Belfast Health Development Unit
Reducing inequality, improving health and wellbeing

Barriers to health

migrant health and wellbeing in Belfast

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Over the last decade Belfast has experienced significant political, economic and social change. As a consequence, the population of greater Belfast has increased substantially over the past decade. This has been as a result of both natural change and net migration gain.

2.1 Summary of migrant numbers

- Net migration flows to Northern Ireland show a rise from a loss of 1900 people in 2000/1 to a gain of around 9800 people in 2006/7, before falling back to a gain of 5700 people last year
- In 2008, the population of Northern Ireland was 1,775m and of greater Belfast, 645,536 people (NISRA 2009)
- In 2009, the total migrant population was estimated to be 73,000 (4.1%) in Northern Ireland (Annual Population Survey 2009)
- The largest, most established minority ethnic community in Belfast is the Chinese community, followed by Indian and Pakistani populations
- In 2009, there were approximately 30,000 migrants from the Accession Countries (37% of the total migrant population)
- Polish nationals are the largest group from the Accession Countries, accounting for some 60% of migrants from A8 countries (NISRA 2009)
- Northern Ireland has received a larger number of people from Lithuania than anywhere else in the UK
- African communities are newer arrivals, and represent diverse nationalities and backgrounds with small numbers of people overall
- The top requested languages, recorded by the Northern Ireland Regional Interpreter Service in 2009, were: Polish, Mandarin, Cantonese, Arabic, Slovak, Lithuanian, Romanian, Hakka, Russian and Portuguese (NIHSCIS 2010)
- Established communities have older age ranges
- Newcomers to Belfast (A8 accession countries and asylum seekers) are predominantly within the age range of 18 to 35 years of age
- There are increasing numbers of births to women born outside the UK, reflecting the increasing number of migrant women living in Belfast.

2.2 Legislation on immigration, work, health & social services and social security entitlements

Legislation on nationality, immigration and asylum is under the auspices of the UK government. Different groups of people living and working in Northern Ireland have varying restrictions on work, health, social care and entitlement to benefits and housing (outlined in the report).

2.3 Health issues

Migrant and Black and Minority Ethnic (BME) communities in Belfast represent a diverse and dynamic population in terms of their reasons for migration, with changing health needs and priorities over time. Priority health needs can be divided into the following areas:

1. Access to health care
2. Racism and racial harassment
3. Adult health
4. Health protection
5. Children's health
6. Women's health

2 Executive summary

7. Mental health
8. Poverty
9. Housing
10. Special groups with complex needs.

2.4 Migrant health priorities identified at the Stakeholder Workshop held in April 2010:

1. Improve access to health care for migrants
2. Develop a One Stop Service for migrants
3. Provide training and guidelines for health and social care professionals.

3 Introduction

Healthy and Wealthy Together is a European Commission funded project under the INTI (Integration of Third Country Nationals) programme, within the Directorate General for Freedom, Security and Justice (QeC-ERAN 2009). The goal of the project is to identify and develop tools and good practice models to address poverty and health inequalities among migrants. The objectives include mutual learning and exchange, dissemination of good practice and support for partners to develop local action plans (Appendix A (10.1): list of partners). The project runs from December 2009 to May 2011. Each partner is required to establish a Local Action Group (Appendix B (10.2): members of Belfast LAG). The Local Action Group has carried out a mapping of migrant health in the local area. This report presents migrant health and wellbeing in Belfast. It consists of an analysis of available information and the conclusions of a stakeholder workshop organised to identify priority health needs. Where figures for Belfast are unavailable, they are presented for Northern Ireland.

3.1 Background to migration in the European Union

In the last twenty years migration figures in the UK have increased in line with the rest of Europe, and current levels are higher than at any time in history; Northern Ireland is no exception (Eurostat, the Statistical Office of the European Communities 2009). Migration has increased worldwide from 75 million in 1965, to 175 million in 2002 (Ghent, A. 2008). Migration is high on the political agenda of the UK and other countries in the European Union. Yet migration in the European Union is not a new phenomenon, rather the issue has gained more visibility and the terms of migration have changed.

Historically, patterns of migration have been driven by poverty and the desire for a better life. Such drivers are still present, but seasonal workers schemes and an increase in refugee and asylum seeker status is a newer phenomenon. The main countries from which individuals migrate have also changed. Disintegration of the Soviet Union has played a big part in the demographics of migration throughout the European Union, and there are increasing numbers of people from Asia, Africa and Latin America migrating to Europe.

It is hard to find accurate information on the number of migrants and their duration of stay. Part of the reason for this is that there is no common definition for the term ‘migrant’, which makes monitoring difficult. The term ‘migrant’ includes short-term and long-term residents, populations in transition and settled communities, people with and without legal status or papers, and first, second and third generation migrants. Governments use the term in different contexts. Migrants are a heterogeneous group and various categories exist according to their legal status and nationality:

- Permanent residents / legally-residing migrants, guest workers, workers, and expatriates
- Irregular / undocumented / without (or with expired) vsa migrants
- Education migrants
- Forced migrants
- Refugees
- Asylum seekers
- Refused asylum seekers

Migration and health are interconnected in many ways. Globalisation is associated with

3 Introduction

migration and has implications for public health. Patterns of disease, health needs and the type of health services required are all changing. The cost of services are increasing and this has an impact on health systems. In addition, types of migration interact with each other and other population parameters, such as age/sex structure, sexual activity, fertility, mortality, and family structure. Thus, migration poses special challenges to national health care systems.

The main health issues for migrants are:

- Sexual health (sexually transmitted diseases, HIV / AIDs, Hepatitis C and B)
- Communicable disease (eg. tuberculosis)
- Women, children and maternity care
- Dependence on drugs, alcohol or other substances
- Chronic diseases (eg. diabetes, cardiovascular diseases)
- Mental health

In December 2007 the Council of the European Union held a policy debate on migration and health in the European Union. They highlighted the association between the health of migrants and that of all European citizens and identified the need for the integration of migrant health issues into national policies, access to health care for migrants, and sharing knowledge, relevant experience and good practice between countries (Council of EU 2007).

To facilitate such conclusions, the Council recommended that the European Commission support action through the 'Programme of Community Action in the Field of Health 2008–2013'. Thus, Member States were invited to integrate migrant health into national policies and requested to facilitate access to healthcare for migrants (DG SANCO and Public Health Executive Agency 2007).

4 Belfast - demographic characteristics

Throughout the 1970s and 1980s, there was a reduction in the population of Belfast. During the 'Troubles', many people left because of extreme poverty and economic decline. However, over the last decade Belfast has experienced significant political, economic and social change. During this period there has been marked economic growth and investment, producing a renewed and revitalised Belfast, along with a dynamic job market and cultural change. Increasing political stability and a return to devolution in 2007 have contributed to a sense of renewed optimism.

Consequently, the population of greater Belfast has increased over the last decade. It is one of the smaller cities of the United Kingdom with a population of 645,536 in the wider metropolitan area as of June 2008. The total population of Northern Ireland has also increased rapidly since the middle of this decade to 1,775m people, 3% of the total population of UK. This has been as a result of both natural change and net migration gain. In Belfast, between 2007 and 2008 population growth due to migration was estimated to be 519 people, a 0.3% increase in population size (NISRA 2001). More recently, in line with the rest of the United Kingdom, Belfast has suffered from the global economic recession.

Following a decade of positive growth, there have been important improvements in the health and wellbeing of the population of Belfast. Life expectancy has improved, unemployment has fallen and the proportion of school leavers attaining more than five GCSE's has increased. The living environment has improved and recorded crime has fallen by over 25%. Yet major health problems remain: smoking prevalence is 30%; 20% of people are sedentary; and obesity is increasing reflecting trends across the United Kingdom. The level of economic inactivity remains high at about 30% in Belfast, one of the highest levels in the United Kingdom. Belfast continues to rank low compared with the rest of the UK on indicators such as life expectancy, long-term limiting illness, child health and economic activity. The Northern Ireland Multiple Deprivation Measure identifies small area concentrations of multiple deprivation across Northern Ireland, based on the Noble Index. Belfast Local Governmental District contains 34% of the most deprived areas in the region (Belfast Healthy Cities 2008).

Due to the change in population size and demographics of the city of Belfast, there is now increasing recognition and awareness of the changing needs of the population.

5 Migrant population in Belfast

Figures from different data sources

Some 98% of the residents of Belfast are of white ethnic origin. Belfast also has a diverse range of Black and Minority Ethnic (BME) communities resident in the city, the most widely recognised of these being the Chinese, Indian and Pakistani communities. There are small numbers of other minority groups although these have been increasing rapidly in number in recent years. There are no distinct ethnic residential areas; instead BME groups are scattered throughout the region (Jarman, N. 2007).

Publication of the results of the 2001 Census made it possible to get more details on the scale and make-up of BME populations. Net migration has changed significantly since the 2001 Census; there has been significant growth in the population of Northern Ireland and in Belfast since 2004. Migration figures have doubled in number each year between 2004 and 2007. The latest figures, not yet published, however, are showing a decline in population increase from migration (NISRA 2009). Figure 1 shows the changes in net migration to Northern Ireland over the last four decades.

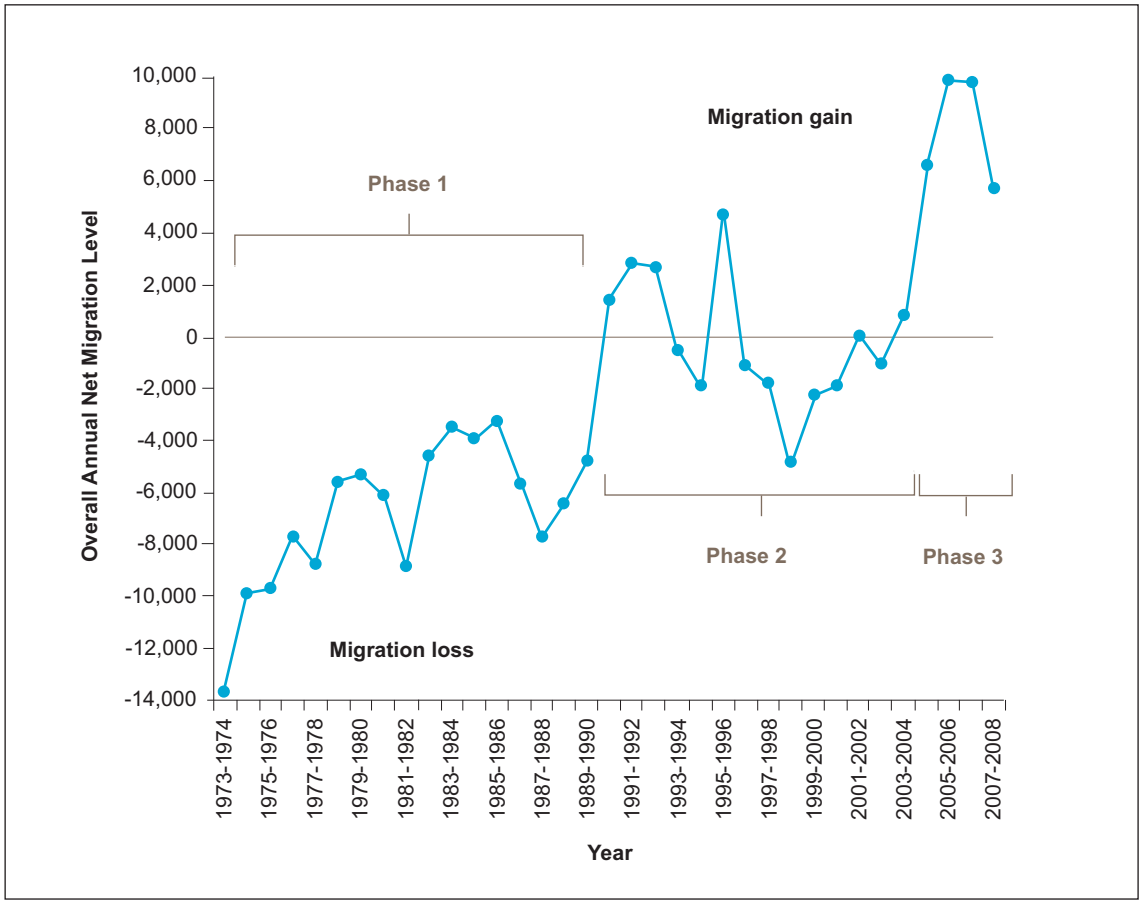

Figure 1: Estimates of long-term net migration - Northern Ireland (1973/4 - 2007/8)

There are different reasons why individuals move from their country of origin: to seek or take up work; to study overseas; to join their families; to seek refugee or asylum seeker status, fleeing persecution in their country of origin; or asylum seekers who have exhausted the asylum appeals process but continue to live in the country of destination.

5 Migrant population in Belfast

In Northern Ireland, the largest proportion of migration is as a consequence of the increase in number of European Union countries. In May 2004, eight Central and Eastern European countries joined the European Union. These countries are known as the A8 countries (Appendix C (10.3)). In 2007, the European Union expanded further. The additional two countries are known as the A2 countries (Appendix C (10.3)). There has also been an increase in the number of non-EU nationals seeking work, particularly within the health and social care sector and food industry. The number of refugees and asylum seekers is also increasing since the introduction of the 1999 Immigration and Asylum Act, which enabled the Home Office to disperse asylum seekers away from London to other regions of the UK (NISRA 2000).

5.1 Census 2001

The 2001 Census recorded 4,310 people from a BME background resident in Belfast (1.6% of the population). Thirty percent of the BME population in Northern Ireland lived in Belfast, with 57% of the BME population of Belfast living in South Belfast (NISRA 2001). Table 1 shows the different BME groups, registered in the 2001 Census, living in Belfast and Northern Ireland.

BME Groups	Number living in Belfast	Number living in NI	Proportion of NI population living in Belfast (%)
Chinese	1660	4145	40
Mixed	886	3319	26
Indians	438	1567	28
Pakistanis	153	668	23
Black African	148	494	30
Black Caribbean	62	256	24
Bangladeshi	62	251	25
Other Black	74	381	19
Other Asian	92	191	42
Other Ethnic Groups	490	1290	38
Total BME Groups	4310	14279	30
Total Population	276 459	1 685 267	
BME Groups per total population	1.6%	0.85%	

Table 1: Figures from 2001 Census

Over half of the BME groups were born in Northern Ireland, some with family histories extending back several generations. Alongside these established communities, the 2001 Census figures also indicated a significant number of other migrant populations; 250 people identified themselves as of Polish descent. Despite the long term presence of these smaller communities, it is only recently that their cultural and religious needs and potential differing health needs have been recognised.

5 Migrant population in Belfast

5.2 Data sources used to monitor migration since the Census

Before 2004, the changing pattern of migration was difficult to identify with any degree of accuracy; there was no systematic collection and analysis of data on migration in Northern Ireland other than the 2001 Census. Limitations in the monitoring of demographic changes in the population poses challenges in measuring the associated health and social care needs, which contravenes the statutory obligation of mainstreaming equality. The 1997 Race Relations (NI) Order and Section 75 of the Northern Ireland Act 1998 places a statutory obligation on all public bodies, both as employers and service providers, to promote racial equality. This requires better information on migrant numbers and needs.

In an attempt to provide more accurate information on migration, the Northern Ireland Statistics and Research Agency published an overview of long-term international migration estimates in 2006 (Beatty, Fegan & Marshall 2006). Annual reports of international migration estimates are now published. Data sources used include:

- UK Border Agency Worker Registration Scheme
- UK Border Agency Schemes for A2 nationals
- Home Office Work Permits Scheme
- National Insurance Numbers registered to foreign nationals
- Department of Education Annual School Census
- Country of birth of new Northern Ireland mothers
- Country of birth of new Northern Ireland fathers
- New registrations with a family doctor
- National Asylum Support Service, UK Border Agency (Belfast branch)

Each data source has its own limitations, causing difficulties for interpretation of figures. Different definitions are used for the term ‘migrant’. In Northern Ireland, the United Nations definition of a long-term migrant is used (UNESCO), which states that:

“A person who moves to a country which is not his or her usual residence, for at least a year, then the country of destination effectively becomes his or her new country of usual residence. From the perspective of the country of departure, the person will be a long-term emigrant and from that of the country of arrival, the person will be a long-term immigrant.”

It is even more difficult to obtain accurate numbers for short-term migrants and at present, there are no official figures for this group. The United Nations defines a ‘short-term international migrant’ as:

“A person who moves to a country which is not his or her usual residence for at least 3 months but less than 12 months, except in cases where the movement to that country is for purposes of recreation, holiday, visits to friends and relatives, business, medical treatment or religious pilgrimage. For purposes of international migration statistics, the country of usual residence of short-term migrants is considered to be the country of destination during the period they spend in it.”

5 Migrant population in Belfast

5.2.1 UK Border Agency Worker Registration Scheme

The Worker Registration Scheme (WRS) provides a statutory obligation for members of A8 countries to register if they want to work in the UK. Workers are registered by employer and the figures are used to estimate migration numbers from these countries by geographical area.

Between 2004 and 2009, 36,500 people registered with the WRS scheme in Northern Ireland, 4% of the total number of WRS registrations in the UK. This is the largest number of WRS workers per 1000 of population in the UK.

The number of WRS registrations in Northern Ireland more than doubled from 2004 to 2005, remaining reasonably constant from 2005 to 2007, with the peak number of registrations in 2006. Since 2008, the number of registrations has declined and the very latest figures show a further decline, most likely in response to the economic downturn (see graph below).

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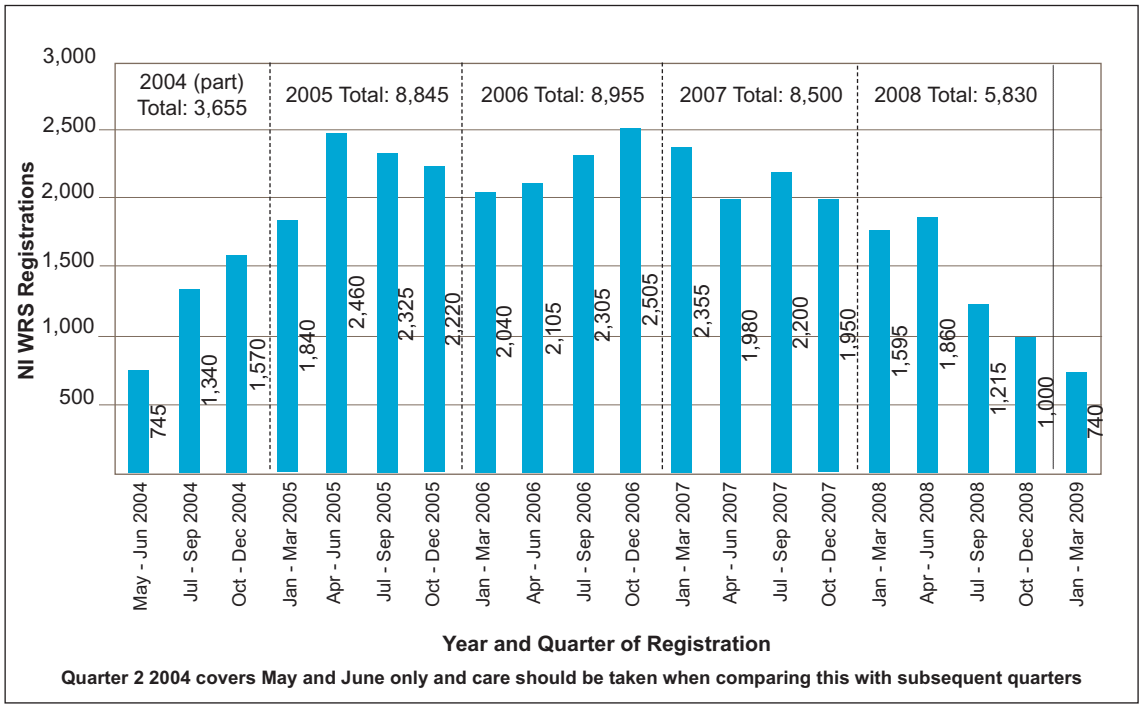

Figure 2: NI Worker Registration Scheme (WRS) registrations by quarter (May 2004 - March 2009)

Table 2 shows the number of WRS registrations in Belfast each year since 2004. Also shown is the total number of WRS registrations in Belfast as a percentage of the total number of WRS registrations in Northern Ireland, and per 1000 residents in Belfast.

	2004/5	2005/6	2006/7	2007/8	2008/9	Total	Belfast/NI (2009)	per 1000 (2009)
Belfast	840	1860	1745	1350	814	6609	18%	3

Table 2: Number of WRS registrations in Belfast each year (2004 to 2009)

5 Migrant population in Belfast

Most people registered to work in Northern Ireland are from Poland. Northern Ireland has received a larger number of people from Lithuania than anywhere else in the United Kingdom, shown in table 3.

Nationality	Total WRS in NI	Nationality as a % of total WRS
Poland	20 618	56%
Lithuania	6630	18%
Slovakia	5070	14%
Latvia	1750	5%
Hungary	855	2.40%
Estonia	80	0.22%
Slovenia	5	
Total	36 525	

Table 3: Breakdown of nationality of WRS registrations in Northern Ireland (2004-March 2009)

5.2.2 UK Border Agency schemes for A2 nationals

Citizens from Bulgaria and Romania are free to move in and out of the UK, with initial right of residence for up to three months. They only have a right to remain indefinitely if they are students, self-employed or self-sufficient. All other A2 nationals have work restrictions for two years and have an annual review by the Home Office. Low skilled workers can only work in one of two schemes: Seasonal Agricultural or Sector Worker Schemes. Highly skilled workers can apply through the Points-based Tier System. (See later for information on the different schemes).

There are limited figures for citizens from the A2 countries. There are statistics for the number of work permits issued in Northern Ireland, but not by region. Some 600 were issued to Bulgarian nationals and 140 to Romanian nationals between January 2007 to March 2009. The figures for work permits underestimate the numbers of A2 nationals living in the region, as the majority are not registered with either of the Worker Schemes.

5.2.3 Home Office Work Permit scheme

Work permits are issued by the Home Office to a specific person for a specific job. The Work Permit scheme allows employment of people from outside the European Union while protecting employment for the local population.

Between 2004 and 2009, a total of 12,465 work permits were issued in Northern Ireland, 1.6% of the UK total. Since 2004 there has been a steady decline in the number of work permits issues, as shown in figure 3.

