Increase Uptake of Breast Cancer Screening Scoping Report.

[60] Barkers Social Marketing (2009). NHS Haringey Increase Uptake of Breast Cancer Screening Scoping Report.

[61] Barkers Social Marketing (2008). NHS Haringey Increase Uptake of Cervical Cancer Screening Scoping Report.

[62] The Survey of Prevalent HIV Infection Diagnosed.

[63] HPA (2008). Sexually Transmitted Infections in Black African and Black Caribbean Communities in the UK.

[64] www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1195733838402?p=1191942152851

[65] National Audit Office figures.
Office. Available at: www.nta.nhs.uk/areas/facts_and_figures/prevalence_data/docs/0607/London_Prevalence_data_0607doc.pdf.

[66] Chief Medical Officer (2009): Guidance on the consumption of alcohol by children and young people. Department of Health.

[67] National Audit Office figures.

[68] Hospital Episode Statistics, England 2007/09.

[69] Smoothed estimates reported in December 2008. This is an estimate based on three prevalence studies from Glasgow University. The latest published study is: Hay G, Gannon M. et al. (2008). Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use (2006/07) London Region. Home Office. Available at: www.nta.nhs.uk/areas/facts_and_figures/prevalence_data/docs/0607/London_Prevalence_data_0607doc.pdf.

[70] Haringey DAAT needs assessment January 2009. Includes restricted statistics from the National Drug Treatment Agency for Substance Misuse.

[71] Calendar year January to December 2008.

[72] Theft, Possession of specified Class A, Burglary, Robbery, Handling stolen goods, TWOC, Supply of specified Class A, Deception, Non-trigger offence, Possession w/i to supply Class A, Aggravated vehicle taking, Going equipped, Attempted theft, Production of specified Class A, Attempted deception, Begging, Fraud (section 1), Attempted burglary.

[73] Ethnicity data missing from 3% of Haringey records, 4% from London and 5% from national figures.

[74] The 'Other White' category is likely to include Turkish, Turkish Cypriot, Polish, Kurdish, Greek and Greek Cypriot as they are known to be some of the largest ethnicity groups in Haringey.

[75] Haringey DAAT Needs Assessment 2009. Data source: National Drug Treatment Monitoring System. Ethnicity breakdown based on ONS definitions.

[76] Fifty-one different nationalities within 800 who reported their nationality. This out of the total of 1,273 in drug treatment population in 2007-08 financial year.

[77] Available at: www.neighbourhood.statistics.gov.uk.

[78] Callum C, White P (March 2004). Tobacco in London: The Preventable Burden. SmokeFree London and The London Health Observatory.

[79] London Health Observatory. Smoking. Available at: www.lho.org.uk/LHO_Topics/National_Lead_Areas/Smoking.aspx#Smoking.

[80] Haringey TPCT. Report of Health Equity Audit of Access and Outcome of Clients to the Haringey Level 2 and 3 Stop Smoking Service (January 2005–December 2006).

[81] Department of Health (2004). At Least Five a Week. Evidence on the Impact of Physical Activity and Its Relationship to Health. A Report from the Chief Medical Officer. Department of Health Publications, London.

[82] Department of Health (2004). At Least Five a Week. Evidence on the Impact of Physical Activity and its Relationship to Health. A Report from the Chief Medical Officer. Department of Health Publications, London.

[83] Sport England (2008). Active People Survey 2 2007/08. National. Available at: www.sportengland.org/research/active_people_survey/active_people_survey_2.aspx.

[84] Sport England (2008). Active People Survey 2 2007/08. National. Available at: www.sportengland.org/research/active_people_survey/active_people_survey_2.aspx.

[85] Haringey Council. Joint Strategic Needs Assessment. 2009. Available at: www.haringey.gov.uk/index/children_and_families/joint_strategic_needs_analysis.htm.

[86] London Health Observatory (2004). Tobacco in London: The Preventable Burden. Available at: www.lho.org.uk/viewResource.aspx?id=8716.

[87] Available at: www.neighbourhood.statistics.gov.uk.

[88] Available at: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles.