

AHPN: Improving Health and Wellbeing

The AHPN is the leading policy organisation that influences policy on the health and wellbeing of Africans in the UK.

We are a network of membership organisations and individuals with a common goal to improve the health and wellbeing of the UK's African population.

The AHPN acts as a focal point and catalyst for individuals and organisations in the African community, providing platforms to share learning and experience, to influence policy and to speak with a collective voice.

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Facts and Figures

Cancer:

- British black women present on average 21 years younger than white women with breast cancer.
- Prostate cancer is three times more common in black men than white men.

Diabetes:

- African and African-Caribbean people in the UK are up to three times more likely than the general population to have Type 2 diabetes.

HIV:

- Africans account for 35% of new HIV diagnoses each year in the UK.
- In 2010, there were 24,397 HIV diagnosed black Africans seen for HIV care in the UK.

Stroke:

- Stroke incidence rates are higher in the black than white ethnic group for both sexes.
- African people are twice as likely to have a stroke as compared to people of European origin.

TB:

- Africans accounted for 18% of reported cases of TB in the UK in 2011.

Mental Health:

- Black and Black British people access mental health services at a rate of 3733 per 100,000 population, compared to 2789 for all groups.
- Mental health-related admission rates to hospitals were at least two times higher for Black Africans than for the rest of the UK population in 2010.

AHPN Policy Vision

“Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.”

(Marmot Review, 2010)

In the 2011 census, people identifying in the category “Black/African/Caribbean/Black British” make up 3.3% of the total population of England and Wales. Under that category, the figures are African 1.8%, Caribbean 1.1% and other Black 0.5% (ONS, 2012). Africans, though the fourth largest ethnic minority in the UK, account for only 1.8% of the total population. Yet Africans account for 35% of new HIV diagnoses each year (Health Protection Agency, 2012a) and accounted for 18% of reported cases of TB in the UK in 2011 (Health Protection Agency, 2012c). African and African-Caribbean people in the UK are up to three times more likely than the general population to have Type 2 diabetes (Diabetes UK, 2010). But statistics only tell part of the story. Health and wellbeing are more than the measurable, the targets, and the statistics. They are also part and product of the ways in which individuals live their lives: their communities, their experiences and their contexts. Tackling health inequalities requires both the data collection to allow us to measure health inequalities, and social interventions in order to actually solve them.

“Our health and wellbeing are bound up with our lifetime experiences and this is the context in which the measurable should be placed.”

Kate Adams, GP (Adams, 2012)

The AHPN is a national health policy organisation, working with and within diverse African communities across the UK to improve the health and wellbeing of Africans. Our aim is to reduce health inequalities for African people in the UK. This aim, to achieve greater equality in health, is shared and prioritised by government and statutory agencies more now than ever before, following the Marmot Review into health inequalities and the Health and Social Care Act 2012. This is evidenced in the Public Health Outcomes Framework, which sets out the desired outcomes for public health in England and Wales and how these will be measured. The two high level outcome objectives across all of public health are:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities

The former reflects a focus not just on how long individuals live but also the quality of their lives, at all its stages. The latter is concerned with reducing health inequalities between people, communities and geographical areas (Department of Health, 2012). In policy terms then, there has never been a better time than now to work to achieve greater health equality. The AHPN has refocused its work to encompass a range of health conditions that disproportionately affect Africans in the UK: cancer, diabetes, HIV, mental health, stroke and TB. AHPN also works to

address the wider determinants of health, including structural, individual, social, cultural and economic factors. Our policy work is predicated on the concept of intersectionality – that experience is defined and shaped by the multiple strands of roles and influences that make up the identities that individuals possess and how these intersect, and the multiple factors that influence their lifestyles, options and opportunities.

This intersectionality of experience is the key to understanding the root causes of health inequalities between and within communities. The different factors that influence health, and that therefore generate or underlie health inequalities, include:

Structural: access to health services, access to appropriate information and advice
Social: immigration status, social capital, peer support
Economic: poverty, housing, employment
Cultural and beliefs: faith, beliefs about health, symptom recognition and comprehension
Individual: priorities, preferences, psychological factors, explanatory models [processes of understanding ill health (Bhui, 2002)].

Each of these factors influences health directly, in combination, and indirectly through the impact they have on the lifestyle choices individuals make. The lifestyle determinants of health (diet, exercise, alcohol and smoking) are root causes of both ill health and health inequalities. The lifestyle choices individuals

make are a consequence of the wider intersecting identities and experiences of the individual. Understanding these causes of lifestyle choices is an essential first step to addressing the health inequalities they create.

Recognising and understanding diversity in all its meanings is also essential. AHPN works for Africans and African communities. In doing so we recognise that the term 'African' does not represent one single ethnicity, but rather a pan-ethnic and contested identity. While our definition is prefaced on research that supports the view that 'African' may not always be a meaningful form of identity and the group itself is not fixed, but subject to personal choices and experiences underscored by socio-political contexts (Aspinall & Chinouya, 2008), we use the term African as a self selected identity referring to people "who consider themselves African, be they African nationals, migrants from Africa, or direct or indirect African descendants" (Sigma Research, AHPN, NAHIP, 2008). As an identity which individuals choose to assign to themselves, we believe it contrasts with terms such as 'Black and Minority Ethnic', which though increasingly commonly used (particularly for data collection), are challenging and limiting to work with, as they are generally externally assigned.

Specifically in terms of health, umbrella terms are also problematic. Whilst we may know that many people from BME communities share a poor experience of a service the reasons why this is the case are unlikely to be substantially the same for different people caught under the BME umbrella when the term is so broad. People from hugely diverse ethnic, cultural and religious backgrounds are described by the term BME, which hides this diversity and therefore gives an incomplete picture. While African is also a broad term, there are at least significant identifiable commonalities in experiences that make the identity meaningful. By recognising the intersectionality of experiences that lead to health inequalities, we acknowledge that health outcomes are influenced by broader factors than simply belonging to a minority ethnicity, and therefore we continue to firmly believe that an African focus allows us to have the greatest impact. However, given that health data is often collected against BME or black categorisations, we will use this data as a closest approximation where specific data on African populations is unavailable.

Recognition of health inequalities between communities, including ethnic communities, forms a significant part of the ongoing NHS reform process. In specific policy terms, AHPN believes that a genuine opportunity for addressing health inequalities lies in implementing the NHS Future Forum's 'make every contact count' initiative:

"Every healthcare professional should "make every contact count": use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact."

(NHS Future Forum, 2012)

Maximising the health benefits of contact with clinicians can have a revolutionary impact on preventative healthcare in the UK, if delivered successfully. To make this initiative work, we believe it is essential that clinicians are supported to recognise and understand the intersecting factors that influence an individual's lifestyle choices. Effective health promotion is based on understanding and meeting an individual's needs. Generic programmes will inevitably always best meet the needs of the majority.

This builds on the concept of 'cultural competence' in healthcare: a term which is often used but rarely defined, and so often is meaningless in application. Following a study conducted in the US, we define cultural competency expansively, including a range of components which include:

"... communication competencies (with use of colloquialisms and accepted forms of address); staff in culturally acceptable roles; culturally framed trust building... stigma reduction, friendly milieus (such as serving culturally familiar foods and playing music popular with the culture), and services; and peer, family, and community involvement."

(Siegel, Haugland, Reid-Rose, & Hopper, 2011)

We want to see health services moving beyond tokenistic cultural competency towards a health promotion model centred on the individual and their specific needs, and delivered opportunistically at all points of clinical contact. This should sit alongside the increasing governmental focus on 'nudge' methods of promoting health behaviours. The 'nudge' theory is an attempt to encourage people to take actions which will benefit their health, encouraging more 'rational' and health-seeking behaviours and 'nudging' people away from unhealthy choices. We believe this approach should also take into account the 'non-rational' reasons people make particular choices,

based on their individual explanatory models and contexts. Approaches to health promotion which prioritise information-giving to promote rational choices fundamentally misinterpret human nature if they do so without also considering wider non-rational motivations.

In order to reduce health inequalities, effective primary, secondary and tertiary prevention programmes are also needed, that are targeted to ensure relevance to the individual, and understanding by the individual. We therefore call for improved primary prevention, which is targeted specifically towards the needs of African communities. Effective prevention interventions, resources and campaigns must be co-produced by African communities, including community and faith based organisations, utilising the assets, skills and knowledge of communities.

Effective programmes are needed:

- 1) To raise awareness of health risks, including risks linked to age, gender, ethnicity, heredity, diet, obesity, alcohol intake and exercise.
- 2) To improve health literacy and symptom recognition within African communities, and promote early presentation to primary care.
- 3) To increase regular and early uptake of testing, screening and other prevention and early detection opportunities.
- 4) To address nutrition and diet, and promote dietary choices and cooking methods that are rooted in cultural preferences but also help to reduce weight gain and improve physical health.
- 5) To promote better lifestyle choices, health and wellbeing and regular physical activity.

Effective secondary and tertiary prevention programmes are also needed, for people with a diagnosed health condition, to prevent or reduce further ill health. We call for action:

- 1) To improve timely access to regular primary and secondary healthcare and provide culturally and linguistically appropriate information and support.
- 2) To provide adherence support to people with long term medication through sensitive discussions about side effects and adverse reactions and support managing treatment choices.
- 3) To support people to improve their own health by providing tailored information and support on

health improvement, healthy lifestyle choices and prevention of co-morbidities.

Achieving greater health equality requires effective prevention, targeted interventions, and working with communities and community organisations such as AHPN's national membership network, to ensure that health interventions are designed and delivered based on understanding of the intersecting factors that influence an individual's health. This asset based approach, recognising the capacity, knowledge and connections within communities, which communities can utilise to improve health outcomes, is the key to overcoming health inequalities.

In these position papers, we outline the disproportionate impact of cancer, diabetes, HIV, mental health, stroke and TB on Africans and people of African descent in the UK, and our view of what needs to be done to address these health inequalities. The first step is to recognise that health inequalities are part of social inequalities, and cannot be understood from just a statistical perspective.

Nevertheless, data is vital, and the overriding call that echoes throughout these papers is for expanded and improved collection of ethnic monitoring data in healthcare delivery. Currently, the collection of ethnicity data is patchy and incomplete, a long-term challenge within the NHS and one which represents a real barrier to overcoming health inequalities: *"One of the greatest challenges for understanding relationships between people from minority ethnic groups and the NHS is the absence or incompleteness of data. Without the right data, we can not know whether ethnic differences in access, quality, outcomes and choice are narrowing or getting bigger."* (Healthcare Commission, 2009)

Collection of ethnic data within primary and secondary care should be incentivised, in England and Wales as it already is in Scotland, to promote the routine and complete collection of ethnic data. Without this data, it is impossible to accurately measure health inequalities (Better Health, 2010). Recognising the causes of health inequalities, and collecting the data to allow us to measure health inequalities, are the two essential bedrocks of an effective response to health inequalities.

Cancer

In the UK, someone is diagnosed with cancer every two minutes, and there were 320,467 cases of cancer in 2009 (Cancer Research UK, 2012b). There are over 200 different types of cancer, with the most common in the UK being breast, prostate, lung and bowel cancer (Cancer Research UK, 2012a). Improving access to and standards of cancer services including treatment, care and support is a priority for the government and a particular necessity given widespread inequalities in the delivery and take up of cancer services, especially by minority ethnic groups including African communities. One limitation is that cancer data is generally collected either with reference to BME or black, rather than African. In this paper, we will use the most appropriate data from each source according to what is available.

How African Communities are Affected

“Awareness of cancer is generally lower in BME groups than amongst white men and women and screening uptake is generally lower in minority ethnic groups than in the population as a whole” (National Cancer Equality Initiative, 2010).

African people in the UK experience higher prevalence of some specific cancers, and poorer health outcomes in relation to cancer in many cases. Research carried out through a retrospective review of women presenting with invasive breast cancer at a hospital in East London between 1994 and 2005 has shown British black women present and are diagnosed on average 21 years younger than white women, suggesting black women are affected at a significantly younger age (Bowen, 2008). Prostate cancer, which is the most common cancer in men in the UK with 35,000 diagnoses every year, is three times more common in black men than white men (Cancer Research UK, 2012c). Black men also tend to be younger at diagnosis, with the PROCESS cohort study finding black men were diagnosed an average of 5.1 years younger than white men (Metcalfe, 2008).