5 Migrant population in Belfast

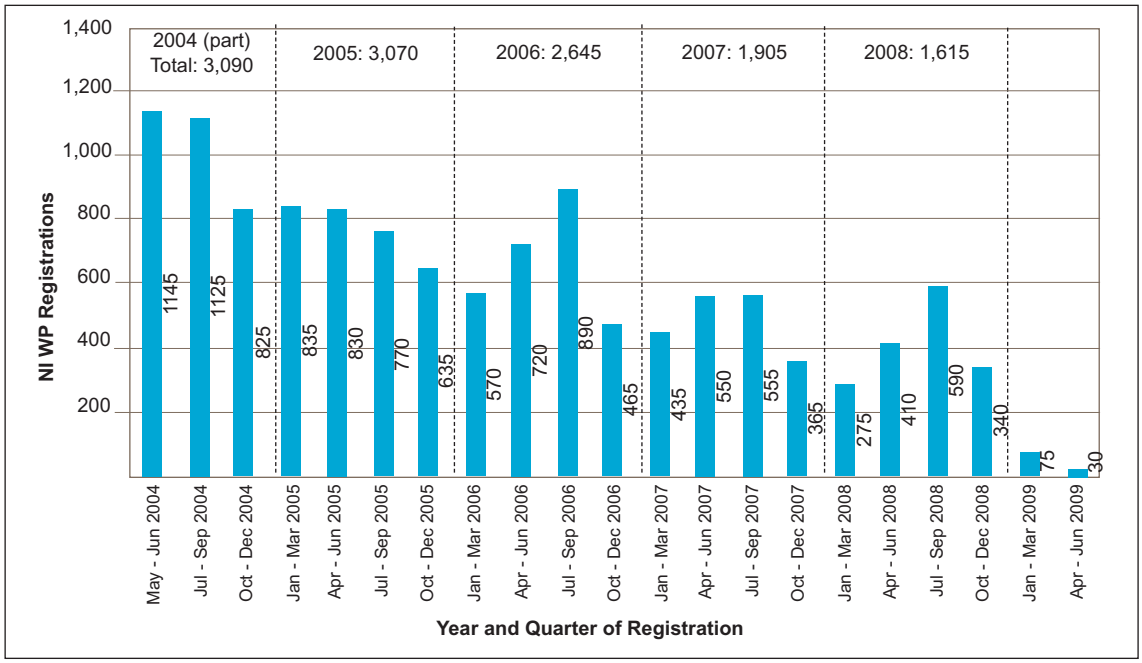

Figure 3: Work Permits issued by quarter of registration (April 2004 - June 2009)

Information on work permits is only available by area of employer. Table 4 shows the number of work permit registrations each year in Belfast since 2004, the number of work permits in Belfast as a percentage of the total number of registrations in Northern Ireland, and per 1000 residents in Belfast.

	2004/5	2005/6	2006/7	2007/8	2008/9	Total	Belfast/NI (2009)	per 1000 (2009)
Belfast	920	630	780	455	385	3170	26%	1.4

Table 4: Number of Work Permit registrations in Belfast each year (2004 to 2009)

For the overall period, approximately 40% of work permits issued have been to Indian and Philippine nationals (table 5). However in 2008/9, the majority of work permits were issued to people from India, Bulgaria and USA (some 890 work permits in total out of 1,410 issued, approximately 60%).

Nationality	Total Work Permits in NI	Nationality as a % of total
India	2855	23%
Philippines	1910	15%
Ukraine	1155	9%
China	885	7%
Bulgaria	865	7%
Romania	830	6.7%
USA	775	6.2%
Pakistan	615	5%
South Africa	315	2.5%
Moldova	225	1.8%

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Nationality	Total Work Permits in NI	Nationality as a % of total
Malaysia	190	1.5%
Canada	150	1,2%
Russia	125	1%
Australia	120	1%
Nepal	105	0.8%
Nigeria	95	0.8%
Bangladesh	90	0.7%
British National Overseas	75	0.6%
Brazil	65	0.5%
Japan	65	0.5%
Kenya	60	0.5%
Belarus	55	0.4%
Morocco	45	0.4%
< 20 registrations	1070	9%
Total	12 465	

Table 5: Breakdown of nationality of Work Permit registrations in Northern Ireland (2004-March 2009)

5.2.4 Northern Ireland National Insurance Number registrations (NINo)

National Insurance numbers are required for employment purposes or to claim benefits and tax credits. In 2003/4, there were 4,500 registrations for NINo from non-UK nationals in Northern Ireland. This increased year-on-year to 17,600 in 2007/8, since when the numbers have fallen, with 7530 registrations in 2009/10.

Figure 4: NINo registrations to Non-UK nationals by financial year of registration (April 2000-March 2009)

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NINo figures at Local Governmental District (LGD) level are allocated by post code. Data from districts with missing or unavailable post codes are included in the total number for Northern Ireland. Table 6 shows the annual number of NINo registrations in Belfast until 2006. Data at LGD level is currently not available from 2006 onwards. Since then this data has been provided by Department for Work and Pensions (DWP) in the UK. Work is ongoing to create figures by LGD and should be available for 2009/10.

	2004/5	2005/6	Belfast/NI	per 1000 Belfast pop.
Belfast	1851	4705	30%	17.6

Table 6: Number of NINo registrations in Belfast each year (2004 to 2006)

A8 countries account for over half of the NINo registrations to non-UK nationals from 2004 to the present day. The highest numbers are Polish (40%), Lithuanian (11%) and Slovakian (8.7%). This trend has been consistent each year with just over 4,200 of the 12,600 registration applications in 2008/9 being from Polish nationals (33%), equivalent to over 60% of the registrations from all A8 country migrant workers.

5.2.5 Annual School Census

Each year the Department of Education in Northern Ireland undertakes a school census. The latest Census figures published are from October 2008. There are two questions associated with children with English as a second language:

1. The number of children in school where English is their second language along with the breakdown of the languages spoken. Table 7 shows the figures for Belfast and Northern Ireland.

	No. of pupils with English as an additional language		Total population of pupils		Pupils with English as an additional language/total	
	Primary	Post-Primary	Primary	Post-Primary	Primary	Post-Primary
Belfast	807	469	23 300	30 000	4%	2%
NI	4311	2142	156 000	148 000	3%	1%

Table 7: Number of children in school with English as a second language in Belfast (2008)

Some 3% of primary school children were recorded in for Northern Ireland in 2008 with English as their second language, which is a 22% increase on the 2007 figure. The number of post-primary school children rose from 1% in 2007 to 24% in 2008. The highest proportion of children was of Polish origin.

2. Since 2006, the number of children with English as a second language who commenced school in the last academic year has also been included in the school census. Table 8 shows the figures for Belfast and Northern Ireland.

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	Pupils who arrived in previous year		Total population of pupils		Pupil who arrived in previous year/total	
	Primary	Post-Primary	Primary	Post-Primary	Primary	Post-Primary
Belfast	376	165	23 300	30 000	1.6%	1%
NI	2042	825	156 000	148 000	1%	1%

Table 8: Number of children who arrived in the last academic year with English as a second language (2008)

5.2.6 Births to mothers born outside Northern Ireland

Births that occur in Northern Ireland are required to be registered with the General Register Office by law. The country of origin of the mother is recorded when the birth is registered.

In Northern Ireland, the number of births to women born outside the UK has markedly increased since 2001. The total number of births in Northern Ireland born to such women was 700 in 2001, rising to 2,300 in 2008. Figures for the first half of 2009 are similar to 2008. Within these figures, there has been an even higher increase in babies born to woman who were born in one of the A8 countries, with approximately 10 such births in 2001, rising to approximately 1,100 births in 2008.

In 2008, Belfast exhibited one of the highest proportions of births to mothers born outside the UK at 12.5%, second only to Dungannon at 20%. Table 9 shows the total number of births, and births to mothers born outside the UK, in Belfast and Northern Ireland.

	Total number of births	Births to mothers born outside UK	Births to mothers born outside UK/Total
Belfast Trust area	4745	570	12.5%
NI	25 631	2347	9%

Table 9: Number of births by mother's country of origin in Belfast (2008)

5.2.7 Births with fathers born outside Northern Ireland

Father's country of origin is also recorded when registering a birth with the General Register Office. Approximately 10% of births each year have no details of the father included; consequently figures will be lower than figures quoted for mothers.

In Northern Ireland, the number of births where the father was born outside the UK shows similar patterns to mothers who were born outside the UK. The total number of births in Northern Ireland to new fathers from outside the UK as 600 in 2001, rising to 2,200 in 2008. Consistent with the figures for new mothers, there has been an even higher increase of births with fathers who were born in one of the A8 countries, with approximately less than ten such births in 2001, rising to approximately 1,000 births in 2008. Some 87% of the 1,100 births in 2008 born to mothers from one of the A8 countries also had a father from one of the A8 countries.

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Table 10 shows the breakdown of the total births registered in Northern Ireland: thirty-three percent of babies born in 2008 had one or both parents born outside the UK.

	Number of births	% of total births registered (No. = 25 631)
Both parents born in NI	17 100	67%
1 parent born in NI	6 200	24%
Neither parent born in NI	2 400	9%

Table 10: Breakdown of total births registered in Northern Ireland (2008)

5.2.8 Health Card Registrations

To register with a General Practitioner in Northern Ireland, a person must be planning to live in Northern Ireland for longer than three months. Information is provided on age, place of residence and length of stay. The Health Card Registration (HCR) system provides the most accurate data on migration, although numbers are likely to be under-represented because some migrants who do not register with a doctor. However many people do not de-register when they leave the country, leading to inflation of the numbers.

The number of people originally from outside the UK who registered in Northern Ireland, has risen markedly over the last five years, which can be seen in figure 5, detailed by quarter.

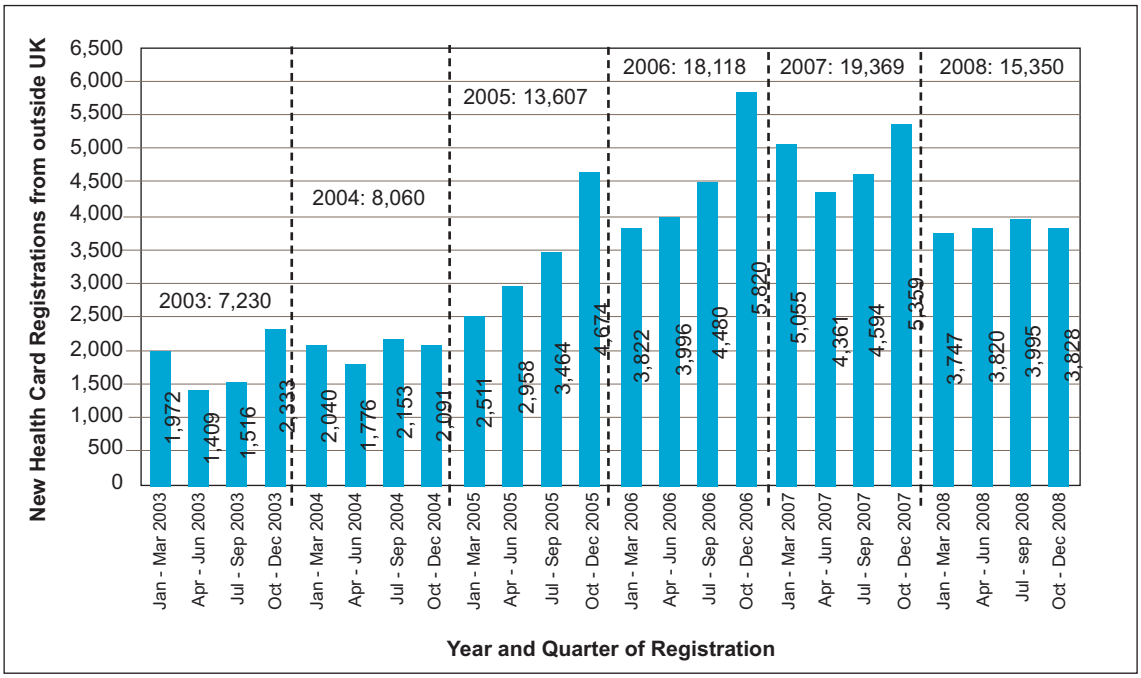

Figure 5: New Health Card Registrations from Non-UK nationals by quarter of application (January 2003 - December 2008)

The majority of the increase in Health Card Registrations from individuals originally from outside the UK and Ireland, is in Belfast. Other areas with high levels of new registrations from people originally outside the UK, are Craigavon, Dungannon, Newry and Mourne districts. The figures for Belfast are shown in table 11.

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	2005	2006	2007	2008	Total No HCR	Belfast /NI total of non-UK national	HCR per 1000
Belfast	2937	3935	4465	4082	15 419	27%	15.2

Table 11: Number of Health Card Registrations from non-UK nationals in Belfast (2005 to 2008)

The Health Card Registration system further analyses figures into electoral wards. In Belfast, the five electoral wards with the highest number of Health Card Registrations of non-UK nationals are Windsor, Botanic, Shaftesbury, Ballynafeigh and Blackstaff. In all twenty-six local governmental districts, Polish nationals were either the highest or second highest nationality registering, unchanged from 2006 to 2008. The majority (56%) said they came for work and educational reasons.

