Guide to the Ethnic Monitoring of Service Users in Health and Social Care in Northern Ireland

(Feb 2016)

CONTENTS

INTRODUCTION

Who the guide is for

This ethnic monitoring guide is intended to assist staff working in Health and Social Care in Northern Ireland. It is targeted at:-

- Frontline staff and their managers who will be responsible for directly asking patients/clients for the information and may need to deal with exceptional or difficult cases;

- Clinical, nursing, paramedical and auxiliary staff who may need to know the questions that patients/clients have been asked;

- Analytical or information staff who need to know how to use ethnic category data; and

- Senior management who may also require to be briefed on the data collection in relation to equality and human rights obligations.

How this guide is structured

Section 1 looks at **why monitoring is needed**. This will help staff understand the vital role monitoring has to play in the provision of accessible, appropriate services that meet the needs of all service users. This understanding will enable staff collecting the data to explain to patients/clients why the information is required and how it will be used.

Section 2 deals with **how the information is recorded** focusing on the OFMDFM standardised framework that will be used to record country of birth and ethnic group.

Section 3 addresses **confidentiality and data protection** issues.

Section 4 looks at the mechanics of **collecting the data** and provides some general advice on how staff should go about doing this in a sensitive manner.

Annex 5 contains background information on this guidance.

1. WHY MONITORING IS NEEDED

Chapter 8 para 8.6.1 of the '*Race Equality in Health and Social Care – A good practice guide*' [1] set out some of the reasons why monitoring ethnicity is important, these included:-

- It helps the provider get to know the local community;
- It indicates a commitment to equality in service delivery;
- It raises awareness of gaps in services;
- It improves access to services;
- It helps guide service provision toward the specific health and social care needs of a variety of black and minority ethnic groups, therefore developing priorities and targeting resources more effectively;
- It enables better targeted health promotion and prevention programmes;
- Human Rights; and
- It measures outcomes.

The chapter then goes on to look at some of the ways the monitoring can help in the context of service delivery, dietary needs, religious needs, communication needs, hospital care, maternity and childcare provision, and, registration, medical records and appointments.

The following section, however, will look at some particular examples which will hopefully help staff understand the issues and enable them to explain to patients/clients how ethnic monitoring will help to provide a better service for everyone.

Facilitating access to Services

Monitoring ethnicity will allow service providers to see whether the uptake of the services is proportionate to the demographics of the

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[1] http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/index/hss/equality/eq-race-diversity/eq-race-equality.htm

population that uses those services. Lower uptake may be an indicator that there is a need for additional action to ensure that services are accessible. The following examples illustrate possible barriers some service users may face.

- **Lack of awareness**. The All Ireland Traveller Health Study was published in September 2010. The associated '*Technical Report 1: Health Survey Findings*'[2] records a higher instance of Traveller children not having access to medical care because their parents believed they would have to pay for them even though they had medical cards.

    "*It is also notable that more Travellers reported not accessing care for their children because of a concern about paying for services than did the comparator population, notwithstanding the fact that they have medical cards.*"

In this particular case monitoring will allow service providers to see whether the uptake of services by Traveller children is what would be expected and if not flag the need to investigate why this is the case.

In some cases the way in which Healthcare is provided in Northern Ireland is different to that provided in other countries and this can lead to difficulties. In October 2009 NICEM published a report ' *'Za Chlebem': The Impact of the Economic Downturn on the Polish Community in Northern Ireland*' [3]. Commenting on complaints about Healthcare the report recognises that some of this is down to different expectations:

    'The health services in Poland and Northern Ireland have very different procedures; in Poland there is a first point of contact to access medical services who will then refer you on to a specialist. This is very different to Northern Ireland where most contact is through GPs who deal with a wide variety of medical issues.

    Additionally, many Polish immigrants become disappointed by the

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[2] http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/technicalrep1.pdf
[3] http://nicem.org.uk/wp-content/uploads/2014/03/Za_Chlebem_Report.pdf

reluctance of their GPs in Belfast to prescribe antibiotics. Poles, who are used to being treated with strong medications, get an impression that their complaints are disparaged by Northern Irish doctors. As a result, many Polish immigrants indicate that they would rather go to doctors for check-ups during their holidays in Poland or book themselves in Polish hospitals for treatment.'

- **Literacy**. The '*All Ireland Traveller Health Study Summary Report*' [4]recognises literacy levels for Travellers are lower than the comparator population.

  "Difficulty in reading and filling out forms was reported by 28.8% of ROI families and 35.3% of those in NI".

  "Asked how easy it was for Travellers to carry out written instructions, for example with information leaflets or prescriptions, most respondents rated this as either difficult (47.2%) or very difficult (26.4%)."

  The Report also flags Traveller concerns about disclosing their Traveller identity and stresses the importance of staff being able to assure Travellers that the net result of monitoring will be positive.

  "What are the drawbacks to an ethnic or cultural identifier? First, there is the fear Travellers might have that they will somehow be discriminated against if they disclose a Traveller identity. This is a very real issue for Travellers, compounded by their fear of written information, which many for literacy reasons cannot read themselves to verify its accuracy. Service Providers at interview raised similar reservations in fact. The only way to combat this is to, on the one hand assure Travellers that the net result will be positive, and on the other to ensure that healthcare delivery staff are aware of the issues particular toTravellers."

- **Language**. Chapter 8 para 8.10 of the *'Race Equality in Health and Social Care – A good practice guide'* [5] deals with communication

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[4] http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/aiths.pdf

needs. It begins by observing that: *'Service users whose first language is not English can be at a disadvantage in getting access to healthcare'*. This is also a common issue flagged by voluntary and community sector organisations. The passage then goes on to suggest some ways in which service providers can address the needs of service users.

There are, however, some questions that only monitoring can answer.

- o How many interpreters will be needed, for what languages and in what locations? Some patients/clients may require interpreters and in some situations this can be vital, for example, in ensuring that people who don't speak English know how much prescription medication to take and when to take it.

- o What are the requirements for translated leaflets? Knowing the ethnic make-up of service users will also allow service providers to ensure that there are well translated leaflets on important topics such as, opening times, what services are available and how to access them, and other information on public health issues.

Addressing particular health issues

Research has shown that the prevalence of some health conditions and issues can be greater among some ethnic groups. Monitoring ethnicity will allow service providers to see who their service users are so that they can plan accordingly. This information will also be beneficial in reducing some health inequalities. The following examples are included solely to illustrate how ethnicity can be linked with certain health concerns and issues and are not intended to be exhaustive. This includes evidence from sources outside Northern Ireland which indicate that there are likely to be wide inequalities in both risk factor levels and health outcomes by ethnic group.

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[5] http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/index/hss/equality/eq-raceeqhealth.htm

- **Coronary Health Disease (CHD)**. In England the mortality among Pakistani men was almost 50% higher than the general population. As well as being relatively more common, in absolute terms CHD was also by far the most common single cause of death among Pakistani men. CHD mortality was similarly raised among Indian- and Bangladeshi-born men but substantially lower for Chinese men.

- **Smoking**. Smoking is widely recognised as a health risk factor. Research in England (Newcastle Heart Project)[6] found that among Indian, Pakistani and Bangladeshi women smoking is less common compared to the general population. However, the proportion of Bangladeshi men who smoke is the highest of any ethnic group.

- **Diabetes**. In England the prevalence of type 2 diabetes is reported as 3–5 times higher among Indians, Pakistanis, Bangladeshis and Afro-Caribbeans, but among Chinese is similar to the general population. Impaired glucose tolerance, dyslipidaemia and C-reactive protein levels all showed marked ethnic variations.

  This is similar to Northern Ireland, the Public Health Agency [7] has reported that:

  > '*diabetes is more prevalent in Asian and black ethnic groups (12.4% and 8.4% respectively) compared to Northern Ireland population (5.4%)*'

- **Maternity.** A 2007 national survey ('*Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey*' [8]) of women (16 years or over) about their experience of maternity care found that Ethnic minority women were more likely to access services late, not have a scan by 20 weeks, and experience complications during pregnancy and birth.

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[6] Ethnicity, race and health in multicultural societies – RS Bhopal
[7] http://www.publichealthagency.org/sites/default/files/Guide%204%20BME%20Groups_0.pdf
[8] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862068/?tool=pubmed

- **Mortality/ Infant Mortality.** The 'All Ireland Traveller Health Study' [9] reported that:

  '*On average, Travellers die about 15 years earlier than the general population. Only 1 in 10 of the Traveller population is over 40 years of age and only 1 in 100 is over 65.*'

  '*Allowing for the age differences between the Traveller and general populations, overall Traveller mortality is 3.5 times higher. Traveller males have 3.7 times the mortality of males in the general population; for females the mortality is 3.1 times higher.*'

  '*Looking at the gap between the Traveller and general population in terms of a relative difference the situation has deteriorated since 1987. Traveller infants today are 3.6 times more likely to die than infants in the general population.*'

- **Sickle Cell Disease (SCD).** In the UK, about 12,500 people have SCD. It is more common in people whose family origins are African, African-Caribbean, Asian or Mediterranean. It is rare in people of North European origin. On average, 1 in 2,400 babies born in England has SCD, but rates are much higher in some urban areas - about 1 in 300 in some places. SCD is now one of the most common inherited conditions in babies born in the UK[10].

- **Tuberculosis**. The UK Health Protection Agency carries out enhanced TB surveillance [11]. The data shows a marked difference between those born in the UK and those that are not born in the UK. In addition the prevalence per 100,000 was higher for certain ethnic groups - Black African (199), Indian (154), Pakistani (132), and Black other (123) compared with Black-Caribbean (29) and White (3).

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[9] http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/aiths.pdf
[10] http://www.patient.co.uk/health/Sickle-Cell-Disease-and-Sickle-Cell-Anaemia.htm
[11] http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/TBUKSurveillanceData/EnhancedTuberculosisSurveillance/

Monitoring future demand for services.

Northern Ireland's ethnic population has changed considerably over the past decade. At the time of the 2001 Census[12] the largest ethnic group in Northern Ireland was Chinese (4,145).

The number of people from A8 and A2[13] Central and Eastern Europe has grown and they are now estimated to make up 2% of the Northern Ireland population, particularly Polish and Lithuanians. It is important to be able to monitor ethnicity to ensure that we can monitor changes in service users to ensure that their needs are considered. For example.

- **Maternity Services**. In 2001 the number of births registered in Northern Ireland from mothers whose country of birth was an A8 country was recorded as 12. In 2012 the corresponding figure was 1,202[14].

- **Interpreters**. The Business Services Organisation provides a Regional Interpreting Service for all Health & Social Care Organisations throughout Northern Ireland. The Interpreting Service was set up in 2004 and demand has grown from 10,257 requests in the year 2005/06 to 51,734 in 2010/11. It is not just the volume that has changed but profile of the service users. In 2005/06 the three largest groups were Portuguese (3,672), Lithuanian (1,786) and Polish (1,705). In 2010/11 the same three groups featured but the profile had changed – Polish (18,224), Lithuanian (10,174) Portuguese (5,248).

Ethnic diversity in Northern Ireland may continue to change as more immigrants from diverse backgrounds arrive. This means that the challenge of meeting the healthcare needs of Northern Ireland's ethnic minorities is unlikely to disappear, and that reliable data on ethnicity will be a crucial part of meeting that challenge.

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[12] http://www.nisra.gov.uk//Census/2001%20Census%20Results/KeyStatistics.html

[13] A8 countries joined EU in 2004 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia – Cyprus and Malta also joined at that time). A2 countries joined the EU in 2007 (Bulgaria and Romania)

[14] http://www.nisra.gov.uk/demography/default.asp8.htm   (3.15)

2. HOW THE INFORMATION IS RECORDED

In July 2011 OFMDFM issued - '*Guidance for Monitoring Racial Equality*'[15] which provided a standardised framework to help public bodies collect information in a consistent but flexible manner.

In keeping with the OFMDFM guidance ethnic monitoring will focus on recording two key pieces of information: country of birth and ethnic group. The coding is consistent with the 2011 Census which will enable comparability and benchmarking with the whole population.

Country of birth

OFMDFM have recommended the use of the 2011 Census question on country of birth this provides an alternative option to Northern Ireland, England, Wales, Scotland and Republic of Ireland in the form of 'elsewhere, write in'. i.e.

> What is your country of birth?
> • Northern Ireland
> • England
> • Wales
> • Scotland
> • Republic of Ireland
> • Elsewhere, write in the current name of country.

It is preferable not to use ethnic group to monitor new migrants such as Eastern Europeans as they are likely to fall mainly under the white category. Country of birth, however, can be used in conjunction with ethnic group to allow for multivariate analysis with the ethnic group variable e.g. Portuguese Black, Polish White. For this reason i**t is recommended that the country of birth question should be asked before the ethnic group question**.

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[15] https://www.ofmdfmni.gov.uk/sites/default/files/publications/ofmdfm_dev/guidance-for-monitoring-racial-equality.pdf

It should be noted that on some systems, e.g. Child Health, may record mothers country of birth rather than the country of birth of the actual patient/client.

A four character code will be used to record country of birth / mother's country of birth. Details of the current agreed codes can be found in **Annex 1**. The first character of the code will represent the region, see **Annex 2**. This is normally the first letter of the region, however, where this could generate a duplicate code (Africa, Asia and Australasia) the second letter is used. The remaining three characters are taken from and denote the particular country within that region.

Coding Queries

Staff should keep a note of any country coding queries and refer these to the HSCB Data Standards Service at HSCDataStandards@hscni.net .

Ethnic group

Ethnicity is complex to define as it is multi-faceted. Importantly, ethnicity is subjective: **a person should self-assign his or her own ethnic group**. While other people may view an individual as having a distinct ethnic identity, **the individual's view of their own identity takes priority**. Features that help to define ethnic group are as follows: a shared history; a common cultural tradition; a common geographical origin; descent from common ancestors; a common language; a common religion; and forming a distinct group within a larger community.

