Glasgow Centre for Population Health
GCPH Management Board
Monday 10 June 2019

Beyond 'being heard': How might GCPH usefully address issues of racialised under-representation in the sites of action within public health?

Recommendations

The Board are asked:

- To recognise the challenge presented to the Centre and wider the Public Health system stemming from the persistence of racialised inequalities in power and representation as heard at the GCPH event 'Considering racism as a fundamental cause of health inequality.'
- To support and assist the development of responses through engaged discussion around potential areas of action and focus.
- To highlight connections with work elsewhere in addressing issues of racialised under-representation in strategic priority setting and governance.
- To be aware of the potential for learning on action to address racialised under-representation to support efforts to mitigate and address other areas of inequality in power and voice.

Background

1. This preliminary paper is designed to begin a conversation on how GCPH should, and would be best positioned to, respond to a set of challenges which came in to focus at the recent GCPH event 'Considering racism and racialisation as fundamental causes of ill health and health inequality'. This paper aims to faithfully represent the views heard to convey the sense of urgency generated at the event. The risks of inaction to the concerns listed here are twofold. The first flows from public heath information and the actions grounded in such evidence failing to capture and address issues of racialised inequality. The second relates to diversity and the capacity to address racialised imbalances in power, knowledge production and opportunities for agency and influence for racialised communities.

2. Previous GCPH work has highlighted the changing ethnic profile of the city and the implications for service investment and design. The learning from this event adds further the need to include the experiences, knowledge and expertise of racialised communities historically under-represented as a key component of investment in empowerment, working upstream on the fundamental determinants of health outcomes and appropriately shaping service investments. The event highlighted that a historical legacy of racialisation remains to this day with implications for the design and use of health services, how research and evidence is produced, understood and used and how services are designed, delivered and experienced with particularly reference to mental

health services. The risk of inaction is the failure to understand adequately the experiences which shape current and future health inequalities, the patterning of disease and how to shape the future delivery of services in response.

3. This paper sets out the challenges presented and explores some potential responses appropriate to Centre's existing role and resource. An initial conversation has taken place with EMT to be followed by a period of wider engagement with the GCPH staff team and with expertise and experience in the city to identify and develop further actions. When moving forward, it is essential that people of colour are fully involved in this process.

4. Given that the GCPH workplan has been approved for 2019/20 and associated budget allocated, any developments would need to be pursued in the context of existing capacity and resource in the first instance and following consideration by the Management Board and Scottish Government sponsor. Longer term work may require reprioritisation or additional funding.

The event: Considering racism as a fundamental cause of health inequality

5. This event was a follow-on to Professor Laura Serrant's contribution to GCPH's seminar series that explored the issue of health inequalities though the lens of race and inter-sectional identities. Laura's talk the night before had addressed the issue of diversity at the senior level of the NHS workforce (which she refers to as the 'snowy white peaks'). She highlighted the need to provide culturally safe practice where practitioners can understand racialisation and its impact. She challenged us to ask ourselves as organisations: What kind of organisation do we want to be?; what legacy would we like to leave?; and; how can we position ourselves to give equality a chance?

6. The workshop the following morning (Annex A) was developed and chaired by Dr Ima Jackson of Glasgow Caledonian University who has spent her career working with and evidencing the experience and perspectives of marginalised groups. The invite list (Annex B) was curated to bring together senior policy makers and influencers with participants with both lived experience of racialisation and of working within the context of numerous responses to racial inequality in health policy, practice and research. Plenary inputs focused on Scotland's role in the historic development of systemic racialisation (the slave, sugar, tobacco and rum trades, colonialism) and need to acknowledge how Scotland's past has implications for experiences and inequalities today. Further scene-setting highlighted the production of knowledge and evidence on race as a 'fundamental cause' of heath inequality, that the process of racialisation changes over time while the power dynamic that creates adverse consequences is maintained. Community workers and activists were targeted and supported by Dr Jackson and invited to speak because of their particular expert knowledge and longstanding practice, providing challenge based on their experience of responses from policymakers, service planners and funders historically, raising a number of unresolved challenges discussed below. A 'Long Table' discussion structured the second half of the morning enabling a greater range of perspectives and experiences to be heard and engage in dialogue, including a challenge to the officers and service deliverers to listen to people's experience and act on it in the future.