5.3 National Asylum Support Service (The One Stop Service)

If a person is seeking asylum they are referred to the National Asylum Support Service in Belfast. It is called the One Stop Service, and is the Belfast branch of the UK Border Agency. Destitute asylum seekers are eligible to claim National Asylum Seeker Support (NASS), which provides emergency accommodation in non-public housing, education for children less than 16 years, and benefits. The One Stop Service provides advice to all asylum seekers; they may or may not be destitute; they may be in the process of applying for asylum; or they may have been refused asylum.

In 2009, there were 190 new applicants for asylum in Northern Ireland. One hundred and forty-four of these new applicants required Emergency Accommodation, and 119 people moved into Northern Ireland Housing Executive accommodation via NASS. There were 4,522 clients who used the service for advice.

The client-base is predominantly Somalian, Sudanese, Zimbabwean, Kuwaiti, Eritrean, Iraqi, Iranian and from the People's Republic of China.

5.4 Summary

- Overall, net migration flows to Northern Ireland show a rise from a loss of 1,900 people in 2000/1 to a gain of around 9,800 people in 2006/7, before falling back to a gain of 5,700 people last year
- In 2008, the population of Northern Ireland was 1,775 million and in greater Belfast, 645,536
- In 2009, the total migrant population was estimated to be 73,000 (4.1%) in Northern Ireland
- The largest, most established community in Belfast is the Chinese community, followed by Indian and Pakistani populations
- In 2009, there were approximately 30,000 migrants from the Accession Countries (37% of the total migrant population)
- Polish nationals are the largest group from the Accession Countries, accounting for some 60% of migrants from A8 countries
- African communities are newer arrivals and represent diverse nationalities and backgrounds, with small numbers of people overall
- The top requested languages, recorded by the Northern Ireland Regional Interpreter Service

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in 2009, were: Polish, Mandarin, Cantonese, Arabic, Slovak, Lithuanian, Romanian, Hakka, Russian and Portuguese

- Longer established communities have older age ranges
- Newcomers to Belfast (A8 accession countries and asylum seekers) are predominantly within the age range of 18 to 35 years of age
- There are increasing numbers of births to women born outside the UK, reflecting the increasing number of migrant women living in Belfast

Whether the latest positive trend in migration will continue is difficult to say, given the current economic climate. The very latest 2009 statistics are pointing towards a further reduction. Northern Ireland National Insurance Number registrations, Home Office Worker Registrations and Work Permit scheme data are showing a fall in the migrant population in Northern Ireland. However, that said, the latest data from the School Census and birth registrations remain stable.

6 Legislation on immigration and work, health and social services, and social security entitlements

Legislation on nationality, immigration and asylum is under the auspices of the UK Government. The Home Office UK Border Agency is responsible for the regulation of the UK's borders, controlling migration and customs. There are several immigration laws within the UK that have been modified over the years by successive governments. Different groups of people living and working in Northern Ireland have varying restrictions on work, health and social care entitlement, and entitlement to benefits.

6.1 Immigration and the asylum process within the UK

The Immigration Act 1971 was introduced following increased immigration from Commonwealth countries in the 1960s and 1970s. Before this time, Commonwealth citizens were entitled to move freely in and out of the UK. The Act enabled only individuals with strong links to the UK to have the right to live and work in the UK and to be classed as British citizens. A person who is not a citizen has to obtain permission to enter the country, with restrictions on the length of stay and employment. There have been several amendments to this Act since 1971, to include further laws on seeking asylum.

The British Nationality Act 1981 is used by the UK Border Agency to make decisions on applications for citizenship. The law further defined multiple categories of British nationality for the purposes of defining British citizenship.

The 1951 United Nations Convention relating to the status of refugees gives protection and support to genuine refugees. Asylum is protection given by a country to someone who is fleeing persecution in their own country. To be recognised as a refugee, the individual must have left their country and be unable to go back because of a well-founded fear of persecution. Since 1951, there has been one "amending" and updating Protocol relating to the Status of Refugees, adopted in 1967.

The Asylum and Immigration Appeals Act 1993 incorporated the convention relating to the status of refugees into domestic law, thus enabling refugees to live in the UK. Previously asylum appeals came under the provisions of the Immigration Act 1971.
Since 1993, there have been a number of amended Acts on asylum appeal (see Appendix D (10.4)):

- The Asylum and Immigration Act 1996
- The Immigration and Asylum Act 1999
- The Nationality Immigration and Asylum Act 2002
- The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004
- The amended Immigration, Asylum and Nationality Act 2006.

6.2 Expansion of the European Union

The European Union (accession) Act in 2003 expanded the European Union to 27 countries (the A8 countries followed by the A2 countries).

The Immigration EEA Regulations 2006 allowed citizens from any of the EEA countries, and their family members, to enter and live in the UK without being subject to immigration control.

6 Legislation on immigration and work, health and social services, and social security entitlements

Although the new countries' citizens have the right to move freely in and out of the UK, they do not all have the same automatic rights to work, to health and social care, and social security benefits.

6.3 Human Rights

The European Convention on Human Rights was drafted after World War Two and listed an individual's civil, political and freedom rights. It was used as a declaration of right and as a legal instrument, to which the UK adheres. The Human Rights Act 1998 came into force in 2000, making the European Convention on Human Rights part of domestic law. The Act consists of several articles stating different rights to which the public authorities must adhere. Article three of the Act prohibits torture, inhumane and degrading treatment, and Article Fourteen of the Act prohibits discrimination.

6.4 Racial Law in Northern Ireland

The Race Relations (N.I) Order 1997 (a) was amended by the Race Relations Order (Amendment) Regulations (N.I) 2003 to implement the requirements of the EU Race Directive 2003/43/EC. These amendments give people greater protection from unlawful racial discrimination and harassment on the grounds of race, ethnic or national origins.

The Race Relations (N.I) Order 1997 ("the 1997 Order") was amended by the Race Relations Order (Amendment) Regulations (NI) 2009 to give full effect to indirect discrimination (as per Article 2(2)(b) of the Council Directive 2000/43 EC, known as "the Directive"). "The Directive" concerns the principle of equal treatment between persons, irrespective of racial or ethnic origins, in the areas of employment (and related matters), social protection, social advantage, education and access to and supply of goods and services which are available to the public, including housing.

Section 75 of the Northern Ireland Act 1998 places a statutory obligation on all public bodies, both as employers and service providers, to promote racial equality in employment, facilities and services, education, housing and accommodation, and management and disposal of premises. The European Convention on Human Rights underpins the statutory obligations of the Northern Ireland Act. The Equality Commission for Northern Ireland is an independent body established under the Act.

6.5 Employment

6.5.1 EEA nationals

Citizens from the original fifteen countries have no restrictions. They can apply for a National Insurance number and a Health Registration Card.

6.5.2 A8 nationals

The Accession (Immigration and Worker Registration) Regulations 2004 states that citizens from the eight countries that joined the EEA in 2004 have to register to work for longer than one month in the UK under the Worker Registration Scheme. After continuous employment for twelve months legally in the UK, they can obtain a residence permit.

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6.5.3 A2 nationals

Citizens from Bulgaria and Romania have limited access to the labour market. The employer must apply for a work permit, following which the worker can apply for an Accession Worker Card. There are several exemptions, including those who register as self-employed, highly skilled workers or workers entering on a work scheme, of which there are two:

- The Seasonal Agricultural Workers Scheme is designed to allow farmers in the UK to recruit low-skilled overseas workers to undertake short-term agricultural work. Participants in the scheme are issued with a work card, giving them permission to work in the UK for a fixed period of time, up to a maximum of six months. The workers are paid at least the agricultural minimum wage and are provided with accommodation by the farmer employing them.
- The Sector Based Scheme allows UK based employers to recruit low skilled workers from Bulgaria and Romania, to vacancies in the food manufacturing sector that cannot be filled by resident workers. The employer applies for a work permit, specific to that job only, and then the participant applies for an Accession Worker Card. The permit is issued for a maximum of twelve months. After this period, the citizen can apply to the Workers Registration Scheme.

6.5.4 Non-EEA nationals

Application to live and work in UK is through the new Points Tier-Based Scheme. There are five tiers each with different conditions, entitlements and entry clearance checks.

6.5.5 Refugees and Asylum Seekers

Individuals granted full refugee status are entitled to any employment in exactly the same manner as British citizens. Asylum seekers are not able to take on any form of employment.

6.6 Health and Social Service entitlement

The Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005 states that all people who are ‘ordinarily resident’ in Northern Ireland, are entitled to free health services. Eligibility for health services therefore relates to whether a person is ordinarily resident in Northern Ireland and not to nationality. The regulation also defines the categories of visitor to Northern Ireland who are eligible to access health care services.

In Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPS) issued the circular HSS (PCD) 10/2000, which provides guidance to the legislation. The guidance describes a person ‘ordinarily resident’ as someone who is ‘lawfully living in Northern Ireland voluntarily and for a settled purpose as part of the regular order of his or her life for the time being’. The term ‘ordinarily resident’ is a common law concept interpreted by the House of Lords in 1982. The guidance suggests that anyone coming to live here for less than six months is unlikely to be ordinarily resident.

The following individuals are all classed as ordinarily resident:

- Migrants working in employment or self-employed, unless for less than six months, from the EEA countries, on any type of work permit or from one of the Accession countries’ workers schemes. A migrant worker is classed as somebody in employment, looking for employment

6 Legislation on immigration and work, health and social services, and social security entitlements

within a six month period, or working part-time for more than eleven hours per week. If a person is unable to work from ill health or is retired, they may still qualify as a 'worker'. This includes:

- Family and dependents of migrant workers
- Granted refugee status or in the process of applying ie. asylum seekers
- Refused refugee status but continuing to live in Northern Ireland because removal directions have not yet been set out by the Home Office

Individuals who have not entered the country lawfully have no status to be in Northern Ireland. They must either obtain legal status or claim asylum in order to be eligible for health and social care services.

Free health services are:

- Entitlement to register with a General Practitioner
- Use of all medical and social services as required
- Secondary care provision. There are statutory charges for certain services such as dentists and opticians.

Everyone in Northern Ireland, whether ordinarily resident or a visitor, is entitled to the following services free of charges:

- Emergency, requiring immediate treatment at an Accident and Emergency Department
- Treatment of diseases on the Notifiable Disease list (NOID)
- Family planning services
- Treatment of sexually transmitted infections and HIV testing (Treatment of HIV is not free)
- Compulsory psychiatric treatment.

Under the Human Rights Act, a health authority could still be in breach of human rights if treatment is refused, if this is deemed to be inhumane or degrading to the individual.

6.7 Housing entitlement

Everybody is entitled to private rental accommodation. The governmental agency responsible for social housing is called the Northern Ireland Housing Executive (NIHE). There are restrictions on who is eligible for this type of housing.

The Housing (NI) Order 2003 states that a person is eligible for homeless assistance if he or she is 'habitually resident' and has a right to reside. The habitual residence test is a way of demonstrating this. An individual has to prove that he plans to settle in Northern Ireland in the long-term. Several factors are taken into account, including the length of time an individual has been living in Northern Ireland. There is no fixed time frame, but generally speaking, the longer the better. Exemption from the habitual residence test occurs if an individual has already worked in the UK or is an EEA national, provided he or she has a right to live and work in Northern Ireland.

6 Legislation on immigration and work, health and social services, and social security entitlements

If a person becomes homeless, the case is governed by the Homelessness Regulations (NI) 2004 in the same way as for the rest of the population of Northern Ieland. A person is entitled to emergency assistance if he/she becomes unintentionally homeless. An assessment is carried out to determine the circumstances of their homelessness. If it is deemed a priority need case and unintentional, there is a duty to provide temporary accommodation or to find suitable accommodation.

6.7.1 EEA nationals

Any individual who is working, or member of the family, is eligible for social housing. They are not eligible if not in work or they have lost their job.