Patient experience of cancer services is also generally poorer for people from Black and Minority Ethnic (BME) communities. The National Cancer Patient Experience Survey carried out in 2010 showed that BME patients were more likely

to report a poor experience of cancer services than white cancer patients overall (Department of Health, 2010). BME patients were more likely to comment negatively on the way they were treated as patients by clinical staff, as well as reporting concerns about communication and clarity of information (National Cancer Action Team, 2011). Specifically, only 58% of black patients reported receiving answers from a ward nurse that were understandable all or most of the time, and only 66% of black patients felt they received enough help from social services after being discharged (Department of Health, 2010).

People from BME communities are also less likely to be aware of the early signs and symptoms of cancer in comparison to white people in England, which leads to lower uptake of screening and delayed presentation for diagnosis and treatment (National Cancer Equality Initiative, 2010). Research has found that BME women report lower knowledge of the signs of breast cancer (32% saying they did not know much about breast cancer compared to 15% of general population) and are much less likely to practice breast awareness by regularly checking their breasts for changes (Breast Cancer Care, 2005). A study on prostate cancer awareness found that 37% of black participants had heard of prostate cancer and were aware of what it was, compared to 64% of white participants (Rajbabu, 2007).

Lower screening uptake and awareness of the signs and symptoms of cancer lead to increased rates of late presentation and diagnosis among BME communities, negatively affecting health outcomes, treatment options and survival rates. For example, whilst Black British women are less likely to develop breast cancer, the mortality rate is higher due to presenting with more advanced breast cancer and late diagnosis (Betterdays Cancer Care and Black Cancer Care, 2011).

A baseline audit of cancer services for people from BME communities, conducted by the National Cancer Action Team in 2009, found a mixed picture in terms of the standards and availability of culturally competent services. Across some aspects trusts were largely performing well, however, more than 40% of responding services had no culturally specific services provided or commissioned, and more than 20% had no workforce plan for training staff to deliver such services (National Cancer Action Team & Picker Europe Ltd, 2010).

Recent Policy Development

The Department of Health's 2011 strategy for cancer, 'Improving Outcomes', sets out its vision for improving cancer treatment (Department of Health, 2011). This is a key part of the Coalition Government's aim to deliver health outcomes that are among the best in the world, by putting the service user at the heart of public services and empowering local organisations and professionals to drive improvements in services. The objective of the cancer strategy is to drive up England's cancer survival rates so that by 2014/15 an extra 5,000 lives will be saved each year. This is to be achieved by:

- Diagnosing cancer earlier
- Helping people to live healthier lives to reduce preventable cancers
- Screening more people
- Introducing more screening programmes

- Ensuring that all patients have access to the best possible treatment, care and support

'Improving Outcomes' recognises that the links between race and cancer are complex (Department of Health, 2011). It documents patient experience surveys showing that BME groups in general report a worse experience of cancer treatment and care, and maps out strategies to address these inequalities. The strategy argues that it is necessary for every patient to be offered personalised care which addresses their particular needs rather than the perceived needs of any demographic group and that all aspects of cancer services should have equality embedded within them. Delivery against this strategy will be monitored at commissioner level, through data collection on inequalities in cancer populations against other areas, and at provider level where multi disciplinary teams are being encouraged to embed equalities into clinical practice, particularly with Health Equality Audits which will form part of the National Cancer Peer Review Programme.

Public Health Outcomes Framework

The Public Health Outcomes Framework contains 4 domains within each of which are a number of indicators (Department of Health, 2012). The relevant indicators, along with information on the current status of data collection as indicated by the Department of Health on publication of the Framework, are:

Domain	Domain 2: Health Improvement		Domain 4: Healthcare, public health and preventing premature mortality
Indicator	Cancer diagnosed at stage 1 and 2	Cancer screening coverage	Under 75 mortality rate from all cancers

Is data collected nationally/ in upper tier local authorities?	No	Yes	Yes
Is data broken down relative to ethnicity?	No	TBC	No

While the status of data collection is likely to change as the Framework is implemented, AHPN believes urgent priority must be given to disaggregating data on each of these indicators according to ethnicity. Given the weight of existing evidence showing that Africans experience health inequalities in each of the areas covered: late diagnosis; access to screening; and excess mortality, the existence of inequalities is clear. In order to mitigate these, more data is needed to assess the extent and scale of the problem and so begin to explore the causes.

AHPN's Position

While it can be helpful to compile some data on patient experience and health outcomes against the 'BME' categorisation, it is urgently necessary to drill down further into this data to explore the specific experiences and outcomes of different ethnic groups. Overcoming health inequalities

requires understanding the root causes of those inequalities. Disproportionate risk for certain cancers is directly linked to exposure to the risk factors for those cancers, such as poor diet or smoking. These in turn are linked to and caused by wider social, economic, cultural and structural determinants of health. Addressing health inequalities requires addressing these wider inequalities, and as a first step it is essential that cancer outcomes and patient experience data be disaggregated against specific ethnicities.

We welcome the focus on reducing inequalities in the Improving Outcomes strategy, which recognises that mitigating health inequalities is an essential part of improving cancer outcomes overall. Achieving greater equality in cancer outcomes requires achieving equitable access and delivery of screening, diagnosis, treatment and care. In particular, improving uptake of cancer screening and early diagnosis by increasing awareness levels of the early signs and symptoms of cancer in BME communities, as well as dispelling the myths and misconceptions held by different communities about cancer, is of urgent priority. Overcoming cancer inequalities for Africans in the UK requires action to increase awareness and uptake of screening, symptom recognition and knowledge of the signs and symptoms of cancer, that is targeted to the specific needs and experiences of Africans.

Key Directives

- 1) Targeted prevention and health promotion campaigns co-produced and delivered by Africans are needed on prevention, risk reduction, the early signs and symptoms, screening, testing and diagnosis of cancers, especially breast and prostate cancer.
- 2) Specific awareness campaigns, co-produced by African communities and delivered by African peers and organisations, are essential to overcoming myths and misinformation in African communities.
- 3) Research is needed to identify both the barriers to access to screening services and potential solutions to bridge these barriers for Africans.
- 4) More specific and disaggregated data, reflecting the particular experiences of different ethnic and pan-Ethnic groups, are needed to inform an effective approach to mitigating inequalities.

Diabetes

Diabetes is a growing health problem in the UK, both in terms of increasing incidence and escalating costs. The number of people in the UK with diagnosed diabetes has increased from 1.4 million in 1996 to 2.9 million in 2012 (Diabetes UK, 2012). It is estimated that more than one in 20 people in the UK are living with diagnosed or undiagnosed diabetes (Diabetes UK, 2012). Diabetes affects some population groups more than others, as does obesity, which is a major risk factor for developing diabetes. Africans are one of the most affected groups by both conditions in the UK. In England, spending on inpatient care alone for diabetes is around £2.3-2.5 billion per year, about 11% of the total NHS inpatient care expenditure (Kerr, 2011).