An ethnic group can sometimes be perceived as a minority within a larger community, however, ethnic groups cover people from all communities.

OFMDFM have again recommended the use of the 2011 Census question on Ethnic group:

> What is your ethnic group?
> • White
> • Chinese
> • IrishTraveller

- Indian
- Pakistani
- Bangladeshi
- Black Caribbean
- Black African
- Black other
- Mixed ethnic group
- Any other ethnic group

Health and Social Care systems will mirror these categories, however, two additional responses will be monitored:

- Roma Traveller
- Not Stated

Roma Traveller is a separate ethnic monitoring category but the numbers collected may be small due to the relatively small population living in Northern Ireland. When presenting data, if numbers are small (less than 5) this should be amalgamated with 'Any other ethnic group' rather than presented separately.

A one or two character code will be used to record Ethnic Group. Details of the current agreed codes can be found in **Annex 3**.

Language

This is unique code comprised of 4 characters:

–unless a language name is less than four characters in length. If this is the case then the language name will be used as the unique code;

-where practical the first four characters of the name will be used. If this does not give a unique and meaningful code then a unique code will be created by selecting letters from the complete name.

Details of the current agreed codes can be found in **Annex 4**.

3. CONFIDENTIALITY AND DATA PROTECTION

Legal requirements – Data Protection Act

The Department of Health, Social Services and Public Safety and the associated Health and Social Care organisations are committed to safeguarding personal information. As with all information that can be linked to an individual, a patient or client's ethnic group and country of birth must be treated as being strictly confidential. Foremost amongst these requirements are those of the Data Protection Act 1998 (DPA).

The DPA came into force in March 2000. Its purpose is to protect the right of the individual to privacy with respect to the processing of personal data. Under the DPA there is requirement to:

- only collect information that is needed for a specific purpose;
- keep it secure;
- ensure it is relevant and up to date;
- only hold as much as is needed, and only for as long as it is needed; and
- allow the subject of the information to see it on request.

A key requirement of the DPA is that patients / clients are aware of the data collected about them and how these data will be used. It is essential to tell them about the use to which the data will be put, and who will have access to it. Staff will be provided with information leaflets which they can use to reassure patients / clients. These leaflets will:

- set out clearly why the information is being collected and how it will be used;
- make it clear individuals are not obliged to disclose their ethnic identity if they so choose; and
- that any ethnic information they provide will be treated confidentially.

When ethnic group / country of birth data have been collected, the DPA requires that disclosure is allowed only to those who have authorised use for it. If the information is principally used for monitoring / planning

purposes, it is likely to be used in aggregated statistical form only with no need for anyone other than information managers to have any knowledge of what response individuals gave.

Guidance on the Data Protection Act 1998 is available from the Office of the Information Commissioner https://ico.org.uk/

While the DPA is the primary concern staff must also keep in mind the Human Rights Act and Professional Standards.

Human Rights Act

This Human Rights Act 1998 implements the provisions of the European Convention of Human Rights (ECHR). Article 8 of the ECHR provides a right to respect for a person's private and family life. Disclosure of personal information could be a breach of that right unless it was 'in accordance with the law' and necessary for the protection of health. This means that patient / client identifying information should not be disclosed unless there is a lawful basis to do so, such as the consent of the patient, compliance with a legal requirement or the need to protect life.

Professional Standards

All healthcare professionals must maintain standards of confidentiality laid down by their professional body, such as the General Medical Council, NI Social Care Council, etc. As a rule, such standards have been developed to clarify what the law means in a healthcare setting and to set out any additional principles or ethical standards for that profession.

HSC Guidance

The use and sharing of service user personal information forms an essential part of the provision of health and social care. It benefits individual service users, enables health and social services to function effectively and is often necessary in the public interest. However, the essential nature of such uses needs to be set alongside the expectation service users have that all personal information will be kept confidential.

A new Code of Practice was introduced in Northern Ireland in 2009 to support staff in making good decisions about the protection, use and disclosure of service user information. The '*Code of Practice on Protecting the Confidentiality of Service User Information*'[16] and the associated protocol '*DHSSPS & HSC Protocol for Sharing Service User Information for Secondary Purposes*'[17] provide practical guidance to assist decision making when dealing with service user information. The Code of Practice should be the reference point for all staff.

In June 2015, DHSSPS introduced the Health and Social Care (Control of Data Processing) Bill in the Assembly. This Bill will enable the use of health and social care information, which identifies individual service users, to be used for health care or social care purposes which are in the public interest, without the consent of the individuals whose information may be used. The Bill also places an obligation on the Department to establish a Committee to oversee this process and to disseminate information to the public. It will, therefore, be necessary to be aware of the provisions once the legislation becomes an Act.

In addition, the Health and Social Care Board launched a consultation in October 2014 on an eHealth and Care Strategy for Northern Ireland which would include increased use of information.

If you are unsure about sharing service user information, ask your line manager, take advice from Information Governance staff in your organisation and if necessary have the issue drawn to the attention of the Personal Data Guardian.

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[16] http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf
[17] http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/dhssps_hsc_protocol_for_sharing_service_user_information_for_secondary_purposes__final__pdf_.pdf

4. COLLECTING THE INFORMATION

Ethnic monitoring (country of birth and / or ethnic group) still arouses suspicion for some people. Rather than see it as a force for good, some may see it as a means of discriminating against them.

Experience has shown that the collection of this data is most effective when the following key principles and critical success factors are considered:

Senior management commitment.

The role of clinical leaders and senior service managers cannot be emphasised enough as it is their staff in front line practice positions, together with reception staff, who are often best placed to collect the data on reception or at referral.

Equipping staff.

All staff to be involved in collecting or handling of this data should receive training or briefing before doing so. Staff who are familiar and comfortable with the issues are better able to answer queries and to convey the importance of the question.

Collect the information routinely and effectively

Data on country of birth and / or ethnic group, related matters and other personal information should be collected, as far as possible, as a matter of routine at reception or referral or when patients and users register for a service. Reception staff and frontline staff will play the most prominent part in these processes. The more the process is routine and unremarkable the better. While organisations differ with respect to function, structure and procedures, there are some general principles that will stand all organisations in good stead:

- It should always be made clear to patients / clients why we are carrying out ethnic monitoring and that the provision of this data is **voluntary**. There is no obligation on patients/clients to respond to the country of birth and ethnic group questions and no pressure should be put on patients / clients to answer, or on staff to obtain an answer.

- Locally, managers may wish to monitor use of the "*Not stated or not available*" category. If this response constitutes a high percentage, managers may wish to investigate reasons for this. Elsewhere it has been found that the "*Not stated or not available*" response will tend to be used less where there is clear evidence of support for the collection from senior management, and when staff are well-trained and understand the reasons for collecting information.