6.7.2 A8 and A2 nationals

Individuals are entitled to apply for social housing if they are registered with the Home Office (the Workers Registration Scheme for A8 nationals, and the Workers Authorisation Scheme for A2 nationals), self-employed or have been in continuous employment for greater than twelve months. If a person loses their job before allocation of social housing then the rental property may be revoked. They are entitled to Homelessness Regulations if they have become homeless unintentionally and they are priority case.

6.7.3 Non-EEA nationals

Individuals are not entitled to apply for social housing if their passports state 'no recourse to public funds'. They are not entitled to Homelessness Regulations, however, the NIHE should provide advice and help to find somewhere else to live but will not allocate accommodation.

6.7.4 Refugees and Asylum Seekers

Refugees are eligible for social housing in the same way as residents of Northern Ireland. Only Asylum Seekers who are entitled to NASS are placed in housing accommodation, which is not social housing.

6.8 Social Security Benefit entitlement

The Social Security Agency in Northern Ireland is responsible for decisions on state benefit entitlement. To claim benefits, an individual has to have a National Insurance number, which is also required for employment or if looking for employment. If a person is not entitled to a National Insurance number then they are not entitled to benefits. There are different types of benefits with different entitlements:

- Means-tested benefits: individuals need to be habitually resident and have right to reside
- Non-means tested benefits: these are awarded if individuals have paid enough National Insurance number contributions in the UK
- Non-contributory benefits: these are not related to National Insurance number contributions
- Child Tax Credit, Working Tax Credit and Child Benefit: individuals need to have right to reside.

6 Legislation on immigration and work, health and social services, and social security entitlements

6.8.1 EEA nationals

Individuals need to have proof that they are planning to live, work and settle in Northern Ireland. If this is the case, they can claim child benefits and means-tested benefits, if on a low income. They need to have sufficient National Insurance number contributions to qualify for non-means tested benefits (also known as 'contributory benefits').

6.8.2 A8 nationals

Individuals not working have no registration and no entitlement to any benefits. During the first twelve months of living in Northern Ireland individuals who are working and registered with the Workers Registration Scheme, can only claim for child benefits and means-tested benefits, if on low income. They need to have sufficient National Insurance number contributions to qualify for non-means tested benefits (also known as 'contributory benefits').

6.8.3 A2 nationals

Individuals who are not working will have no accession card, and therefore no entitlement to any benefits. If they have employment with an accession card, they can only claim means-tested and child benefits if they are on a low income. In the first three months, individuals not in employment can claim child benefits; after this they need employment. After continuous employment for twelve months, individuals qualify for some benefits.

6.8.4 Non-EEA nationals

Certain groups of people (including work permit holders) are 'persons subject to immigration control'. They only have a right to enter or remain in Northern Ireland conditional on not having 'recourse to public funds', which is stamped on the passport. They are not entitled to any Social Security benefit. Social services can help in an emergency (Appendix E (9.4): benefits under public funds).

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Migrant and BME communities represent a very diverse and dynamic population in terms of their reasons for migration, with changing health needs and priorities over time. Individuals who have just arrived to the country will have different needs to communities that have been living in Belfast for generations. Equally the health care needs of second generation children and teenagers will be very different to their first generation relatives.

The majority of newcomers are young and healthy on arrival, with no greater health needs than that of the general population. Issues often arise because of the obstacles faced from living in a new society. A migrant's health needs depend on their age and gender, country of origin, circumstances for migration, and the socioeconomic conditions in their host country. Consequently, irregular migrants, refugees and asylum seekers are particularly vulnerable groups.

In Belfast, the Chinese and Indian communities have built a strong infrastructure with a number of different support groups. African communities are newer arrivals and represent diverse nationalities and backgrounds with small total numbers of people from different countries. This causes difficulties for them in accessing services, resulting in increased marginalisation and vulnerability. The Belfast Trust recognises that numbers are not the only way to prioritise the health needs of a population, as the Trust has a responsibility to meet the needs of the most vulnerable. Whilst there is increasingly excellent innovative work in the Belfast area, practice is not consistent across the area. There is still a need for recognition of cultural and religious practices and to tackle the health inequalities that exist between different communities.

Priority health needs can be divided into the following categories:

- Access to health care
- Racism and racial harassment
- Adult health
- Health protection
- Children's health
- Women's health
- Mental health
- Poverty and housing
- Special groups with complex needs.

7.1 Access to health care

In 2001, following Section 75 of the Northern Ireland Act (1998) and the Racial Relations Order (1997) (Equality Commission for Northern Ireland 2000), which outlawed both indirect and direct racial discrimination, the Department of Health, Social Services and Public Safety commissioned a literature review to identify issues relating to service delivery and policy development and on the provision of health and social services. At this time, research and information was in its infancy regarding equality and race relations. New literature and a follow up report have been published since (DHSSPS 2006).

7.1.1 Common barriers

There are a number of difficulties experienced by all migrant and BME groups when accessing any of the public services. Most difficulties centre on language barriers. For many, English is

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their native language or they speak English fluently and for them language is not a barrier; yet they are still faced with many barriers in accessing services (Connelly 2002) :

- Lack of awareness and lack of appropriate information of the services available
- General Practitioner registration is low amongst certain groups, in particular those with no permanent address, a requirement for registration in Northern Ireland
- Fears about entitlements to health care
- Lack of confidence, frustration and stress reported by the process of accessing the health care system, often a system different to their country of origin
- Failure to meet even the most basic of cultural needs, for example, dietary requirements and religious observance are not routinely taken into consideration
- Institutional racism and the negative attitudes of some health care staff
- Staff training and cultural awareness not a priority for many public services
- Immigration restrictions and confusion

7.1.2 Language barriers

Where little or no English is spoken, language is cited as the most significant barrier to accessing health services. Not addressing such an issue by public authorities could constitute indirect racial discrimination under the Race Relation Order. Health and Social Care (HSC) has an obligation to provide interpreter services and produce information leaflets in a range of languages. The 'Racial Equality in HSC Good Practice Guide' developed by the DHSSPS, states that: "...failing to provide interpreting facilities in relation to service provision, when it is known that there is a language barrier, could be construed as unlawful racial discrimination" (Equality Commission for Northern Ireland 2003). General Practitioners can claim for costs incurred for interpreter services.

The Belfast Trust provides a Regional Interpreting Service for all HSC organisations in Northern Ireland. It is a 24 hour service providing face-to-face interpreting in 33 registered languages. There has been a marked increased usage of the interpreter service in Belfast and Northern Ireland. The table below shows the increasing number of requests for an interpreter each year (NIHSCIS 2010).

Year	No. requests in Northern Ireland	No. requests in Belfast Trust
2004-2005	1850	186
2005-2006	10 257	1402
2006-2007	21 283	3450
2007-2008	31 284	5853
2008-2009	35 103	7474
2009-2010	42 516	10 588

Table 12: Number of requests to NIHSCIS (2004-2010)

The most requested languages are Polish (more than 50%), Lithuanian, Chinese (Cantonese and Mandarin) and Portuguese.

In Belfast there are some good practice initiatives on the use of interpreter services and

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provision of information leaflets. However, practitioners report not knowing where to source information or how to use the interpreter service. Consultations have to be pre-booked and are time consuming. In some cases family members and children act as interpreters. In small migrant communities, there are problems cited when using interpreters that the patient may know the interpreter and be reluctant to disclose personal medical details.

Information leaflets have been produced by the DHSSPS but it is not a straightforward translation task. Communities speak different dialects and written word; consequently some information leaflets produced to improve the language barrier, have been ineffective. A mapping report of minority languages in Northern Ireland, 'In other words', has been produced to provide information on the minority ethnic languages used. This has helped with the production of effective written information for migrant groups (Holder, D. 2003).

Non-verbal signals may also be misinterpreted. Health care professionals may not be aware of culture-based differences, and may inadvertently cause offence or misinterpret, resulting in inaccurate assumptions and judgments on an individual.

English proficiency has been shown to correlate strongly with age, gender, country of origin, education and social class. Migrant men are more proficient in English than women, which can have implications for a woman's health, particularly where her husband acts as an interpreter. Indian and African communities tend to have higher levels of English proficiency. Occupation and education is also an important factor, with 90% of Indian professionals able to speak English fluently compared with 45% of Indians employed in businesses or trade. Communities living in Belfast tend to have better English than communities living in rural areas of Northern Ireland (Connelly, P. 2002).

7.2 Racism and Racial Harassment

In recent years, race and race relations have been of considerable political and legislative concern in Belfast. Since the signing of the Northern Ireland Act (Good Friday Agreement) in 1998, there has been a rise in the number of racial incidents recorded by the police. In Northern Ireland, recorded crimes with a racist motivation have increased tenfold: in 2008/9 there were 315 recorded crimes in Belfast, and 771 in Northern Ireland (PSNI 2010). These figures are likely to under-represent the true position. Belfast has received a lot of negative press from the media, with publication of personal stories portraying Belfast as the 'race-hate capital of Europe'.

In 2009, twenty Roma Romanian families had to leave their homes after intimidation and violence directed at their houses. Police and community leaders helped the families evacuate their homes and most of the families requested support to return back to Romania. Earlier in the year, riots occurred during a football match between Poland and Northern Ireland, and since 2004 there have been various attacks during anti-racist rallies in the city. Children in Belfast have also reported direct experience of racism at school, on public transport and in public spaces (National Children's Bureau (NI) 2010).

In 2008, an equality awareness survey showed that whilst the social attitudes of the majority of the population were positive, a significant proportion still expressed negative attitudes towards

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certain groups of people (Equality Commission for Northern Ireland 2008). The respondents perceived racial discrimination to be the most prevalent type of discrimination (54%). Twenty per cent of the population said they had negative attitudes towards migrant workers and approximately a quarter of people said they would mind living beside or working with a migrant worker.

Migration has increased in a relatively short period of time in a country where for a long time the majority of people have been white and English speaking. Across the political spectrum and throughout the media, the idea that racism is replacing sectarianism in Northern Ireland has become widespread (South Belfast Roundtable 2008).

7.3 Adult health

Migrants arriving from less developed regions of the world may have had less access to preventive care, health promotion programmes and diagnostic or therapeutic interventions for disease. Cancer detection programmes, regular health checks, access to healthcare and basic services, and smoking and substance abuse prevention programmes may not be commonly accessible, unequally distributed or subject to limited availability in many places. As a consequence, migrants may present with disease in more advanced stages than normally observed in the destination country. This has implications for both primary care and secondary care service provision.

In terms of lifestyle-related, non-infectious illnesses, many new arrivals display health parameters that are better than those of the receiving population. Over time and resulting from a variety of factors, including adaptation to a new culture, diet and behavioural changes, immigrant populations may acquire and display common adverse health indicators more similar to those of the receiving population.

In addition, there is evidence that certain non-communicable diseases are an increasing burden on migrant populations, in particular hypertension, cardiovascular diseases, diabetes and cancer. Certain diseases have higher prevalence in different ethnic groups:

- In Northern Ireland, the estimated prevalence of diabetes in adults is 5.4% (CMO (NI) 2004). It is considerably higher in certain ethnic groups such as Asians from the Indian subcontinent (12.4%) and those of Afro-Caribbean descent (8.4%) (Diabetes UK 2001)
- Asians from the Indian subcontinent and Afro-Caribbean people have a higher risk of Cardiovascular Disease
- Hypertension has a higher prevalence in Afro-Caribbean people
- Helicobacter Pylori infection is higher in people from African countries, resulting in increased prevalence of gastritis and peptic ulcer disease
- Vitamin D deficiency is higher in women with covered dress code, with resulting increased prevalence of osteopenia or osteoporosis
- Iron deficiency, B12 and folate deficiency anaemia and micronutrient deficiencies, are more common in individuals who originate from less well developed countries
- Haemolytic anaemia (thalassaemia anaemia or sickle cell disease), are more common in certain European countries and African countries respectively

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7.4 Health protection

For the majority of migrants entering the country, there is no greater risk of infectious diseases than for the indigenous population. However, there are certain individuals who come from countries with high prevalence of diseases such as tuberculosis, hepatitis B and C and HIV. The Health and Social Care system has a responsibility to ensure policies are in place for screening of individuals entering the country, have the resources available to be able to offer appropriate medical services for treatment of such individuals and to prevent further transmission of disease. This, in itself, has implications for individual human rights if assumptions are made about health status based on country of origin. Health professionals must be aware of this and provide universal screening policies.