How African Communities are Affected

African and African-Caribbean people in the UK are up to three times more likely than the general population to have Type 2 diabetes (Diabetes UK, 2012). This increased risk is generated by a range of complex and interrelated factors, including genetic, social, economic and cultural factors. In 2004, when the health of ethnic minorities was the focus of the Health Survey for England, the breakdown for diabetes by ethnic group and age showed higher prevalence in Black Africans than the general population across all age categories (Health Survey for England 2004, Volume 1: the health of minority ethnic groups, 2004).

Cultural dietary and cooking practices can contribute to an increased risk of obesity, as some traditional African foods are high in sugar, salt or fat. Cultural beliefs and perceptions of what constitutes a healthy weight can also be a factor. One of the risk factors for type 2 diabetes is the accumulation of fat (adipose tissue) around the abdomen and waist area, which genetically some African peoples are pre-disposed to. Additionally, Africans in the UK along with other minority ethnic groups are more likely to live in low-income households than the general population, due to higher levels of unemployment, and are also more likely to live in areas of high deprivation, which increases risk for obesity (Higgins & Dale, 2009). In 2006, the NHS reported that low income is a

risk factor for obesity, which is a risk factor for diabetes (NHS: The Information Centre, 2006).

Recent Policy Development

The National Service Framework for diabetes was published in 2001 and recognised that while diabetes is indiscriminate, the:

“burden of disease falls disproportionately on people from minority ethnic groups and those socially excluded from society (including prisoners, refugees, asylum seekers and people with mental health problems and learning disabilities)” (Department of Health, 2001).

Consequently, the Framework calls for all multi-agency interventions developed to reduce the risk of individuals developing diabetes to *“include elements developed with and appropriate for, these communities”*. The Framework proposes opportunistic screening of individuals with multiple risk factors (e.g. belonging to an affected Ethnic group and a Body Mass Index indicating obesity), as an effective strategy to assist with earlier detection of diabetes.

Progress against the standards for diabetes care set in the 2001 Framework has recently been assessed by the Audit Commission. In its report, the Audit Commission finds that the Department of Health has not met all the standards set in the

National Service Framework resulting in (National Audit Office, 2012):

- People with diabetes developing avoidable complications
- A high number of preventable deaths
- Increased costs for the NHS

The 'Diabetes in adults' quality standard 2011 covers the clinical management of diabetes and supports the National Service Framework (National Institute for Health and Clinical Excellence, 2011a). The standard consists of 14 quality statements including access for people with diabetes to a structured educational programme, receiving personalised advice on nutrition and exercise and an annual assessment of risk for and presence of complications. This annual review should contain the nine key tests for diabetes care, including weight, blood pressure, and cholesterol, which help to ensure that diabetes is under good clinical control. A review by the National Diabetes Audit found that in 2008/9 only just over half of patients with type-2 diabetes and a third of patients with type-1 diabetes received all nine tests (National Institute for Health and Clinical Excellence, 2010).

Public Health Outcomes Framework

The Public Health Outcomes Framework contains 4 domains within each of which are a number of indicators (Department of Health, 2012). The relevant indicators, along with information on the current status of data collection as indicated by

the Department of Health on publication of the Framework, are:

Domain	Domain 2: Health Improvement
Indicator	Recorded diabetes
Is data collected nationally/in upper tier local authorities?	Yes
Is data broken down relative to ethnicity?	Breakdown not currently published or collected but can be constructed from data already collected

We welcome this indicator, though note with concern that an ethnic breakdown of data is not directly collected. We also believe that the additional quality statements outlined in the 'Diabetes in adults' quality standard 2011 should continue to be prioritised, in both action and funding, in order to ensure that inequalities in outcomes are also tackled.

AHPN's Position

Given the disproportionate impact of diabetes on Africans, the AHPN believes that targeted prevention programmes are urgently needed. Specifically, work with communities is needed, to co-produce health promotion materials and interventions that address cultural understandings of weight and healthy eating. Recognising the interlinking factors, structural, social, economic and cultural, which increase obesity and therefore risk of diabetes for Africans, multi-faceted prevention interventions are needed that are rooted in an understanding of these factors and the impact they have.

Key Directives

- 1) Increased efforts are needed to achieve greater progress against the National Service Framework for diabetes, including through co-produced prevention interventions
- 2) GPs should ensure that everyone with diagnosed diabetes receives the 9 key tests to reduce preventable complications annually.
- 3) Additional resources are needed to support community-led work to address healthy eating, food poverty, and perceptions of healthy weight. These interventions are essential to reduce rates of obesity and therefore reduce risk of diabetes.

HIV

In the 30 years since the start of the global HIV pandemic, significant medical advances have been achieved, particularly the development of antiretroviral treatment, such that HIV is now a chronic condition that can be managed with medical treatment and care. Despite these improvements in treatment, people living with HIV continue to face a range of challenges, including stigma, ignorance and discrimination about HIV, as well as barriers to access to the information, services and treatment they need to manage their condition and maintain their health. In the UK, there are an estimated 100,000 people living with HIV (Health Protection Agency, 2012b). While this is a relatively small HIV epidemic compared to some parts of the world, the numbers of people living with HIV have increased dramatically since the 1990s.

How African Communities are Affected

The black African community in the UK bears a disproportionate burden of HIV (Health Protection Agency, 2012b). Whilst constituting 1.8% of the UK population, black Africans account for 35% of new HIV diagnoses each year. In 2011, half of the people accessing HIV care in the UK acquired HIV heterosexually, 64% of whom were black African. In the past decade, the number of individuals seen for HIV care increased almost four-fold among black Africans (6,730 in 2001 to 24,397 in 2010). HPA figures suggest that the HIV prevalence for black Africans in the UK is 37 per 1000 population, compared to the overall population figure of 1.5 per 1000. During 2011 Black Africans represented 28% of newly diagnosed cases of HIV (Health Protection Agency, 2012b). In England, the number of HIV diagnosed black Africans was highest in London in 2010 (44%; 10,277/23,244), followed by East of England SHA (10%; 2,213) and West Midlands SHA (8%; 1,897) (Health Protection Agency, 2012a).