7. Fifty-five people registered for the event with forty-five attending on the day. It was reflected on by the organisers that attendance by senior decision-makers was slighter than originally hoped in part due to relative short notice and the event's timing during the Easter holidays/recess. There is an intention to run a similar event in future with greater attention given to targeting and timing of invitations.

The challenges presented

8. A number of recurring issues and themes were heard. These centred around issues of under- representation, particularly in decision-making structures and sites of action; of how lived experiences were conceptualised, sought and used within knowledge and evidence frameworks and; the persistence of racialised power dynamics against apparent policy and strategic efforts to address racial inequality.

9. Questions were raised about the representation of BME groups at the forefront of decision-making, particularly in the composition of executive Boards. Whereas it has become a component of standard approaches to reflect diversity and respond to equalities legislation through seeking a diversity of perspectives, it was noted that it has become common and accepted for the racialised to have voice but opportunity to become active agents in processes of change has not followed. Policymakers were described as being responsive to hearing problems with great appetite for research. However, people of colour are not represented in the sites where action is developed and policy made. This challenge felt pertinent to GCPH as much as the wider health system.

10. Other key points of learning discussed related to:

- The failure of activity designed to address racialised inequality to become embedded in mainstream actions and agendas. Despite research and a proliferation of pilots, there was said to be little legacy. Without meaningful evaluation of short-term work, long-term change has not followed.
- A failure to diversify the composition of decision-making structures and systems. This described on the day as through a process of 'co-opting' knowledge and experience to approve the actions of those in power. It was stated that *"in many cases people are co-opted who have little knowledge about the policy area or little knowledge about the policy process"* and that consultation can therefore be tokenistic without changing the composition of existing power structures. In short, capacity and capability has not increased through consultation and research.
- In research and the identification of issues, terminology and a focus on 'single issues' can be unhelpful in shaping action to address structural and historical determinants. For example, the terminology of 'new communities' currently pervades, when in fact some have been here for 70 years. This does not help in terms of mainstreaming. Similar to the situation in terms of decision-making, people of colour have also been understood as 'subjects' rather than active participants in research design.
- Despite ostensible policy support such as equalities legislation and a mandatory requirement to publish outcomes, it has failed to deliver change the racial profile of the policy community. This was powerfully summarised by Judy Wasige (speaker on the day) as a situation where "*whiteness is firmly rooted in Scottish policy making."*
- This comes despite a strong history of health activism by BME communities within the city including the African Caribbean Women's Association (formed 1988), Sickle Cell Thalassemia Support Group and the Meridian Centre.
- The prevalence of mental health issues within BME communities was highlighted. BME people have double the rate of PTSD diagnosed but are less likely to be diagnosed with depression/anxiety.
- People of colour have been simultaneously over and under researched. Under researched in terms of lived experience of racism and exposure to racial injustice.
- The issue of racial trauma; the psychological consequences of racism, was prominent. The pervasiveness of racism and intersectional vulnerability; that people

who experience multiple forms of marginalisation are at risk of experiencing a greater number of trauma -related experiences. For example, people who have experienced a trauma in the past, such as abuse or being separated from parents, are impacted more severely to when exposed to racism.

- The weight of the past. Racial trauma is intergenerational and a failure to address historical trauma (described as 'the conspiracy of silence') has maladaptive consequences across generations.
- The role of the practitioners – when individual experience meets racism there can be a failure of services, including mental health services, to identify and address the fundamental cause as racism.
- That systemic racism has cost for all in society.

Areas of response

11. The challenges indicate that responses are required at a system level but they also indicate a need for GCPH to reflect on its role both as a site of capacity and action internally but also through its influencing role in regard to knowledge generation and supporting new approaches to reducing inequality.

12. Link and Phelan's framework on the mechanisms which cut across a range of 'the fundamental causes' to produce unequal health outcomes (presented by Professor Carol Tannahill during the workshop) offers a useful starting point for considering responses. Key elements of these mechanisms can be summarised as the influence of: knowledge; money and resource; power and prestige; and beneficial social connections.