7.4.1 Tuberculosis (TB)

The latest figures published for Northern Ireland are from 2006 (Health Protection Agency (NI) 2007). There were 61 tuberculosis cases notified in 2006, giving a rate of 3.5/100,000 population. Provisional analysis for 2007 indicates that the number and rate of notification has risen to 65 (3.7/100,000). Rates of TB in Northern Ireland are approximately three times lower than for England and Wales.

In 2006, 38% of TB cases diagnosed in Northern Ireland were in individuals originally from outside the UK and Ireland. This is an increase from 26% in 2005. Between 1992 and 2002, an average of 10% of all notified TB cases were in individuals known to be born outside the UK and Ireland. Of the 23 cases (38%) diagnosed in 2006, nine were born in the Indian sub-continent, seven in South East Asia, three in Africa and four in Europe.

Policy and guidelines relating to new entrant TB screening have been published by several bodies. All see a place for ongoing new entrant screening as part of TB control. Port health arrangements have been reviewed in the UK, and are seen as inadequate, with the system for notification of new entrants to the Consultant in Communicable Disease Control being inefficient and ineffective. Registration with a General Practitioner is central to effective TB screening and is an entitlement for all asylum seekers, refugees and those with leave to stay for longer than six months.

7.4.2 Hepatitis B

The prevalence of hepatitis B in the UK and Ireland is less than 1%, and most cases are in well defined risk groups. Individuals who were born in hepatitis B endemic countries, such as South East Asia, Africa, the Middle and Far East and Southern and Eastern Europe, are at higher risk. In Northern Ireland, the prevalence of chronic hepatitis B infection is lower than in either the UK or Ireland. At present there is only a surveillance system to record confirmed positive cases of hepatitis B; the system does not give any information on the country of origin of each case. Figure 6 shows the total number of cases annually, with increases from 1992 to 2008.

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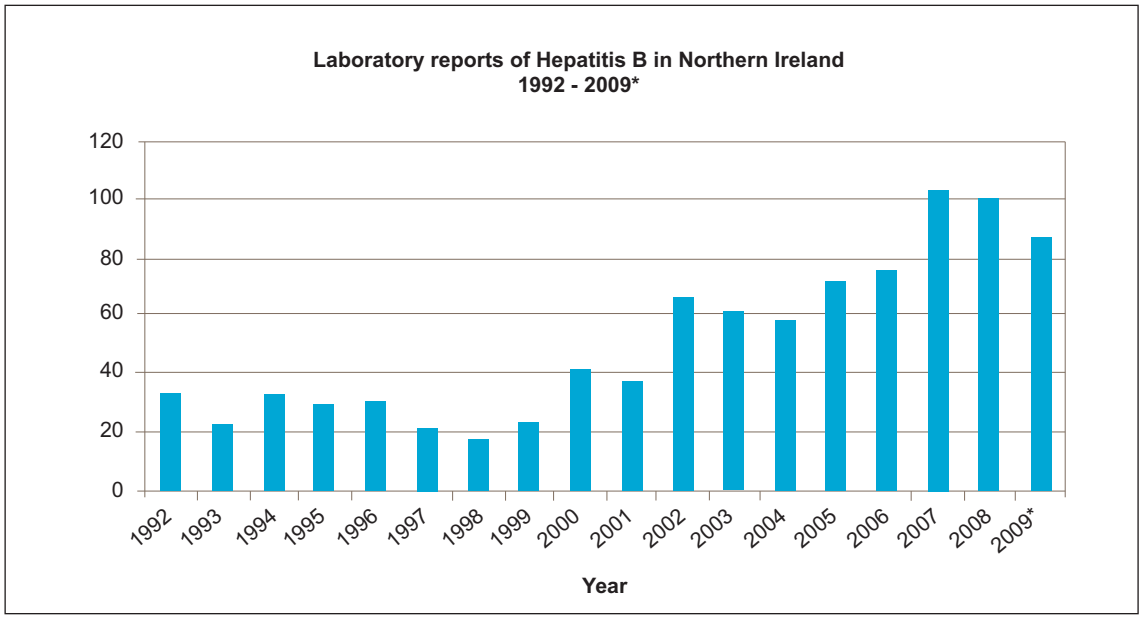

Figure 6: Annual Cases of Hepatitis B in Northern Ireland (1992-2009)

At present, the UK does not offer hepatitis B vaccination as part of the routine childhood immunisation programme; it is offered to infants at high risk. The Republic of Ireland introduced the vaccination to the childhood schedule in 2008.

7.4.3 Hepatitis C

The prevalence of hepatitis C in UK and Ireland is low and confined to certain at risk groups. In Northern Ireland, the prevalence is estimated to be three-fifths of the prevalence in England, with approximately 4,000 cases in 2009. Testing and detection is increasing in Northern Ireland; there are approximately 100 new confirmed positive cases each year, seen in figure 7.

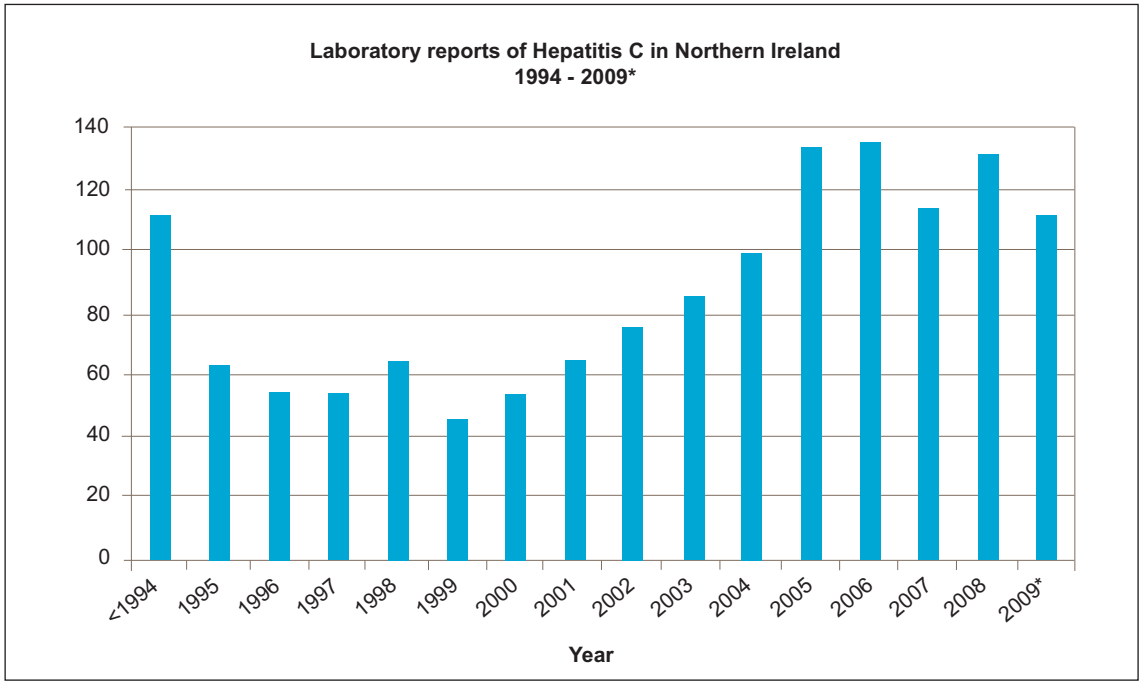

Figure 7: Laboratory reports of Hepatitis C in Northern Ireland (1994-2009)

* Data provisional

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At present there is no surveillance system in Northern Ireland to identify cases according to ethnic group. Individuals originally from a country with a high prevalence of hepatitis C will be at greater risk of having the virus.

7.4.4 HIV

Prevalence of HIV in Northern Ireland is lower than in the rest of the UK. New diagnoses have increased year on year since 2001, almost doubling between 2003 and 2004 (Health Protection Agency (NI) 2007). Diagnoses increased by 51% between 2007 (61) and 2008 (92). Provisional data for the first six months of 2009 (24) suggest a potential decrease in the annual figure. Cumulative data show that for cases acquired through heterosexual exposure and where location of exposure is known, the majority have been infected through exposure outside the UK (73% or 178/245).

7.5 Children's health

The Child Health Surveillance and Health Promotion Programme is a national statutory requirement, implemented at local level by each of the four countries of the UK. Core areas addressed are childhood screening, the childhood immunisation schedule, assessment of each child's needs, with early intervention and health promotion.

In Northern Ireland, the Child Health System collects and stores information obtained from health visitors and school nurses, and acts as a call and recall system for immunisations and screening tests. The system records name, date of birth, address and ethnic class as per the categories of the census. Information is collected during the health visitor's first meeting with the family. However, ethnicity is poorly recorded by health visitors and the census categories do not accurately distinguish between different BME groups. Consequently, it is difficult to obtain accurate records of child health surveillance and immunisation rates in different migrant groups. Recognition of the need for more accurate information, based on anecdotal research and increasing health visitor case load, has prompted the development of the ethnic monitoring group in the Belfast Trust, to improve and collect information. The group has made the following recommendation: information on mother's country of origin and first language has been introduced, collected at birth by the midwife and confirmed by the health visitor at the first meeting.

7.5.1 Child health surveillance

All children are entitled to routine child health surveillance and health promotion. Migrant children may not have had neonatal screening tests depending on the country of origin.

Accidents are more common in migrant children, due to temporary, poor accommodation, which is often cramped and overcrowded, so that opportunities for children to play are severely limited. Health promotion and information on accident prevention is an important part of the health visitor's role.

7.5.2 Immunisations

Routine appointments for immunisations will not be sent for a child unless they are permanently registered with a family doctor. This has implications for the uptake of the childhood schedule. Currently, in Belfast, it is not possible to get data on immunisation rates per BME group. The

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childhood immunisation schedule varies depending on the child's country of origin and it can be difficult to obtain records of previous immunisations. Restarting a primary course is sometimes necessary depending on the age of the child and country of origin.

7.5.3 Communication and language

A study of the issues faced by migrant children in Belfast (National Children's Bureau (NI) 2010), identified the importance of effective communication between professionals and children. Children need to speak English to be able to integrate in school, make friends and progress in their education. In Belfast there are no clear guidelines and policies for health and educational professionals, yet the importance of child-friendly interpreters is emphasised. Children are often used as interpreters for their parents or grandparents, which is inappropriate.

7.5.4 Education

Education is generally seen as important by many migrant populations and has been identified as a positive experience for children by the National Children's Bureau. Parents are often not aware of the processes for applying for school places and of the compulsory school age in Northern Ireland. Poor attendance is common amongst refugees, asylum seekers and children from A2 countries, particularly Roma Romanian children, who are especially vulnerable. Children change schools more frequently due to changes in housing which impacts on school attendance. Accessing education for those over 16 years or teenagers arriving in May or June is very difficult.

In April 2007, the Education and Library Boards created the Regional Inclusion and Diversity Service (IDS) to strengthen and improve support to newcomer children, young people and their parents. This offers services such as interpreters, translators, a multi-lingual website for teachers and newcomer parents, diversity officers, in-service training, teaching resources and a toolkit for primary school teachers. In April 2009, the Department launched its policy 'Every School a Good School – Supporting Newcomer Pupils'. The policy outlines the framework that has been put in place, through the various support services of the IDS, to ensure that newcomer pupils receive the support they need to access the curriculum so that they can fulfil their potential.

7.5.5 Child protection

The Belfast Trust has a responsibility for the health and wellbeing of all children under the age of 16 who reside in the area. In the period from October 2007 to March 2008, the Belfast Trust Parenting Report recorded 34 children in need and 11 children on the Child Protection Register from BME groups (Community Child Health Service 2008).