People from African communities are more likely to test and be diagnosed late than other groups. The prevalence of previously undiagnosed HIV is higher among heterosexuals born in sub-Saharan Africa (13 per 1,000) than among UK-born heterosexuals (1.4 per 1,000) (Health Protection Agency, 2012b). The figures from 2011 show that late diagnosis was highest among Black African

men (65%) and Black African women (61%) followed by Black Caribbean women (46%) and Black Caribbean men (42%). Late diagnosis contributes to poorer health outcomes and impedes the effectiveness of treatment. A number of factors impede early testing and contribute to late diagnosis in the African community, including: lack of access to health services; negative experiences of HIV in countries of origin; lack of knowledge of HIV and treatment; misinformation; immigration; poverty; and stigma and discrimination.

There are a number of specific factors that influence the impact of HIV on African individuals and communities. These include gender, with around twice as many African women as men diagnosed with HIV every year in the UK. African women are more likely than men to access services and support, but they are also more likely to experience gender based and intimate partner violence following disclosure, while African men living with HIV report feelings of isolation and emasculation. HIV also has a disproportionate impact on African men who have sex with men, who may experience difficulties in accessing appropriate services (Sigma Research, AHPN, NAHIP, 2012). Poverty is also a significant factor. Compared to other people living with HIV in the UK, in a 2003 research project African people with HIV were ten times more likely to report problems associated with their income, seven times more

likely to report problems with their living conditions, three times more likely to report problems with discrimination and twice as likely to report problems with mobility and personal relationships (Sigma Research, 2003).

Recent Policy Development

The inclusion within the Public Health Outcomes Framework of an indicator specifically relating to HIV represents a significant achievement for the UK HIV policy sector, through the work of the Halve It coalition (of which AHPN is a member) (Halve It Coalition, 2012). Recent policy development on HIV has also been influenced by a House of Lords Select Committee on HIV, which reported in September 2011 (House of Lords Select Committee on HIV and AIDS in the United Kingdom, 2011). The report makes over 50 recommendations on diverse subjects. Though committee findings are not binding on government, they usually have an impact on forthcoming policy and some recommendations have already been debated in Parliament.

Unlike many other countries, the UK does not have a national strategy for responding to HIV. Standards and guidelines of HIV clinical care and treatment are set by the British HIV Association, whilst guidance on HIV testing is set by the National Institute for Health and Clinical Excellence (NICE).

In its guidance ‘Increasing the uptake of HIV testing among black Africans in England’, NICE makes recommendations covering areas such as

community engagement, promoting testing and referral pathways (National Institute for Health and Clinical Excellence, 2011b).

Public Health Outcomes Framework

The Public Health Outcomes Framework contains 4 domains within each of which are a number of indicators (Department of Health, 2012). The relevant indicators, along with information on the current status of data collection as indicated by the Department of Health on publication of the Framework, are:

Domain	Domain 3: Health Protection
Indicator	People presenting with HIV at a late stage of infection
Is data collected nationally/in upper tier local authorities?	Yes at national level
Is data broken down relative to ethnicity?	Not collected but possible to construct at upper tier local authority level
	Breakdown not currently published or collected but can be constructed from data already collected

AHPN’s Position

A national HIV strategy is urgently needed to ensure that the UK’s HIV response is effective and achieves equality of outcomes. It is important to recognise that the needs of African communities are better met in terms of HIV than with respect to many other health conditions, demonstrating the achievements of the many African community organisations who have led the HIV response for Africans in the UK. Further action is needed now to address the differences in outcomes for Africans compared to other groups, especially the disproportionate impact of late diagnosis.

Key Directives

- 1) Additional resources and action is needed to reduce both the rate of late diagnosis and in individual cases the length of time between HIV transmission and diagnosis.
- 2) Efforts to tackle stigma and discrimination by and within communities should be continued, extended, and funded. These and other programmes should be led and shaped by people living with and affected by HIV, in accordance with the GIPA principle (Greater Involvement of People Living with HIV and AIDS) and recognising the unique insight and knowledge that those affected have.
- 3) Clinical developments, including New Prevention Technologies and improved medications, should be made available equally to all who can benefit from them, through meaningful consultation and engagement of different communities and ensuring equitable access based on need.

Mental Health

Mental health is a broad term, which we understand to mean broadly mental and emotional wellbeing. It is defined by the World Health Organisation as “*a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*” (WHO, 2010).

Mental ill health is the largest single cause of disability in the UK, contributing almost 23% of the overall burden of disease (HM Government/Department of Health, 2011). The most common mental illnesses experienced in the UK are anxiety and depression. Mental ill health consumes a significant proportion of NHS and other public spending: economic and social costs of mental health problems in England are estimated at around £105 billion each year (HM Government/Department of Health, 2011). A range of conditions come under the label of ‘mental ill health’ and consequently a range of interventions and treatments are needed.

How African Communities are Affected

Mental health problems are very common; in fact one in four people in the UK will experience a mental health problem each year (Mental Health Foundation, 2012). Data on individuals accessing mental health services is published in the Mental Health Minimum Dataset annual returns, which disaggregates data on broad ethnic category – the closest available approximation for our purposes generally being the Black or Black British group.

According to the 2011 report, the rate of access to mental health services, adjusted for age and sex, is 3733 per 100,000 population for the Black and Black British group, compared to a rate of 2789 for all groups. Black Africans have the highest rate of access to hospital inpatient care for those in contact with mental health services, at 16.5 per 100 mental health service users, compared to 8.5 in the White British Group. The report also finds that 19.5% of people on a Supervised Community Treatment order under the Mental Health Act at the end of 2011 were Black or Black British. In terms of individuals detained under the Act, all ethnic groups showed small increases between 2009/10 and 2010/11, but the Black and Black British group showed the largest increase of 4.9% (NHS Information Centre, 2011)

In addition to overall data on access to services, specific population groups have differing risk and experiences of mental ill health, and so in assessing the impact of mental ill health on communities it is useful to consider different demographic groups separately.