- As with all personal information, procedures should be in place to ensure **privacy** and the sensitive and confidential handling of information when personal data of any sort is sought. Local procedures should, therefore, avoid collecting in crowded reception areas, or where the person behind can hear every word spoken.

- When responding to the ethnic group question, individuals should not select more than one code. If the patient / client wants to tick more than one box, they should be asked whether this means that they are 'Mixed Ethnic Group' or 'Other Ethnic Group' depending on the categories chosen.

- When responding to the country of birth question, individuals should not select more than one code. If the country of birth is not on the list it should be noted and a coding query raised (see page 10).

- Patients / clients should be shown the full range of codes so that they can select the code that best describes them.

- Where possible, the data should be collected once only to ensure that patients, clients and staff are not repeatedly asked for the same information.

- Collecting country of birth and / or ethnic group information at the same time as the bulk of registration, admission or referral information is collected is natural and efficient. Staff should be able

to explain why such information is being sought.

- Staff should be trained in the relevant aspects of policies relating to child protection and the protection of vulnerable adults.

- Staff should be trained and supported in identifying and working with patients and users with communication needs, such as individuals with learning disabilities.

Self Classification.

The principle of self-classification is a fundamental human right and important as it helps to ensure uniformity of data quality. How an individual sees her or himself may be different from how that person's parents, other family members or third parties see them. It is, therefore, important that the person to be classified is responsible for classifying themselves, and that their reply is their own perception. There are, however, some unavoidable exceptions to this.

Parents or carers should speak on behalf of **babies and young children**. However, a baby or young child should not be automatically accorded the ethnic group of the mother. As far as **children** are concerned, their views should be sought if they are capable of understanding and responding to what they are being asked. Parents or carers may support children in giving their answers.

Close relatives or advocates may speak on behalf of individuals who because of **physical illness or disability, learning disability, cognitive impairment or mental ill-health**, are unable to speak for themselves or are not able to understand what is being asked of them or give an accurate reply. Where staff members read out the questions on county of birth and / or ethnic group they should take care to read all the instructions and codes.

For the **temporarily lacking capacity** (confused, traumatised or the unconscious) whether confusion is due to emotional or physical stress, there will be instances when it is more appropriate to collect some data

at a later time. The Ethnicity field is mandatory and cannot be left blank in such cases "*not stated or not available*" should be recorded.

For patients suffering from **dementia**, experience suggests that country of birth and / or ethnic group should be gathered from a relative, or an advocate.

As with all other aspects of the care process, some **individuals who have difficulty in communicating in spoken or written English**, may need the support of translators or interpreters[18] to help them understand and respond to questions.

With regards to **visually impaired** individuals, braille or other accessible versions of the necessary paperwork may need to be provided. It is imperative that the individual is presented with the same information as other respondents. So, for example, it would be inappropriate to ask "What is your ethnic group?" without presenting the available options. It is also important not to overload the respondent with too much information at once – for example, by reading through the full list of categories all in one go.

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[18]http://webarchive.proni.gov.uk/20150724114332/http://www.dhsspsni.gov.uk/race_equality_guide_march_2011.pdf

Country of birth / mother's country of birth codes[19]

CODE	C O U N T R Y
AAFG	AFGHANISTAN
ABAN	BANGLADESH
ABHU	BHUTAN
ABRU	BRUNEI
ACAM	CAMBODIA
ACHI	CHINA
AHON	HONG KONG
AIDO	INDONESIA
AIND	INDIA
AJAP	JAPAN
AKAZ	KAZAKHSTAN
AKIR	KIRIBATI
AKYR	KYRGYZSTAN
ALAO	LAOS
AMAC	MACAU
AMAL	MALAYSIA
AMDV	MALDIVES
AMON	MONGOLIA
AMYA	MYANMAR
ANEP	NEPAL
ANKA	NORTH KOREA
ANMI	NORTHERN MARIANA ISLANDS
APAK	PAKISTAN
APHI	PHILIPPINES
ASIN	SINGAPORE
ASKO	SOUTH KOREA
ASRI	SRI LANKA

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[19] Source: Ethnic Monitoring Sub Group

ATAI	TAIWAN
ATAJ	TAJIKISTAN
ATHA	THAILAND
ATUR	TURKMENISTAN
AUZB	UZBEKISTAN
AVIE	VIETNAM
CANG	ANGUILLA
CANT	ANTIGUA AND BARBUDA
CARU	ARUBA
CBAH	BAHAMAS
CBAR	BARBADOS
CBER	BERMUDA
CCAY	CAYMAN ISLANDS
CCUB	CUBA
CDOM	DOMINICA
CDOR	DOMINICAN REPUBLIC
CGRE	GRENADA
CGUA	GUADELOUPE (FRENCH)
CHAI	HAITI
CJAM	JAMAICA
CMAR	MARTINIQUE (FRENCH)
CMON	MONTSERRAT
CNET	NETHERLANDS ANTILLES
CPUE	PUERTO RICO
CSKN	SAINT KITTS AND NEVIS
CSLU	SAINT LUCIA
CSVG	SAINT VINCENT AND GRENADINES
CTRI	TRINIDAD AND TOBAGO
CTUR	TURKS AND CAICOS ISLANDS
CVIR	VIRGIN ISLANDS
EALB	ALBANIA
EAND	ANDORRA
EARM	ARMENIA
EAUS	AUSTRIA
EAZE	AZERBAIJAN
EBEL	BELARUS

EBGM	BELGIUM
EBOS	BOSNIA-HERZEGOVINA
EBUL	BULGARIA
ECRO	CROATIA
ECYP	CYPRUS
ECZE	CZECH REPUBLIC
EDEN	DENMARK
EENG	ENGLAND
EEST	ESTONIA
EFAR	FAROE ISLANDS
EFIN	FINLAND
EFRA	FRANCE
EGEO	GEORGIA
EGER	GERMANY
EGIB	GIBRALTAR
EGLD	GREENLAND
EGRE	GREECE
EHOL	HOLY SEE (VATICAN)
EHUN	HUNGARY
EICE	ICELAND
EIRE	IRELAND
EITA	ITALY
ELAT	LATVIA
ELIE	LIECHTENSTEIN
ELIT	LITHUANIA
ELUX	LUXEMBOURG
EMAC	MACEDONIA
EMAL	MALTA
EMOL	MOLDOVA
EMON	MONACO
EMRO	MONTENEGRO
ENET	NETHERLANDS
ENIR	NORTHERN IRELAND
ENOR	NORWAY
EPOL	POLAND
EPOR	PORTUGAL