7.6 Women's health

Whilst migration can cause difficulties for everyone, women are often more seriously affected. In many societies women have a lower status than men (in particular women from the Indian subcontinent, of Chinese origin and Roma Romanians) and are more likely to depend on male family members for decision-making. Many women will not be in employment. They are often lacking their previous social and family supports, and consequently may be lonely and more isolated.

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Pregnant women from BME groups have a lower uptake of antenatal care in the Belfast Trust. Often these women are unfamiliar with the type of antenatal care available; refugee women and asylum seekers have reported being unaware of their entitlement to free antenatal care (British Medical Association 2002). There are also implications for health care providers; for example haemoglobinopathies and certain malformations may be more prevalent in different BME groups and screening should be offered. During pregnancy, and when caring for babies and young children, women of certain BME groups are used to support female family members. Husbands are rarely the major sources of support, which can in turn increase isolation and lead to postnatal depression. Postnatal depression is reported in an audit by health visitors in the Belfast Trust as more prevalent in BME groups, and this is often undiagnosed because of difficulty for women in accessing appropriate services (Community Child Health Service 2008).

Domestic violence has been cited as more prevalent in women from BME groups. All health visitors working in Belfast have families from BME groups on their caseload. 1% of such families in the caseload of health visitors in South and East Belfast were identified as having contact with a domestic violence situation, and 6.9% of such families in the caseload of health visitors in North and West Belfast were identified as having contact with a domestic violence situation (Community Child Health Service 2008). In 2009 Women's Aid reported that 4% of the woman who stayed in the refuges in Belfast had no recourse to public funds, although their partner or husband may have had. Their stay was longer, and as they were not eligible for housing benefit, it had huge financial implications for Women's Aid. If they have no recourse to public funds, their stay is limited to two weeks, after which they have to return to an abusive relationship, live in destitution or return to their home country (Belfast and Lisburn Women's Aid 2009).

7.7 Mental health

Mental Health is a particular issue for many migrant groups, regardless of their reasons for settling in Northern Ireland. Cultural health beliefs and behaviour, previous experiences, and current stressors, shape how an individual copes with health and illness, in particular mental illness. Mental illness is often seen as taboo, meaning that presentation can be with physical symptoms (South & East Belfast Health and Social Care Trust 2005).

The immigration process is a stressful period for all migrants. The majority of migrant workers will have had to access work via a Work Registration Scheme. If they lose their job, they are not entitled to benefits or social housing. They will often have borrowed money to leave their home country and they are not entitled to citizenship until they have been working for 5 years. Asylum seekers have the daily stress of potential deportment, living in the lowest poverty bracket, with no entitlement to employment. They may also be dealing with sequelae from horrific torture and rape, either as direct victims or witnesses to trauma to a family member. All have the added burden of accessing services, fitting into a new society, potential racism and lack of their usual social support. Consequently they are very vulnerable to the repercussions of living with chronic stress, manifesting as insomnia, anxiety, depression, post traumatic stress disorder and drug and alcohol abuse. More than other migrant groups, the Polish community has been reported as having a higher risk of depression and suicide. Consequently the Polish Association has started providing counselling services to support them (Polish Association Northern Ireland 2009). The Polish are also noted to have increased use of addiction services, particularly for alcohol and drug abuse.

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In migrant children there is a higher incidence of emotional and mental health problems. In the National Children's Bureau study, children, however they came to be in Belfast, said they were dealing with loss of some kind, most evident for asylum seekers. Often this loss results in feelings of isolation and adjustment to separation from their immediate or extended family, culture and familiar environment. Children are also affected by their parents' psychological problems. Experience of trauma in asylum seeker and refugee children was shown to increase the risk of mental illnesses such as depression, post-traumatic stress disorder and behavioural problems, such as bed wetting, nightmares and attachment behaviours (National Children's Bureau (NI) 2010).

7.8 Poverty

Migrant workers from the A8 and A2 countries can only access social security benefits if they have been working continuously for over 12 months or are registered with the Workers Registration Scheme (WRS) and on a low income. In addition, there are certain benefits that they are only entitled to if they have made significant National Insurance contributions. Individuals from the A2 countries have limited access to the labour market. Asylum seekers who are destitute are entitled to NASS (free housing and cash support). The weekly cash support is 30% less than the income support the rest of the population receives. As a consequence, migrant groups, unless they have arrived with financial means of supporting themselves, are one of the most deprived groups in society.

In addition, the economic downturn has had a significant impact on migrant communities. Research by the Northern Ireland Council for Ethnic Minorities found a high concentration of unemployment among respondents to their study (the number of respondents in the study equated to approximately 1% of the Polish population living in Northern Ireland). Twenty per cent reported unemployment, almost three times higher than the Northern Ireland unemployment rate of 7.1% in the third quarter of 2009. Despite this, the uptake of Job Seekers Allowance was low, with respondents citing communication difficulties, bureaucracy and difficulties with the WRS as an obstacle to accessing benefits. About 50% of individuals still in work were afraid of losing their jobs or were on temporary contracts (McVeigh, R. 2009). These findings highlight the vulnerability of the Polish community in terms of poverty in their daily lives. These experiences of poverty are common among all migrant communities originating from both A8 and A2 member states.

7.8.1 Child Poverty

Save the Children's latest report (figures from 2007-2008), 'Measuring severe child poverty in the UK', commissioned from the New Policy Institute, revealed that 43,000 (10%) children live in severe poverty in Northern Ireland (New Policy Institute 2010). A child is much more likely to live in poverty, regardless of whether their parents are in employment or not, if they are from migrant or BME groups. In the above study by McVeigh, half of the respondents were married and had dependents living with them. Child poverty in the Polish community is likely to be an increasing problem.

7.9 Housing

Migrant groups will often share private rental accommodation between individuals and one or more families. Individuals can often only afford private rental if they live in overcrowded

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accommodation. Many migrant workers will not want to complain about poor living conditions and the high rents of the accommodation tied in with their jobs, for fear of losing their jobs (Steed, T. 2009).

Asylum seekers who have been granted NASS support, are entitled to housing. They have no choice where in the UK this housing will be. They must reside at the address provided, which is not public housing but shared rental housing, often sharing with other asylum seekers. Often the housing is of poor quality which can have an impact on health. There are strong links between damp housing, asthma and skin problems. Evidence for deleterious health effects is strongest among children.

In a small number of situations there has been friction and racial intimidation between migrant and settled communities in Belfast. One example is the Greater Village area of Belfast, which is an area where Protestant people, traditionally working in the nearby shipyards and other industrial sites, reside. In recent years, private developers have bought houses and renovated them for the purpose of private rental. This area tends also to be the choice of residence for BME groups, particularly new migrants. Unfortunately the visibility of the diverse migrants living in this area is seen as a threat and has been fertile ground for racial tension.

There are only a few situations where non-UK nationals are eligible to access housing benefit. These will predominantly be people from the Accession countries who are registered with the WRS or have been working continuously for over 12 months. There were 1,055 applications for social housing in Northern Ireland in 2008, an increase from 2007. The main nationalities of applicants were Polish (46%), Portuguese (16%) and Lithuanian (13%). North and south Belfast had amongst the highest numbers of applicants from migrant and BME groups in Northern Ireland (NISRA 2009). The NIHE produced a report entitled ‘Black and Minority Ethnic and Migrant Worker mapping update’, which stated that some migrant workers lack awareness of social housing as an option. Language barriers are an issue in accessing housing services (Steed 2009).

7.9.1 Homelessness

Applications to the NIHE by non-UK nationals for homelessness assistance has been reported as a significant proportion of staff’s workload. As a consequence of the economic downturn, the numbers of applicants is increasing (Steed 2009). In Northern Ireland, homelessness assistance is not available to non-UK nationals in a number of situations, yet by legislation, being rendered vulnerable and potentially destitute is a human rights concern.

The Northern Ireland Human Rights Commission showed that people excluded from homelessness assistance and welfare benefits were more vulnerable to various forms of exploitation, ill health and disability. People with insecure immigration status were shown to be particularly vulnerable to domestic abuse and exploitation. The same report found that a number of people with no recourse to public funds became homeless because of ill health or disability, and in a number of cases people became ill as a result of their destitution (Devlin, R. 2009).

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7.10 Groups with complex needs

7.10.1 Roma Community

The Roma people are one of the main minority groups in Romania. They are the most socially and economically deprived minority in Romania, with high illiteracy levels. Since the expansion of the European Union, Roma have migrated throughout Europe, including Northern Ireland. It is difficult to determine exact numbers for the Roma community living in Northern Ireland, because there are no Roma registered in the Worker Schemes, they have a low uptake of Health Card Registration and they do not have National Insurance numbers.

They are a marginalised and vulnerable community, with very complex health and social care needs, and are hard to reach with existing services. The majority of health issues centre on lack of access to services and language barriers with high illiteracy levels and poverty. They have been subject to a series of racial attacks in Belfast, requiring a multi-agency response to ensure their safety and help with their return to Romania in 2009.

There have been a number of initiatives by the public sector to improve engagement with the Roma people and to try to address their needs.

7.10.2 Refugees and Asylum Seekers

A person may enter the country to seek asylum in a number of different ways: planned entry with a visa; through an agency, with a false passport; smuggled in via boat or lorry; or human trafficking. The asylum process can take anything from several months to several years. It commences with an initial screening interview, several interviews in the interim and a final substantive interview which can last up to eight hours. If a person is granted asylum, they must move out of their accommodation within 28 days. If a person is refused asylum they can appeal. They are only entitled to emergency accommodation and supermarket vouchers. There is often an interim period when a person is waiting for Section 4 placement (part of the appeals process); during this period they are entitled to nothing.

An individual may experience different health issues during each stage of the asylum process (Burnett, Fassil 2000):

1. On first entering the country, a person's health depends on any pre-existing disease, their experience from the country of origin, such as rape or torture, the way in which they travelled from their country of origin and the way they were treated in transit.
2. When claiming asylum, an individual may have poor housing conditions with multiple occupancy and little income. They may be very isolated and have little social support. Many asylum seekers experience psychological problems and alcohol and substance misuse. There is a lot of anxiety associated with attendance at immigration interviews.
3. When refugee status has been granted, refugees may suffer from cultural bereavement and isolation. They have to adapt to a new country and obtain employment. Their physical and mental health may have been affected by the asylum process. They may still have family living in their country of origin, or they may have suffered from the death of family and friends.

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7.10.3 Irregular Migrants

Irregular migrants, or 'illegal' migrants, occur when people enter or live in another country without having received legal authorisation from the host country. It can be as a result of human trafficking (someone who is coerced to travel to another country for the purpose of exploitation) or as a result of people-smuggling (someone who travels voluntarily but illegally to another country with the assistance of a third party). On arrival at the destination, the smuggled person is usually free to find their own way (UNESCO).

Human trafficking in Northern Ireland has only recently been recognised. It is difficult to know the extent of the problem both globally and locally, as by definition, they are a hidden group of people. Government agencies and organisations working with victims have noticed signs of increased activity in trafficking in Northern Ireland, mostly in Belfast. As in other jurisdictions, information available in Northern Ireland indicates that trafficking here encompasses the trafficking of women, children and men for the purpose of sexual exploitation and labour exploitation, with the majority being women and children. In 2008, a UK report recorded five victims rescued in Northern Ireland (four of them as victims of sexual exploitation and one of forced labour), six people arrested for controlling prostitution and people-smuggling, nine properties searched and £5,500 confiscated (Martynowicz, A. 2009).

The Northern Ireland Human Rights Commission undertook a scoping study on the nature and extent of human trafficking in Northern Ireland in 2009. People trafficked into Northern Ireland mainly originated from the Baltic States, Eastern and Central Europe, Central Asia, Bangladesh, Jamaica, Sri Lanka, Ukraine and several African countries including Cameroon, Nigeria, South Africa and Sudan. The study reported limited services for victims of human trafficking, particularly for children and young people who arrive in Northern Ireland unaccompanied. Trafficking was identified as being associated with health risks such as psychological trauma, injuries from violence, sexually-transmitted infections, HIV and AIDS, other adverse reproductive health outcomes and substance misuse. These risks are exacerbated by lack of access to services in a foreign country, language barriers, isolation, and exploitative working conditions (Martynowicz, A. 2009).