Knowledge

13. This has two dimensions, one relating to choices made as to *what is prioritised* in terms of evidence production and the messages that come to the fore through analysis and dissemination. The second dimension relates to *what is recognised* as credible knowledge within existing hierarchies of evidence and leads to consideration of how we can become more receptive to a diversity of forms of knowledge and insight.

14. Race and/or ethnicity historically has not been key to organising the shape of the GCPH work plan with a prevailing focus on socio-economic factors as underpinning a range of social determinants. A criticism we have heard in the past is that the analysis of the experiences of a range of characteristics that intersect with economic determinants, such as gender, disability, particular life stages and ethnicity, do not have strong visibility in our work plan. A key exception to this being our 2017 publication 'The changing ethnic profiles of Glasgow and Scotland' that sought to understand the service investment implications of the changing ethnic profiles in Glasgow and Scotland.

15. In terms of influencing our priorities, our current strategy to promoting a diversity of perspectives in setting agendas is delivered through our Community Engagement and Empowerment (CEE) Strategy, our steering groups and networks of collaboration. This sees CEE as a cross-cutting approach, characterising many individual pieces of work and steps taken through our Community Engagement Manager post to mainstream co-productive approaches to research design, data collection and data interpretation. A strong example of this way of working was the GoWell Panel, in which representatives of communities implicated and described within the Go Well study were involved in the interpretation and communication of findings.

16. A similar panel approach could be utilised around work planning, the development of new work and interpretation of findings. Such an approach would require adequate and

not insubstantial resourcing, particularly in terms of time commitment. This said, the gains would be multiple, not only in terms of responding to the criticism of limited input into the Centre's priority setting but also in making an important contribution to some of the 'upstream' factors by utilising GCPH's investment to support the development of capacity and capability for leadership.

17. Other potential actions in the knowledge realm could be through PhD projects co-hosted at the Centre with Glasgow Caledonian University (pending funding applications). These could be developed to explore and evaluate approaches to removing the barriers that prevent the experiences of people of colour moving beyond consultation and engagement to embedded action and leadership positions. Complementing this, we could explore the place of race and racialisation within public health datasets and knowledge production and implications for priority setting and public health investment.

Money and resource

18. Our work recognises both income and income inequality as important determinants of population health outcomes and their distinct patterning. However, we have tended not to operationalise ethnicity or race in our headline analyses but view it as a factor intersecting with a range of other demographic characteristics. This means key intersectional experiences and outcomes can be less prominent in our headline reporting. The above discussion around our role in the production and translation of knowledge may lead to a reappraisal of this approach.

19. We may also wish to utilise the Centre's role as an economic actor and employer as space for action. Although the scope for broader impact is small due to our size, we could explore activity to develop and understand scalable practice to increase opportunity to public health, academic or NHS posts for population groups currently poorly represented within these sectors. The Centre is currently exploring a means of formalising work placements with community organisations, an approach which could be adapted to promote access to leadership experience by partnering with organisations such as the Council for Ethnic Minority Voluntary Sector Organisations (Cemvo). Any such engagement would position our partners as experts and as an opportunity for mutual learning and capacity building. Our location within the Social Research Hub may offer additional value and synergy through joint activity in this regard.

Power, prestige and beneficial social connections

20. The GCPH's governance structures – its Board and Executive Management Team – are designed to ensure representation of our partner organisations rather than the population the Centre serves. This is for well-established reasons, particularly to ensure the alignment and relevance of our work with partner policy concerns to create the conditions that increase the likelihood of impactful work. Our existing governance structures are not only about advice but also embody relationships of ownership and responsibility by including the organisations who have made a commitment to GCPH (politically, financially or in kind) round the table with responsibility for how those shared resources and collective commitments are utilised.

21. Demographically, these structures reflect the structural imbalances and inequalities found elsewhere in the workforce. For this reason, there are strong reasons to justify activity focussing on promoting learning to inform action for change 'upstream' in terms of understanding how pathways to leadership can be supported and/or existing capacity, experience, talent and resources of a greater diversity of communities can better utilised. However, we may also want to discuss with the Board opportunities for diversifying the range of perspectives that offer strategic input.