EROM	ROMANIA
ERUS	RUSSIA
ESAN	SAN MARINO
ESCO	SCOTLAND
ESER	SERBIA
ESJM	SVALBARD AND JAN MAYEN ISLANDS
ESLK	SLOVAKIA
ESLO	SLOVENIA
ESPA	SPAIN
ESWE	SWEDEN
ESWI	SWITZERLAND
EUKR	UKRAINE
EWAL	WALES
FALG	ALGERIA
FANG	ANGOLA
FBEN	BENIN
FBOT	BOTSWANA
FBOU	BOUVET ISLAND
FBRI	BURUNDI
FBUR	BURKINA FASO
FCAM	CAMEROON
FCAP	CAPE VERDE
FCAR	CENTRAL AFRICAN REPUBLIC
FCHA	CHAD
FCOM	COMOROS
FCON	CONGO, REPUBLIC OF
FDJI	DJIBOUTI
FDRC	CONGO, DEMOCRATIC REPUBLIC OF THE (ZAIRE)
FEGY	EGYPT
FEQU	EQUATORIAL GUINEA
FERI	ERITREA
FETH	ETHIOPIA
FGAB	GABON
FGAM	GAMBIA
FGHA	GHANA
FGUB	GUINEA BISSAU

FGUI	GUINEA
FIVO	IVORY COAST (COTE D`IVOIRE)
FKEN	KENYA
FLBY	LIBYA
FLES	LESOTHO
FLIB	LIBERIA
FMAD	MADAGASCAR
FMAL	MALI
FMAU	MAURITANIA
FMAY	MAYOTTE
FMOR	MOROCCO
FMOZ	MOZAMBIQUE
FMUR	MAURITIUS
FMWI	MALAWI
FNAM	NAMIBIA
FNGA	NIGERIA
FNGR	NIGER
FREU	REUNION
FRWA	RWANDA
FSAF	SOUTH AFRICA
FSAI	SAINT HELENA
FSEN	SENEGAL
FSEY	SEYCHELLES
FSIE	SIERRA LEONE
FSOM	SOMALIA
FSTP	SAO TOME AND PRINCIPE
FSUD	SUDAN
FSWA	SWAZILAND
FTAN	TANZANIA
FTOG	TOGO
FTUN	TUNISIA
FUGA	UGANDA
FZAM	ZAMBIA
FZIM	ZIMBABWE
MBAH	BAHRAIN
MIRN	IRAN

MIRQ	IRAQ
MISR	ISRAEL
MJOR	JORDAN
MKUW	KUWAIT
MLEB	LEBANON
MOMA	OMAN
MQAT	QATAR
MSAU	SAUDI ARABIA
MSYR	SYRIA
MTUR	TURKEY
MUAE	UNITED ARAB EMIRATES
MYEM	YEMEN
NBEL	BELIZE
NCAN	CANADA
NCOS	COSTA RICA
NELS	EL SALVADOR
NGUA	GUATEMALA
NHON	HONDURAS
NMEX	MEXICO
NNIC	NICARAGUA
NPAN	PANAMA
NSPM	SAINT PIERRE AND MIQUELON
NUSA	UNITED STATES
SARG	ARGENTINA
SBOL	BOLIVIA
SBRA	BRAZIL
SCHI	CHILE
SCOL	COLOMBIA
SECU	ECUADOR
SFAL	FALKLAND ISLANDS
SFRE	FRENCH GUIANA
SGUY	GUYANA
SPAR	PARAGUAY
SPER	PERU
SSGS	SOUTH GEORGIA AND SOUTH SANDWICH ISLANDS
SSUR	SURINAME

SURU	URUGUAY
SVEN	VENEZUELA
UAME	AMERICAN SAMOA
UAUS	AUSTRALIA
UCHR	CHRISTMAS ISLAND
UCOC	COCOS (KEELING) ISLANDS
UCOO	COOK ISLANDS
UFIJ	FIJI
UGUA	GUAM (USA)
UMAR	MARSHALL ISLANDS
UMIC	MICRONESIA
UNAU	NAURU
UNCA	NEW CALEDONIA (FRENCH)
UNIU	NIUE
UNOR	NORFOLK ISLAND
UNZE	NEW ZEALAND
UPAL	PALAU
UPAP	PAPUA NEW GUINEA
UPIT	PITCAIRN ISLAND
UPOL	POLYNESIA (FRENCH)
USAM	SAMOA
USOL	SOLOMON ISLANDS
UTIM	TIMOR-LESTE (EAST TIMOR)
UTOK	TOKELAU
UTON	TONGA
UTUV	TUVALU
UVAN	VANUATU
UWFI	WALLIS AND FUTUNA ISLANDS

NS   **NOT STATED OR NOT AVAILABLE**

Region codes[20]

CODE	REGION
F	AFRICA
A	ASIA
U	AUSTRALASIA
C	CARIBBEAN
E	EUROPE
M	MIDDLE EAST
N	NORTH AMERICA
S	SOUTH AMERICA

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[20] Source: Ethnic Monitoring Sub Group

Ethnic Group codes[21]

CODE	ETHNIC GROUP
W	White
C	Chinese
IT	Irish Traveller
I	Indian
P	Pakistani
B	Bangladeshi
BC	Black Caribbean
BA	Black African
BO	Black Other
M	Mixed Ethnic Group
O	Other Ethnic Group
RT	*Roma Traveller
NS	*Not Stated or not available

* These are additional to the 2011 Census groupings (see page 11).

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[21] Source: Ethnic Monitoring Sub Group

Annex 4

Language codes[22]

ABRO	ABRON
ACEH	ACEHNESE
ACHU	ACHUAR SHIWIAR
ADYG	ADYGHE
AFAR	AFAR
AFRI	AFRIKAANS
AGUA	AGUARUNA
AGUL	AGUL
AJYI	AJYININKA APURUCAYALI
AKAN	AKAN
AKHV	AKHVAKH
AKLA	AKLANON
ALBA	ALBANIAN
ALTA	ALTAY
ALUR	ALUR
AMER	AMERICAN SIGN LANGUAGE
AMHA	AMHARIC
AMIS	AMIS
ANCA	ANCASH QUECHUA
ANYI	ANYI
ARAB	ARABIC
ARAG	ARAGONESE
ARAK	ARAKANESE
ARME	ARMENIAN

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[22] Source: Ethnic Monitoring Sub Group

AROM	AROMANIAN
ARRE	ARRERNTE
ASHA	ASHANINKA
ASSA	ASSAMESE
ATAY	ATAYAL
AUSL	AUSLAN
AVAR	AVAR
AWNG	AWNGI
AZAN	AZANDE
AZER	AZERBAIJANI
BACH	BACHAJON TZELTAL
BAI	BAI
BALI	BALINESE
BALO	BALOCHI
BAMB	BAMBARA
BAOU	BAOULE
BASH	BASHKIR
BASQ	BASQUE
BATA	BATAK
BEJA	BEJA
BELA	BELARUSIAN
BEMB	BEMBA
BENG	BENGALI
BERB	BERBER
BETA	BETAWI CREOLE
BETI	BETI PAHUIN
BHIL	BHILI
BHOJ	BHOJPURI