8 Migrant health and wellbeing workshop

A half-day workshop involving a wide range of relevant stakeholders in migrant health, was held in April 2010 as part of the mapping exercise (Appendix E). The objective of the workshop was to identify key priorities for action. The details of the project and a summary of the results of the mapping report were presented to the stakeholders. Five focus groups were held to explore the following issues: mental health; poverty and destitution; women's and children's health; adult health and chronic disease; and building capacity of professionals working with migrants within the voluntary and statutory groups. The stakeholders provided feedback on the details of the report, discussed the relevant issues in migrant health and well-being within their focus groups, and identified priorities.

8.1 Mental health and wellbeing

Issues identified:

- Lack of support mechanisms for migrants with mental health problems
- Language barriers for people with mental health problems. The interpreting service is limited when assessing patients' mental status and providing talking therapies.
- People from some migrant groups may not seek help
- Cultural differences cause different presentations of mental illness. Professional staff require training to assist them in diagnosing mental illness in people from different cultures.
- Accessing crisis response services was reported to cause great distress and confusion
- Increasing numbers of social problems are emerging, such as divorce, abuse, stress and domestic violence
- Gambling is prevalent in certain groups, in particular, the Chinese community
- The economic downturn has affected the migrant community severely, with worsening levels of drug and alcohol problems.

Priorities agreed:

- Language barriers when dealing with mental health problems and the limitations of the interpreter service in this context
- Recognition of the relationship between alcohol and drug misuse and mental health within migrant communities. There is a need for the development of targeted prevention programmes.
- Staff training on cultural awareness, capacity building and protocols on issues specific to mental health
- Development of an inter-agency forum on migrant mental health issues

8.2 Poverty and destitution

Issues identified:

- Language barriers cause significant problems when accessing the housing sector
- Migrants' housing choices depend on the individual's knowledge of housing available and their personal finances
- Migrants living in multiple occupancy housing with poor working conditions
- Migrants mainly live in deprived areas in Belfast, where communities are under pressure. They may be seen as a threat, increasing racial tensions.
- Lack of information and knowledge on entitlements leads to poverty
- Improved links to existing migrant support groups is necessary for all public services

8 Migrant health and wellbeing workshop

- Increased awareness and training for health professionals. Legal requirements, entitlements and human right issues are complex and confusing for professionals. Education is required for those working with migrant populations
- Access to financial support for migrants who are destitute, in the form of an emergency fund

Priorities agreed:

- Improved access to information and services for migrant groups. An orientation course and welcome pack with information for migrants, was recommended.
- Training for healthcare professionals on human right issues and cultural awareness
- Mapping of the services and support available for migrant groups in Belfast.

8.3 Women's and children's health

Issues identified:

- Increased numbers of pregnant, migrant women presenting to hospital with no advanced booking for antenatal care and no awareness of the antenatal care process in Northern Ireland
- Larger proportion of health visitors' work load is with migrant children. Their care is more time consuming.
- Communication is more difficult because of language barriers and cultural differences
- Migrant children may not have had the full childhood screening and vaccination schedules in their country of origin
- No system to vaccinate children of illegal immigrants
- Increased referrals to health visitors by staff in Accident and Emergency Departments. This is an inappropriate system for dealing with child protection cases and puts extra pressure on Accident and Emergency staff
- Refugee children identified as vulnerable, especially in accessing services
- One Stop Shop for migrant families suggested to improve co-ordination of services. This would include NIHE, health visitors, social services, education and interpreters.
- Training of staff highlighted as an issue; no uniform awareness of all available services and support mechanisms in the community
- Funding for a specialist nurse in migrant health recommended
- Emergency funding required, with the development of a designated team to co-ordinate new arrivals.

Priorities agreed:

- One Stop Shop: a multi-disciplinary, multi-agency service
- Training and increased awareness for health professionals on support services
- Ring fenced money to promote a holistic service specific to the migrant community.

8.4 Adult health and chronic disease

Issues identified:

- There are more legislative rights for children and women with families. Single men and women have fewer rights. Complex medical problems often become a human rights issue. This causes anxiety and confusion for health professionals.
- Irregular migrants are an increasing burden on Accident and Emergency services. Patients with chronic illness cannot access more appropriate health care services, as they are not

8 Migrant health and wellbeing workshop

entitled to be registered with a general practitioner.
- Adults with a disability are often not entitled to specialised accommodation, social services and allied health professional services
- Rising numbers of ethnic minority groups will increase the prevalence of certain chronic diseases, such as diabetes and cardiovascular disease
- Health promotion services, sensitive to cultural and dietary differences, should be developed for migrant populations
- A social welfare fund was recommended
- Support and training for health professionals on available services and entitlements is needed
- Many migrant communities, for example the Roma Romanians, are suspicious of the healthcare system.

Priorities agreed:
- There are language barriers in accessing health and social care services, particularly for chronic disease and disability, and support is needed
- General health promotion for migrant communities is needed
- A clear Trust policy on migrant health and entitlements is required for health professionals, with telephone support on human rights and legislation.

8.5 Building capacity of professionals working with migrants within the voluntary and statutory groups

Issues identified:
- With the increased number of ethnic minority children coming to local schools, many schools do not have the capacity and experience to work with them. There is a lack of resources for capacity building for staff to address the needs of BME children.
- Different BME Groups have different entitlements. It is difficult to understand the legislation and entitlements of different groups.
- There are language and cultural barriers for BME people in accessing primary health care services. It is difficult for staff working with migrants who are under the restriction of 'no recourse to public fund'.
- There is no single point of contact for migrants or staff working with them.
- There are concerns about the entitlement of adults with dependent children under 'statutory' duty of care.
- Staff are concerned that they may breach their code of conduct laws because they do not understand the relevant laws and policies relating to migrants.

Priorities agreed:
- Clear guidelines for staff and training on their statutory duties to migrants and on immigration status
- Partnership and information sharing, including a strategic partnership with OFMDFM
- Communication and training for health professionals, eg. website and e-learning on entitlements and child protection training.

9 The three priorities for action identified for Belfast

9.1 Improve access to health care for migrants

Workshop participants identified three overall priorities to improve access to health and social services for migrants in Belfast.

- Further develop the interpreter service, by increasing the number of trained interpreters and increasing the range of languages available
- Improve information for migrants; welcome pack and orientation course for new arrivals.

9.2 One stop service for migrants

- Multi-disciplinary involvement, including housing sector, social services, health visitors, interpreters, medical officer and education, with a central co-ordinator
- Central location alongside existing clinics
- Refer new arrivals to the service.

9.3 Training and guidelines for health and social care professionals

- Increase awareness of changing demographics of Belfast
- Increase awareness of migrant health and well-being needs
- Training on Cultural Awareness
- Clear guidance on statutory duties of professionals
- Clear trust policy on migrant health issues and entitlements
- Telephone support, web-site and e-learning with information on issues such as human rights and legislation.

10 Appendices

10.1 Appendix A: European Partners in Healthy and Wealthy Together

Camara Municipal Amadora	Portugal
Exfini Poli	Greece
University of Birmingham	UK
Municipality of Milan	Italy
Belfast Health and Social Care Trust/Belfast City Council	UK
Municipality of Roquestas de Mar	Spain
Réseau Samdarra,	France
Province of Piacenza	Italy

10.2 Appendix B: Membership of Belfast Local Action Group for Healthy and Wealthy Together

Alfred Abolarin	Assistant Principal, Community Cohesion Unit, Northern Ireland Housing Executive
Orla Barron	Health and Social Inequalities Manager, Belfast Health and Social Care Trust
Leslie Boydell *	Associate Medical Director for Public Health Belfast Health and Social Care Trust
Margaret Donaghy	Senior Manager, Multi Cultural Resource Centre
Donna Gleek	Health and Well-being Co-ordinator, Belfast City Council
Jillian Johnston	Specialist Registrar, Public Health Agency
Sandra McCarry	Senior Manager, Public and Personal Involvement, Belfast Health and Social Care Trust
Denise Wright	Race Relations Co-ordinator, South Belfast Roundtable against Racism
Jennifer Yu	Community Development Practitioner Advanced, Belfast Health and Social Care Trust
Patrick Yu	Executive Director, Northern Ireland Council for Ethnic Minorities

* Project Co-ordinator

10.3 Appendix C: Accession Countries

A8 Countries	A2 Countries
Czech Republic	Bulgaria
Estonia	Romania
Hungary	
Latvia	
Lithuania	
Poland	
Slovakia	
Slovenia	

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10.4 Appendix D: Amendments to asylum appeal legislation

The Asylum and Immigration Act 1996 introduced a list of countries deemed safe with little risk of persecution. Entitlement to housing and welfare benefits were restricted.

The Immigration and Asylum Act 1999 gave asylum seekers more protection when entering the country illegally, if they had good cause for entering. National Asylum Support Service (NASS) was introduced to co-ordinate arrangements for support and allow dispersal of asylum seekers throughout the UK.

The Nationality Immigration and Asylum Act 2002 significantly amended the law with an emphasis on ensuring asylum seekers were more effectively tracked throughout the system, and promoted a commitment to integration of people recognised as refugees.

The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004 further altered the asylum process. New offences of entering without a passport or reasonable excuse were introduced. Laws against human trafficking were introduced into domestic law. Entitlements for NASS were altered dependent on the success of the appeals.

The amended Immigration, Asylum & Nationality Act 2006 imposes penalties on employers who employ adults (over the age of 16), who are subject to immigration controls, and have not been granted leave to enter or remain in the UK, or whose leave is invalid, ineffectual or subject to conditions preventing them accepting the employment (“illegal workers”).

10.5 Appendix E: Benefits classed under public funds

Attendance Allowance
Carers Allowance
Child Benefit
Child Tax Credit
Council Tax Benefit
Disability Living Allowance
Housing Benefit
Income Support
Income Based Job Seekers Allowance
Pension Credit
Severe Disablement Allowance
Social Fund Payments
Working Tax Credit

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10.6 Appendix F: Attendees at the Stakeholder Workshop 28th April 2010

Barnardos	Joanna Tarach, Karolina Winiecka-Morgan
Belfast City Council	Jelena Buick, Leish Dolan, Donna Gleek
Belfast Education and Library Board	Roger Kelly. Miriam Moore
Belfast Health and Social Care Trust	Orla Barron, Leslie Boydell, Sharon Christie Cathy Doherty, Siobhan Donald, Alison Donnelly Janice Flanigan, Claire Hamilton, Bernie Kelly Jacintah McCaffrey, Mary McCann, Sandra McCarry Deirdre McCrory, Joanna McCullough Yvonne McKeever, Geraldine Mullan, Bryan Nelson Tracy Reid, Joan Rodgers, Ida Ross, Jennifer Yu
Belfast Islamic Centre	Muhammad Al Qaryooti
Belfast Local Commissioning Group	Iain Deboys
Bulgarian Association	Ivaylo Cankov
Chinese Welfare Association	Eileen Chan Hu
Czech & Slovak Association of Northern Ireland	Roman Vilkovic
Department of Education Northern Ireland	John McGoran
Department of Health, Social Service & Public Safety	Andrea Begley, Hilary Harrison
Filipino Association	Ricky Gallo
Indian Community Centre	Donald Bell, Raj Puri
Multi Cultural Resource Centre	Margaret Donaghy, Lillian Nellem
Northern Ireland Council for Ethnic Minorities	Patrick Yu
Northern Ireland Housing Executive	Stephen Reynolds, Brian McFaul
Police Service Northern Ireland	Heather Carson, Crawford Thompson
Polish Association Northern Ireland	Maciek Bator
Public Health Agency	Mary Black, Jillian Johnston, Maurice Meehan
OFMDFMNI	Carol Murphy
SDLP	Conall McDevitt
South Belfast Roundtable against Racism	Denise Wright
Ulster People's College	Karen McCartney

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