22. If work responding to the challenge of under-representation was approved, an advisory group consisting of existing expertise and those who have engaged thus far, can be convened to shape the future direction of research and action. The relationship of such a group to our decision-making structures would need to be clear.

Beyond GCPH

23. The Centre's role as a partnership hub can be utilised to develop broader system wide responses and activities to the challenges raised by the morning and summarised here. This ambition can be supported by continuing joint work within NHSGGC and the inclusion of Mental Health services.

24. A second event should be held, focussing on similar issues and utilising the 'the Long Table' method with greater attention to impact with senior decision-makers within NHSGGC, Glasgow City Council, Scottish Government and Public Health Scotland.

Conclusion

25. The Board are asked to consider and advise on the Centre's response and approaches highlighted to address issues of racialised under-representation in the decision-making spaces of public health and research and action around the issues of race and racialisation more broadly.

26. We recognise two broad strands of potential activity. One area is how the Centre responds and develops approaches to ensure greater contribution of a diversity of voices from communities of colour, to our priority setting. We are aware of other areas of under-representation in both the Centre's programmes of work, priority setting and our wider network and look for advice on how we approach future development in this area.

27. The second is wider in scope, utilising GCPH role in a broader partnership across the landscape of Public Health to generate discussion, debate and help in the identification of new investments to reduce inequality.

May 2019
Pete Seaman and Jackie Erdman

Annex A

Considering racism as a fundamental cause of health inequality

Thursday 18th April 2019, St Andrew's in the Square, Calton, Glasgow G1 5PP
9.00 for 9.30 start – 13.30 (lunch included)

Dear colleague,

The existence of unjust and avoidable health inequalities in Scotland is well evidenced. The fundamental causes of heath inequality include a wide range of social circumstances that impact on health including visible identities and the effects of prejudice and discrimination. This event will consider racism as a fundamental cause of ill health and the implications it has for all aspects of our health services, including research, service decision-making and delivery.

We are inviting you to join a facilitated conversation to explore the experience of racialisation and marginalisation and their role in the production of health inequalities. The event will use the Long Table method to provide an opportunity to hear directly from those who experience racialisation. Our aim is that the event and method will enable participants to work together to open up conversations that acknowledge the need for a deeper understanding of what is required to ensure we serve diverse perspectives in our systems of public health.

You have received this personal invite as someone with a strategic remit for policy, research priority setting and/or service decision-making and in a position to explore the organisational changes required. If you are unable to attend please do nominate a colleague who could deputise for you in such a role. Although we recognise the role equalities officers play within our institutions, this event is intended for those who have strategic responsibility. If you would like to attend alongside your Equalities Officer, please contact us as capacity is limited and we will try to accommodate.

About the facilitators
The morning will be chaired by Dr Ima Jackson of Glasgow Caledonian University who has spent most of her career working with and evidencing the experience and perspectives of marginalised groups.

Ima will be joined in facilitation by Professor Laura Serrant OBE, Professor of Community and Public Health Nursing at Manchester Metropolitan University. Laura will draw on her personal and professional experience as a Black practitioner to encourage us to explore why the impact of racism on health is missing from research, professional leadership and service development.

Guilaine Kinouani is a Senior Psychologist and Adjunct Professor of Cross-Cultural Psychology, and an experienced and renowned equality consultant, researcher and writer. Guilaine will lead the workshop on how the everyday experience of racism impacts on the health and wellbeing of those that are racialised.

Please RSVP to Carol Frame **by Friday 12th April** at carol.frame@glasgow.ac.uk or on 0141 330 1915. Please also let Carol know of any requirements you may have, including any dietary or access needs.

We hope that you are able to attend this event and look forward to seeing you on 18th April.

Yours sincerely

Jackie Erdman
Head of Equality and Human Rights
NHS Greater Glasgow and Clyde

Pete Seaman
Acting Associate Director
Glasgow Centre for Population Health