BIKO	BIKOL
BINI	BINI
BORA	BORA
BOSN	BOSNIAN
BRAH	BRAHUI
BRET	BRETON
BRIT	BRITISH SIGN LANGUAGE
BUGI	BUGINESE
BULG	BULGARIAN
BUNU	BUNUN
BURM	BURMESE
BURY	BURYAT
BUYE	BUYEI
CAND	CANDOSHI SHAPRA
CANT	CANTONESE YUE
CARO	CAROLINIAN
CACA	CASHIBO-CACATAIBO
CASH	CASHINAHUA
CATA	CATALAN
CEBU	CEBUANO
CAYU	CENTRAL ALASKAN YUPIK
CAYM	CENTRAL AYMARA
CHN	CENTRAL HUASTECA NAHUATL
CHAM	CHAMORRO
CHTZ	CHAMULA TZOTZIL
CHAY	CHAYAHUITA
CHEC	CHECHEN
CHER	CHEROKEE

CHWA	CHICHEWA
CHAW	CHICKASAW
CHIG	CHIGA
CHIN	CHIN
CHIP	CHIPAYA
CHIR	CHIRIPA
CHOK	CHOKWE
CHUK	CHUKCHI
CHUV	CHUVASH
COMA	COMANCHE
COOK	COOK ISLANDS MAORI
CORS	CORSICAN
CREE	CREE
CROA	CROATIAN
CULI	CULINA
CZEC	CZECH
DAGA	DAGAARE
DAGB	DAGBANI
DANI	DANISH
DARG	DARGIN
DHIV	DHIVEHI
DINK	DINKA
DOGR	DOGRI
DOLG	DOLGAN
DONG	DONG
DUTC	DUTCH
DZON	DZONGKHA
EBGU	EASTERN BOLIVIAN GUARANI

EHNA	EASTERN HUASTECA NAHUATL
EBIR	EBIRA
ENET	ENETS
ENGL	ENGLISH
ERZY	ERZYA
ESPE	ESPERANTO
ESTO	ESTONIAN
EVEN	EVENKI
EWE	EWE
FARO	FAROESE
FIHI	FIJI HINDI
FIJN	FIJIAN
FINN	FINNISH
FNSL	FINNISH SIGN LANGUAGE
FLSL	FLEMISH SIGN LANGUAGE
FON	FON
FRAN	FRANCO PROVENCAL
FREN	FRENCH
FRSL	FRENCH SIGN LANGUAGE
FRIU	FRIULIAN
FULA	FULA FULFULDE
GALI	GALICIAN
GAN	GAN
GARH	GARHWALI
GARI	GARIFUNA
GBAY	GBAYA
GEOR	GEORGIAN
GERM	GERMAN

GIKU	GIKUYU
GILA	GILAKI
GILB	GILBERTESE
GODO	GODOBERI
GOGO	GOGO
GOND	GONDI
GREE	GREEK
GUAR	GUARANI
GUJA	GUJARATI
GUJI	GUJARI
GUSI	GUSII
GWAR	GWARI
HAIT	HAITIAN CREOLE
HAKH	HAKHA CHIN
HAKK	HAKKA
HAUS	HAUSA
HAYA	HAYA
HEBR	HEBREW
HERE	HERERRO
HPNA	HIGHLAND PUEBLA NAHUATL
HTOT	HIGHLAND TOTONAC
HILI	HILIGAYNON
HINU	HINDI URDU
HINK	HINDKO
HINH	HINUKH
HIRE	HIREN
HMON	HMONG
HO	HO

HUAM	HUAMBISA
HUIC	HUICHOL
HUIT	HUITOTOT
HUNG	HUNGARIAN
IBIB	IBIBIO EFIK
ICEL	ICELANDIC
IGBO	IGBO
IJAW	IJAW IZON
ILOK	ILOKANO
INAR	INARI SAMI
INDI	INDIAN SIGN LANGUAGE
INDO	INDONESIAN
INGR	INGRIAN
INGU	INGUSH
INUI	INUINNAQTUN
INUK	INUKTITUT
INUP	INUPIAQ
IRIS	IRISH
ISRA	ISRAELI SIGN LANGUAGE
ISTR	ISTRO-ROMANIAN
ITAL	ITALIAN
IU M	IU MIEN
JAMA	JAMAICAN CREOLE
JAPA	JAPANESE
JPSL	JAPANESE SIGN LANGUAGE
JAQA	JAQARU
JAVA	JAVANESE
JULA	JULA

KABA	KABARDIAN
KAIW	KAIWA
KALA	KALA LAGAW YA
KALL	KALAALLISUT
KALE	KALENJIN
KALM	KALMYK
KAMB	KAMBA
KANN	KANNADA
KANU	KANURI
KAPA	KAPAMPANGAN
KARA	KARACHAY BALKAR
KARE	KARELIAN
KARN	KAREN
KASH	KASHMIRI
KASU	KASHUBIAN
KAWE	KAWESQAR
KAYA	KAYARDILD
KAZA	KAZAKH
KENY	KENYAN SIGN LANGUAGE
KERN	KERNEWEK CORNISH
KET	KET
KHAK	KHAKAS
KHAN	KHANDESHI
KHAT	KHANTY
KHIN	KHINALUG
KHME	KHMER
KICH	KICHE
KILD	KILDIN SAMI

KIMB	KIMBUNDU
KINA	KINARAY A
KINY	KINYARWANDA
KIRU	KIRUNDI
KODA	KODAVA TAKK
KOLI	KOLI
KOMI	KOMI
KOMP	KOMI PERMYAK
KONG	KONGO
KONK	KONKANI
KORE	KOREAN
KORO	KORO
KORY	KORYAK
KUMA	KUMAUNI
KUMY	KUMYK
KURD	KURDISH
KURU	KURUX
KVEN	KVEN
KWAN	KWANYAMA
KYRG	KYRGYZ
LADI	LADIN
LADO	LADINO
LAK	LAK
LAKO	LAKOTA
LAMP	LAMPUNG
LAO	LAO
LATV	LATVIAN
LAZ	LAZ

LEON	LEONESE
LEZG	LEZGIAN
LIGU	LIGURIAN
LIMB	LIMBU
LIMH	LIMBURGISH
LING	LINGALA
LITH	LITHUANIAN
LIVO	LIVONIAN
LLAN	LLANITO
LOMB	LOMBARD
LOZI	LOZI
LUDI	LUDIC
LUGA	LUGANDA
LUGB	LUGBARA
LULE	LULE SAMI
LUO	LUO DHOLUO
LURI	LURI
LUSO	LUSOGA
LUXE	LUXEMBOURGISH
LUYI	LUYIA
MACE	MACEDONIAN
MADU	MADURESE
MAGI	MAGINDANAW
MAIT	MAITHILI
MAKA	MAKASAR
MAKH	MAKHUWA
MAKO	MAKONDE
MALG	MALAGASY