African Young people: Mental ill health among young people is increasingly associated with life chances, and linked to issues of deprivation and disadvantage. The Prince’s Trust Macquarie Youth Index survey, weighted to be representative of all UK 16-25 year olds, found that unemployment has a significant impact on young peoples’ mental health (Prince's Trust, 2010). The survey found 34% of young people who were not in education, employment or training felt down or depressed most or all of the time, increasing to 42% where unemployment had lasted more than a year. This compares to 15% for those in education and 17% of those in employment. 48% of unemployed young people reported that unemployment had caused problems including self harm, insomnia, self loathing and panic attacks. The issue is particularly urgent for young black male jobseekers: “Unemployment among young black men has doubled in three years, rising from 28.8%

in 2008 to 55.9% in the last three months of 2011” according to unpublished ONS figures reported in the Guardian (Guardian, 2012).

African refugees and asylum seekers: The immigration process is inherently stressful, and can cause isolation, uncertainty and inactivity, which can lead to poor mental health, potentially compounded by traumatic experiences in countries of origins. Research has suggested that refugees and asylum seekers, while significantly at risk from stress, anxiety and depression, are poorly served by mental health services (Mind, 2012). Specific elements of the immigration system, particularly immigration detention, can have severely negative impacts on mental health. AHPN’s qualitative research with 21 African people who had experienced immigration detention found almost all had experienced deterioration in their mental health during detention (AHPN, 2012).

African older people: Awareness of dementia and depression among African older people is low, and assumptions may be made by medical professionals about the availability of family care, leading to a lack of support and appropriate information (Royal College of Psychiatrists, 2009). Although in general the risk of dementia is about the same for Africans and other ethnic groups, some evidence shows that risk of dementia in the UK is higher among ethnic minority older people who do not speak English (Royal College of Psychiatrists, 2009).

African Men: African and Caribbean men in particular are over-represented at the acute end of mental health services, with disproportionate diagnoses with psychotic disorders (Mind, 2012). Men in general may find it more difficult to seek help for a mental health problem.

Africans with diagnosed mental illness: according to the *Count Me In* census 2011, 23% of people receiving in-patient mental health care

were from ethnic minority groups, with admission rates to hospitals at least two times higher for Black Africans in 2010 (Community Care, 2011). People with mental health conditions are affected by lower uptake of screening and preventative health services, and excess mortality in conditions including cancer (National Cancer Action Team & National Cancer Equality Initiative, 2012).

Recent Policy Development

The government’s mental health strategy, ‘No Health without Mental Health’, published in February 2011, sets out a strategy for both improving the mental health and wellbeing of the population in general, and improving outcomes for people with mental health problems through high quality services that are accessible to all (HM Government/Department of Health, 2011). The strategy outlines a new more holistic approach to mental health that situates it more in the community and states it is ‘everyone’s business’. It advocates focusing more on wellbeing and the prevention of mental illness than severe psychotic illnesses, and taking a ‘life course approach’. Focus within the strategy is given to tackling mental health stigma, backed by a national anti-stigma campaign: Time to Change (led by Mind and Rethink). In addition, tackling inequalities and wider social determinants are prioritised.

Further to the strategy and specific guidelines, the Improving Access to Psychological Therapies (IAPT) programme was set up to support services to deliver increased access to Cognitive Behavioural Therapy and other psychological therapies in primary care to tackle anxiety and depression (NHS, 2012). IAPT aims to provide universal access to psychological therapies in primary care. Political support and increased funding has led to an expansion of the programme, though uptake and access differs between communities.

Public Health Outcomes Framework

The Public Health Outcomes Framework contains 4 domains within each of which are a number of indicators (Department of Health, 2012). The

Domain	Domain 1: Improving the wider determinants of health		Domain 4: Healthcare, public health and preventing premature mortality
Indicator	People receiving secondary mental health services in settled accommodation	People in prison who have a mental illness or significant mental illness	Excess under 75 mortality in adults with serious mental illness (<i>placeholder</i>)
Is data collected nationally/ in upper tier local authorities?	Yes nationally Not collected but possible to construct at upper tier local authority level	TBC	Not collected but possible to construct at both national and upper tier local authority level
Is data broken down relative to ethnicity?	No	TBC	No

relevant indicators, along with information on the current status of data collection as indicated by the Department of Health on publication of the Framework, are:

The indicators linked to mental health that are included in the Framework relate to specific population groups, rather than population level outcomes. The lack of a specific indicator related to either incidence of mental illness or access to services is a cause for concern.

AHPN's Position

AHPN supports the priority given to mental health at governmental level, especially through the mental health strategy 'No Health without Mental

Health (HM Government/Department of Health, 2011). In particular, our views are echoed in the commitment within the strategy to:

"Shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification of intervention as soon as mental illness arises"

(HM Government/Department of Health, 2011).

However, we share concerns voiced by other agencies about the impact of spending cuts on achieving this objective, and how it will be affected by local level decision making and funding disbursements (Mind, 2010).

With respect to the Increasing Access to Psychological Therapies (IAPT) programme, while we support initiatives to increase access we are concerned that the extent of provision continues to be unequally distributed across different areas. In particular, there is an urgent need for improved data collection in order to assess the level of take-up of IAPT services by African communities, and the recovery rates and outcomes they experience. In the absence of this data, as currently stands, an evaluation of the programme will miss out the needs of diverse communities. In terms of meeting the diverse mental health needs of Africans, we also support maintaining and increasing access to a range of therapies and interventions, in addition to cognitive behavioural therapy, the preferred model of therapy in the IAPT programme (NHS, 2012).

Race, ethnicity and culture are factors that are important to the mental health of the UK's African population, particularly in their perceptions and experiences of mental health services. AHPN believes that the issue of race equality in mental health care has still not been adequately addressed, in spite of numerous initiatives in recent years (Afiya Trust & NHS Confederation, 2012). The issue is significantly neglected in *No Health without Mental Health*, which focuses on

equality more generally rather than race as a discrete area. We believe it is essential that a new targeted strategy for race equality in mental health care is developed.

African people in general may be more likely to experience difficulties in accessing mental health services and care. Barriers to accessing appropriate treatment for Africans experiencing mental health conditions may include lack of knowledge, social stigma, and fear of, or actual discrimination within services. Overcoming these barriers is essential to improving mental health outcomes for Africans.

Evidence on mental health and African people in the UK tends to come from the acute end of services, such as mental health inpatient units, where it has repeatedly been shown that ethnic

minorities in general are over-represented, and the quality of treatment they receive may be compromised due to a combination of “cultural misunderstanding coupled with institutional racism” (The King's Fund & Mind, 2010).