MALA	MALAY
MALM	MALAYALAM
MALT	MALTESE
MALV	MALVI
MANC	MANCHU
MAND	MANDARIN
MANA	MANDINKA
MANI	MANINKA
MANS	MANSI
MANX	MANX GAELIC
MAOR	MAORI
MAPU	MAPUDUNGUN
MARA	MARA
MARO	MARANAO
MARH	MARATHI
MARI	MARI
MAUR	MAURITIAN CREOLE
MAZA	MAZAHUA
MAZI	MAZANDERANI
MBYA	MBYA GUARANI
MEAN	MEANKIELI
MEGL	MEGLENO ROMANIAN
MEIT	MEITHEI
MEND	MENDE
MERU	MERU
MEXI	MEXICAN SIGN LANGUAGE
MEZQ	MEZQUITAL OTOMI
MÍKM	MÍKMAWÍSIMK

MIN	MIN
MINA	MINANGKABAU
MING	MINGRELIAN
MINI	MINICA HUITOTO
MIRA	MIRANDESE
MISK	MISKITO
MLAB	MLABRI
MOKS	MOKSHA
MONG	MONGOLIAN
MORE	MORE
MUND	MUNDARI
MURU	MURUI HUITOTO
NAGA	NAGA
NAHU	NAHUATL
NAMA	NAMA
NAVA	NAVAJO
NDEB	NDEBELE
NDON	NDONGA
NEAP	NEAPOLITAN
NENE	NENETS
NEPA	NEPALI
NGAB	NGABERE
NGAN	NGANASAN
NIVA	NIVACLE
NOGA	NOGAI
NORF	NORFUK
NFRI	NORTH FRISIAN
NSAM	NORTHERN SAMI

NSOP	NORTHERN SOTHO SEPED
NORW	NORWEGIAN
NOSL	NORWEGIAN SIGN LANGUAGE
NYAK	NYAKYUSA
NYAM	NYAMWEZI
NYAN	NYANKORE
OCCI	OCCITAN
OJIB	OJIBWE
OMET	OMETO
ORIY	ORIYA
ORIZ	ORIZABA NAHUATL
OROM	OROMO
OSSE	OSSETIC
OTTO	OTTOMAN
PAHA	PAHARI POTWARI
PAIW	PAIWAN
PAJO	PAJONAL ASHENINKA
PANG	PANGASINAN
PAPI	PAPIAMENTO
PARD	PARDHAN
PASH	PASHTO
PERE	PERENE ASHENINKA
PERS	PERSIAN
PICH	PICHIS ASHENINKA
PIEM	PIEMONTEIS
PIRA	PIRAHA
PITE	PITE SAMI
PITK	PITKERN OR PITCAIRNESE

PNAR	PNAR
POLI	POLISH
PONT	PONTIC GREEK
PORT	PORTUGUESE
PUNJ	PUNJABI
PURH	PURHEPECHA
QUEB	QUEBEC SIGN LANGUAGE
QUEC	QUECHUA
QUSQ	QUSQU QULLAW
RAJB	RAJBANGSI
RAPA	RAPA NUI EASTER ISLANDER
REJA	REJANG
REUN	REUNION CREOLE
ROMI	ROMANI
ROMN	ROMANIAN
ROMH	ROMANSH
RUSS	RUSSIAN
RUTU	RUTUL
RYUK	RYUKYU
SAIS	SAISIYAT
SAKH	SAKHA
SAMO	SAMOAN
SANS	SANSKRIT
SANT	SANTALI
SAEQ	SANTIAGO DEL ESTERO QUICHUA
SARA	SARA
SARI	SARAIKI
SARD	SARDINIAN

SASA	SASAK
SATE	SATERLAND FRISIAN
SCOT	SCOTTISH
SELK	SELKUP
SENA	SENA
SENO	SENOUFO
SERB	SERBIAN
SERE	SERER
SESO	SESOTHO SOUTHERN
SHAN	SHAN
SHE	SHE
SHON	SHONA
SHOR	SHOR
SICI	SICILIAN
SIDA	SIDAMO
SIND	SINDHI
SINH	SINHALESE
SIOU	SIOUX
SISW	SISWATI
SKOL	SKOLT SAMI
SLOK	SLOVAK
SLOE	SLOVENE
SOMA	SOMALI
SONG	SONGE
SONI	SONINKE
SASL	SOUTH AFRICAN SIGN LANGUAGE
SBOQ	SOUTH BOLIVIAN QUECHUA
SEST	SOUTH ESTONIAN

SUCA	SOUTH UCAYALI ASHENINKA
SAYM	SOUTHERN AYMARA
SOUT	SOUTHERN QUECHUA
SSAM	SOUTHERN SAMI
SPAN	SPANISH
SPSL	SPANISH SIGN LANGUAGE
SRAN	SRANAN TONGO
SUKU	SUKUMA
SUND	SUNDA
SURE	SURETH
SUSU	SUSU
SWAH	SWAHILI
SWED	SWEDISH
TABA	TABA
TABN	TABASARAN
TAGA	TAGALOG
TAHI	TAHITIAN
TAJI	TAJIK
TAMA	TAMANG
TAMI	TAMIL
TATA	TATAR
TAUS	TAUSUG
TAY	TAY
TELU	TELUGU
TEMN	TEMNE
TER	TER SAMI
TESO	TESO
TETU	TETUM

THAI	THAI
THSL	THAI SIGN LANGUAGE
THAR	THARU
TIBE	TIBETAN
TICU	TICUNA
TIGR	TIGRINYA
TIV	TIV
TOBI	TOBIAN
TOGA	TONGA
TOGN	TONGAN
TSEZ	TSEZ
TSHI	TSHILUBA
TSON	TSONGA
TSWA	TSWANA
TUAM	TUAMOTUAN
TUAR	TUAREG
TULU	TULU
TUMB	TUMBUKA
TURK	TURKISH
TURN	TURKMEN
TUVA	TUVALUAN
TUVN	TUVAN
UCAY	UCAYALI YURUA ASHENINKA
UDMU	UDMURT
UKRA	UKRAINIAN
ULST	ULSTER SCOTS
UMBU	UMBUNDU
UME	UME SAMI

UYGH	UYGHUR
UZBE	UZBEK
VEND	VENDA
VENE	VENETIAN LANGUAGE
VEPS	VEPS
VIET	VIETNAMESE
VLAX	VLAX ROMANI
VORO	VORO
VOTI	VOTIC
WALL	WALLOON
WALM	WALMAJARRI
WANK	WANKA QUECHUA
WARA	WARAO
WAWA	WARAY WARAY
WARL	WARLPIRI
WASH	WASHO
WAYU	WAYUU
WELS	WELSH
WFRI	WEST FRISIAN
WDEL	WESTERN DESERT LANGUAGE
WHUN	WESTERN HUASTECA NAHUATL
WLHG	WICHI LHAMTES GUISNAY
WLHV	WICHI LHAMTES VEJOZ
WOLO	WOLOF
WU	WU
XHOS	XHOSA
XIAN	XIANG
YGHN	YAGHAN

YAGH	YAGHNOBI
YGHI	YAGUE
YAO	YAO
YI	YI
YIDD	YIDDISH
YORU	YORUBA
YUCA	YUCATAN MAYA
ZAPO	ZAPOTEC
ZARM	ZARMA
ZAZA	ZAZAKI
ZHUA	ZHUANG
ZULU	ZULU
ZUNI	ZUNI

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Background Information

In Northern Ireland the past decade has seen a significant increase in the migrant population. The number of persons born outside the UK and Ireland rose from 27,200 (1.6%) in 2001 to 81,500 (4.5%) in 2011. A large proportion of this rise can be attributable to the accession of 12 countries to the EU since 2004[23].