AHPN recognises that there are a variety of settings in which to address the mental ill health and promote the mental wellbeing of Africans in the UK, and many policy areas that contribute. We believe a more holistic and less medicalised understanding of and approach to mental health and care would lead to better outcomes for Africans. A more holistic approach would recognise other models of knowing and experiencing the life of the mind and emotions. Such alternative support structures may be better provided by the African voluntary and faith sectors than statutory services.

Key Directives

- 1) Government investment is needed to support increased community understanding of what good mental health is, and improving mental health literacy including early recognition of symptoms, knowledge of available primary and secondary care services, and timely access to services.
- 2) In line with the focus in the NHS reforms on patient led services, the Department of Health should support access to a range of psychological therapies and support, based on individual need and cultural appropriateness and including services by non-traditional providers including community, voluntary and faith groups.
- 3) Additional support for community and voluntary sector mental health and non-specialist organisations is needed in order to support them to meet the diverse needs of Africans affected by mental health problems and to address cultural and religious beliefs about mental health. This should include funding, access to and support to work with influencing structures and developing new partnerships between these groups and statutory services.
- 4) Every Clinical Commissioning Group's Mental Health Partnership Board should have membership of African or BME organisations to reflect these groups' over representation in Mental Health services.

Stroke

A stroke occurs when the blood supply to part of the brain is cut off and brain cells are damaged or die, and can have a devastating impact on an individual's life. In the UK, 150,000 people have a stroke every year and it is the third largest cause of death, after heart disease and cancer (NHS Choices, 2012). The impact of stroke can be catastrophic, leaving an individual with numbness, weakness or paralysis on one side of the body or with slurred speech. The damage to the brain caused by stroke can lead to disability, and stroke is the largest cause of adult disability in the UK (NHS Choices, 2012). Stroke comes in different forms including: ischemic, where the blood flow to the brain is blocked; haemorrhagic, where a blood vessel in the brain bursts; and transient ischemic attacks (TIAs), a temporary blockage in the blood supply to the brain. The impact of stroke varies between individuals affected, depending on the type of stroke, the part of the brain affected and the severity of the stroke.

How African Communities are Affected

Stroke incidence rates are higher in the black than white ethnic group for both sexes (British Heart Foundation, 2010). Evidence has shown that people of African origin are twice as likely to have a stroke as compared to people of European origin (Stroke Association, 2012b). The high rate of stroke among people of African origin is linked to a number of interlocking risk factors. These include disproportionate rates of other conditions which increase stroke risk, including high blood pressure, diabetes and obesity. Unhealthy lifestyles also increase the risk of stroke, especially through lack of adequate regular physical exercise, diet, alcohol consumption and smoking.

Recent Policy Development

The National Stroke Strategy for England sets out a comprehensive ten-year framework to improve stroke services and care. The strategy is based around a ten-point plan of action, including increasing public awareness, improved prevention and rehabilitation (see box for full list). Further to the strategy, in 2010 NICE published quality standards focusing on clinical care for stroke, including screening within six weeks of

diagnosis to identify cognitive impairment and support for carers of stroke survivors (Stroke Association, 2012a).

National Stroke Strategy Plan of Action

- 1) Awareness: both public and professional awareness of stroke symptoms
- 2) Preventing stroke
- 3) Involvement: of stroke survivors in their care
- 4) Acting on warning signs
- 5) Treating stroke as a medical emergency
- 6) Stroke unit quality
- 7) Rehabilitation and community support
- 8) Participation: assistance to engage in the community
- 9) Skilled workforce to treat people with stroke
- 10) Service improvement

(Department of Health, 2007)

Public Health Outcomes Framework

The Public Health Outcomes Framework contains 4 domains within each of which are a number of indicators (Department of Health, 2012). The relevant indicators, along with information on the current status of data collection as indicated by the

Department of Health on publication of the Framework, are:

Domain	Domain 4: Healthcare, public health and preventing premature mortality
Indicator	Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)
Is data collected nationally/in upper tier local authorities?	Yes
Is data broken down relative to ethnicity?	No

The inclusion of stroke within the Public Health Outcomes Framework sits within a broader indicator and relates exclusively to mortality. Continued investment in achieving the ten-point plan set out in the National Stroke Strategy is therefore needed alongside the implementation of the Framework.

AHPN's Position

There are three distinct objectives which are necessary to improve health outcomes for Africans

related to stroke. Firstly, it is imperative to reduce the risk of stroke, through targeted prevention campaigns and interventions informing and supporting Africans to make healthier lifestyle choices.

Secondly, improved information is needed, to support people to recognise stroke and seek timely medical help. We recognise the achievements of the existing FAST campaign, which encourages people to recognise stroke symptoms: Facial weakness; Arm weakness; Speech problems; Time to seek medical assistance. We particularly welcome that the campaign materials were made available in multiple versions featuring individuals of different ethnicities, including black men and women – a vital step. To ensure that this objective is met, the FAST campaign should receive sustained funding and expanded reach.

Finally, increased investment is needed in services to meet the needs of diverse communities, in particular to support rehabilitation, which is essential to stroke recovery.

Key Directives

- 1) Government investment in prevention and awareness campaigns to promote understanding in African communities of stroke risks, how to reduce these risks, healthier lifestyle choices and recognising stroke symptoms.
- 2) Statutory investment is needed in stroke support for distinct and diverse patient groups, to ensure the individual needs of people after stroke are met appropriately.
- 3) In light of the imperative of 'no decision about me without me', there is a greater need for patient-led advocacy and involvement in the design and delivery of stroke services.

Additionally, AHPN supports the Stroke Survivors' Five Demands for Action (Stroke Association, 2008):

- 1) Stroke must be treated as a medical emergency at all times.
- 2) All stroke patients must be taken immediately to and spend the majority of their time in a stroke unit.
- 3) All stroke survivors must receive a smooth transition from hospital to home.
- 4) All stroke survivors must receive all the rehabilitation and long-term support that meets their specific needs.
- 5) All transient ischemic attacks must be treated with the same seriousness as stroke.

TB

Tuberculosis is a disease caused by bacteria. It is possible for the bacteria to develop in any part of the body, but it is most common in the lungs, which is called pulmonary tuberculosis (TB Alert, 2012). Rates of TB infection in the UK have increased over the past two decades. London has the highest rates of TB in the country with 39% of cases, followed by the West Midlands with 11% (Health Protection Agency, 2012c). There are a number of initiatives being carried out aiming to bring down the rates of TB in London, such as the London TB register, where all cases of TB are recorded to facilitate action to limit onward transmission. In cases where ethnic group was available in 2011 (96% of the total), the largest proportions were from Indian (26%), White (20%) and Black African (18%) ethnic groups (Health Protection Agency, 2012c).