Northern Ireland has a long-established Chinese community who first came here in the 60's and now has members into their 3rd and 4th generation, as well as people from Indian and Pakistani origin. However, since 2004, the number of people from Central and Eastern Europe has grown and they are now estimated to make up 2% of the Northern Ireland population, particularly Polish and Lithuanians.

The lack of available data on minority ethnic and migrant people has long been recognised as a significant barrier to the full implementation of racial equality. *The Southern Area had identified a need for Ethnic Monitoring, recognising the impact of changing demographics and in particular the needs of BME communities living in the area. A local Children's Services Planning BME Working Group, set up through the Southern Area Children and Young People's Committee, who in partnership with STEP, WAH HEP and the Legacy SHSSB completed a study into BME access to services across the Area and identified a number of key recommendations which were endorsed by Junior Minister Kelly at its launch. One of these recommendations is "the introduction of ethnic monitoring, by the Department of Health, Social Services and Public Safety…". These recommendations were reinforced at NICEM's Ethnic Monitoring Seminar in April 2009. The legacy Southern Area Children and Young People's Committee, which has since evolved into the regional Children and Young People's Strategic Partnership, commenced a pilot* to address this data gap and improve ethnic monitoring a number of changes are being implemented

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[23] http://www.nisra.gov.uk/archive/demography/population/migration/Mig_Report11_12.pdf

on Health and Social Care systems. The changes currently cover the following areas:

- Child Health System (CHS),
- Community Systems -
    - Social Services Client Administration and Retrieval Environment (SOSCARE),
    - Regional Sure Start Database,
- Hospital Systems –
    - Patient administration System (PAS) inpatients,
    - Northern Ireland Maternity System (NIMATS).

This guidance will, however, apply to any other HSC system(s) which implement Ethnic Monitoring.

These changes aim to help Health and Social Care commissioners and providers to robustly capture critical patient/ service user information and through this help Health and Social Care organisations to develop and enhance service provision to all members of the community, and respond to the needs of a changing society, and help to ensure that Equality and Human Rights obligations are met.

Equality and Human Rights requirements

It is important that all Health and Social Care organisations comply with the requirements of Equality legislation and Human Rights obligations.

Section 75 of the Northern Ireland Act 1998 requires public authorities:

> "*in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity between persons of different … racial group…*" *, and to*

> *"have regard to the desirability of promoting good relations between persons of different …racial group*".

Equality Schemes also commit public authorities to the carrying out of an audit of existing information systems to identify the extent of current monitoring and facilitate consideration of possible actions to address any significant gaps. This covers all the Section 75 groups. While this

particular guidance focuses on ethnicity further work will be considered in relation to the needs of the other categories.

The Race Relations (Northern Ireland) Order 1997 (RRO) was amended by the Race Relations Order (Amendment) Regulations (Northern Ireland) 2003 to give effect to the EU Racial Equality Directive. The Regulations came into effect on 19 July 2003 and the Direction applies to public bodies, in relation to a wider range of areas in particular "*social protection, including social security and healthcare*".

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) was ratified by the UK in 1969. Article 5 requires that:

> *"in compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: …..*
>
> > *(e) Economic, social and cultural rights, in particular: …*
> >
> > > *(iv) The right to public health, medical care, social security and social services; …."*

The Committee on the Elimination of Racial Discrimination examined the UK in August 2011. The Committee's concluding observations[24] states that:

> "The Committee recommends that the State party develop and adopt a detailed action plan, with targets and **monitoring procedures**, in consultation with minority and ethnic groups, for tackling race inequality as an integral part of the Equality Strategy, or separately provide an action plan for an effective race equality strategy."

International Covenant on Economic, Social and Cultural Rights (ICESCR) was ratified by the UK in May 1976. Article 2 requires that:

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[24] http://www2.ohchr.org/english/bodies/cerd/docs/CERD.C.GBR.CO.18-20.pdf

*"…. 2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to **race, colour**, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."*

Article 12 then goes on to address Health.

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
>
> *(b) The improvement of all aspects of environmental and industrial hygiene;*
>
> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
>
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."*

OFMDFM monitoring guidance

The Racial Equality Strategy 2005-2010[25] published by OFMDFM, states that:

> '*ethnic monitoring by service providers of key aspects of their services is essential to achieve racial equality. To have a racial equality policy without ethnic monitoring has been likened to aiming for good financial management without keeping financial*

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[25] https://www.ofmdfmni.gov.uk/sites/default/files/publications/ofmdfm_dev/racial-equality-strategy-2005-2010.pdf

records. A proper system of ethnic monitoring will allow services providers to:

• Highlight possible inequalities

• Investigate their underlying causes and

• Remove any unfairness or disadvantage.'

In July 2011 OFMDFM issued a new publication- '*Guidance for Monitoring Racial Equality*'[26]. This provided a standardised framework to help public bodies collect information in a consistent but flexible manner. It also facilitates the benchmarking of monitoring data with the 2011 Census of Population results.

The OFMDFM guidance also complements the Equality Commission for Northern Ireland's '*Section 75 Monitoring Guidance for use by Public Authorities*'[27] published in July 2007.

The effective implementation of any monitoring system will of course require investment in the training of staff so that they know the reasons behind monitoring and can explain them to the people who are monitored and reassure them about the use to which the data will be put.

The importance of ethnic monitoring is clearly set out in chapter 7 of the new Racial Equality Strategy 2015 – 2025[28].

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[26] https://www.ofmdfmni.gov.uk/sites/default/files/publications/ofmdfm_dev/guidance-for-monitoring-racial-equality.pdf
[27] http://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/S75MonitoringGuidance2007.pdf
[28] https://www.ofmdfmni.gov.uk/sites/default/files/publications/ofmdfm/racial-equality-strategy-2015-2025.pdf

Further Information

OFMDFM

Guidance for Monitoring Racial Equality

https://www.ofmdfmni.gov.uk/sites/default/files/publications/ofmdfm_dev/guidance-for-monitoring-racial-equality.pdf

Equality Commission for Northern Ireland

Race Equality in Health and Social Care - A short guide to good practice in service provision

http://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/Public%20Authorities/Race_equality_in_health_care.pdf

Racial Discrimination Law in Northern Ireland – A short guide

http://www.equalityni.org/ECNI/media/ECNI/Publications/Individuals/RaceDiscrimShortGuide2010.pdf

Section 75 Monitoring Guidance for use by Public Authorities

http://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/S75MonitoringGuidance2007.pdf