How African Communities are Affected

Black Africans represent 1.8% of the population of England and Wales, yet Black African people made up 18% of reported cases of TB in the UK in 2011, with one of the highest rates of 100 per 100,000 in the black ethnic group (Health Protection Agency, 2012c). There are a number of factors which can increase the risk of contracting TB:

Socio-economic factors: Africans in the UK are twice as likely to live in low-income households, compared to the general population, due to higher levels of unemployment (The Poverty Site, 2006). Consequences of poverty, such as poor living conditions or nutrition, may weaken the immune system, and make active TB disease more likely.

HIV co-infection: Having a lowered immune system, which HIV can cause, makes it harder for the body to fight TB bacteria making it more likely that the individual will contract the disease (TB Alert & AHPN, 2010). The African community is the disproportionately affected by HIV in the UK, which contributes to a disproportionately high burden of Tuberculosis.

Completing treatment: for TB to be successfully treated, it is vital that the full course of antibiotic treatment is completed. Failure to do this can lead to the development of resistance, complicating further treatment and leading to poorer health outcomes. Completing the treatment course can be very

challenging for some people, as six months treatment is normally required (The Truth About TB, 2009).

Stigma: stigma and negative connotations continue to be attached to tuberculosis, causing many individuals with TB to be reluctant to disclose this information even to close family and friends. Without support during treatment it is less likely that the patient will successfully complete their treatment.

Recent Policy Development

‘Stopping Tuberculosis in England: An Action Plan from the Chief Medical Officer’ was published by the Department of Health in 2004 with an overall goal to reduce and eventually eliminate TB in the UK (Department of Health, 2004). The immediate aims it sets out for the national TB programme are to:

- reduce the risk of people being newly infected with tuberculosis in England
- provide high quality treatment and care for all people with TB
- maintain low levels of drug resistance, particularly multidrug resistant (MDR) TB

The action plan contains ten actions, including: increasing awareness of TB, strong commitment and leadership, well organised and coordinated patient services and an expert workforce. The action plan was later supplemented by a TB toolkit to support service commissioners and delivery and by NICE guidelines on

clinical care (Houses of Parliament: Parliamentary Office of Science and Technology, 2012).

Public Health Outcomes Framework

The Public Health Outcomes Framework contains 4 domains within each of which are a number of indicators (Department of Health, 2012). The relevant indicators, along with information on the current status of data collection as indicated by the Department of Health on publication of the Framework, are:

Domain	Domain 3: Health Protection
Indicator	Treatment completion for tuberculosis
Is data collected nationally/in upper tier local authorities?	Yes
Is data broken down relative to ethnicity?	Not collected but possible to construct at upper tier local authority level
	Yes

The indicator on treatment completion is an important imperative, to improve individual health outcomes and to reduce drug resistance.

AHPN's Position

The key to tackling the disproportionate rates of tuberculosis among Africans in the UK lies in raising awareness of the disease and working with communities to fight the stigma attached to it. Giving people the right information will help to improve diagnosis rates and increase community awareness of the symptoms of tuberculosis.

AHPN welcomes the inclusion of treatment completion for tuberculosis in the Public Health Outcomes Framework, given the necessity of additional support for individuals to achieve this. We particularly welcome that this data is broken down relative to ethnicity, which is essential given the ethnic inequalities associated with TB in the UK.

We also welcome the recognition given within the Action Plan to the disproportionate burden of TB borne by ethnic minorities, and support the call for TB services to be targeted where they are most needed, including “among those population groups most at risk, recognising that these differ in different parts of the country” (Department of Health, 2004)

Key Directives

- 1) Increased investment is needed in programme and interventions to raise awareness about TB, including symptom recognition and treatment options, in African communities.
- 2) Investment in the engagement of African communities in the co-production, design and delivery of prevention campaigns and at all levels of service delivery.
- 3) Support, training, resources and funding should be directed towards voluntary and faith based organisations within African communities to deliver TB interventions, including support for treatment completion, recognising the privileged access and standing of these groups as compared to statutory bodies.

Summary

Health inequalities are a barrier to achieving improved health outcomes and a better, more efficient NHS. In this, they represent a problem for the health system overall, in addition to the impact on the affected communities. Health inequalities for Africans, in prevalence, outcomes, patient experience and access to services, exist across a range of conditions, and emerge out of a range of social inequalities. Tackling inequalities requires energy, focus and determination. AHPN is calling for a new focus on equality in the health system, in both identifying and meeting the needs of diverse communities, the delivery of healthcare and services and achieving equality in outcomes. This equality-focussed approach would necessarily include:

- Focus on the social determinants of health and health inequalities, including action to identify and address the structural, social, economic, cultural, and individual factors that influence health.
- Improved collection and disaggregation of ethnic health data, including through incentivising data collection.
- Targeted health promotion, focussing on the individual and influenced by their needs, to address lifestyle determinants of health, including through a reality of Making Every Contact Count
- Meaningful cultural competence, achieved through working with communities and funding community-led interventions.
- Primary, secondary and tertiary prevention programmes, targeted to specific communities and focussing on the health conditions and concerns that most affect them.
- Taking an asset based approach that recognises and capitalises on the skills, abilities and competencies of communities.

Focusing on equality, and implementing and integrating that focus, is not merely a matter of principle: though the ethical argument is compelling. It is also a pragmatic call, as this approach would yield improved outcomes, and a more efficient health service. Health inequalities represent an excess in ill health, which is an expense that can be avoided in both financial and human costs. Equality makes sense, as a matter of principle, for health outcomes and to improve efficiency.

At the outset of the health reforms being implemented this year, a commitment to reducing health inequalities was demonstrated, through the Health and Social Care Act 2012, which sets out reducing inequalities as a duty of the Secretary of State and the NHS Commissioning Board and an objective of Monitor, as well as the overarching outcome of reducing inequalities in the Public Health Outcomes Framework. Yet the baseline data for measuring achievements about the Framework contains limited inequalities data, with only two indicators disaggregated on ethnicity. If the promise of those earlier commitments is to be realised, then greater focus and energy is needed. We urgently need to regain momentum in tackling inequalities, and refocus on delivering equality in the health system. Losing focus now risks generating even greater health inequalities.

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Policy Position 2013



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