practice paper

The BME third sector: marginalised and exploited

Mary Tilki, marytilki@hotmail.com
Rose Thompson, Lisa Robinson, Joss Bruce, Eddie Chan, Orin Lewis,
Frank Chinegwundoh and Heather Nelson
National BME Cancer Alliance, UK

The black and minority ethnic (BME) third sector can play a key role in meeting needs through partnerships with statutory and mainstream third sector organisations. In the United Kingdom the BME sector is disproportionately affected by government reforms, which involve funding programmes and a contract culture that favour large mainstream charities close to government. BME voluntary and community organisations can feel marginalised and exploited by large organisations that do not appreciate their expertise or understand how they work.

key words BME • VCO • third sector • marginalised

Introduction

The economic downturn, demographic change and a welfare reform agenda are creating the need for new ways of delivering health and social care services. As statutory bodies reduce services and increase the criteria by which people become entitled to them, there is increasing expectation that voluntary and community organisations (VCOs) will pick up the pieces. While government cuts bite into National Health Service (NHS) and local authority funding and other grant streams become more competitive, resources available to the voluntary and community sector diminish and small organisations in particular are struggling for survival.

This paper points to the disproportionate impact of reforms on the black and minority ethnic (BME) VCO sector and the role that the statutory and mainstream third sectors play in exacerbating this disadvantage. It highlights lessons learned from an alliance of BME VCOs. In particular, it draws on the experiences and everyday practice of the National BME Cancer Alliance – a coalition of BME VCOs working together to improve cancer and other health outcomes among different minority ethnic groups in England. The aim is to draw lessons from our experiences in order to highlight the importance of our work but, crucially, to demonstrate how BME VCOs are marginalised by current contracting mechanisms, the practices of mainstream voluntary sector providers and unequal partnerships.

The paper is written by eight people who are practitioners or trustees of different BME VCOs within the National BME Cancer Alliance. It draws together commentary from recent conferences, frequent contact with Alliance members and experiences within our own organisations. It demonstrates an emerging pattern of marginalisation,

which is summarised towards the end of this paper, and we suggest ways in which collaborations could be fairer and more effective.

Alliance members work with diverse communities, providing information, awareness, advocacy and support during diagnosis, treatment and aftercare. In addition to the Alliance's one-to-one services, it aims to keep BME cancer inequality on the commissioning agenda; voicing issues common to our respective communities; sharing good practice; and undertaking or facilitating research. Although the main focus of the Alliance is cancer, we see similar issues emerging in the wider BME VCO sector in a political context where the issues of BME health inequalities are disappearing from debate.

There are two definitional issues to consider before we go further. First, there are many definitions of what constitutes a minority ethnic group and terminology has changed over time amidst social and political developments. Although in the United Kingdom (UK), the terms 'black and minority ethnic' (BME) or 'black, Asian and minority ethnic' (BAME) tend to describe people who are not White, this article uses BME to refer to 'a group of people whose members identify with each other through a common heritage, often consisting of a common language, common culture (which can include a religion) and or an ideology which stresses a common ancestry' (Institute of Race Relations, 2014: unpaginated).

Second, the authors acknowledge shifting and contested definitions of the 'third sector' and its diversity in size, activities and income (Milbourne and Murray 2014), but for this paper the term refers to major charities, VCOs and cooperatives. Small, low-income VCOs form a subset of this sector within which the majority of BME VCOs fit. Many of these organisations operate 'below the radar', providing services that the mainstream cannot or will not provide (Craig, 2011; McCabe and Phillimore, 2012; Carr, 2014). There is no single definition of what a BME VCO is and the notion of a distinct BME third sector is widely contested (Mayblin and Soteri-Proctor, 2011). For simplicity, and reflecting usage in cited literature, we use the term BME VCO to refer to VCOs working with and on behalf of diverse ethnic and cultural groups and not just those defined by skin colour.

The article is structured in the following way. First, there is a brief outline of the thrust of national policy and its impact on BME VCOs. This is followed by an account of the experiences of BME organisations, with a particular focus on those of the National BME Cancer Alliance. Then, we set out some of the lessons drawn from the practice, experiences and reflections of Alliance members and suggest how the contribution of the BME sector can be better harnessed to address ethnic health inequalities. Finally, we conclude the paper.

Background and context

In order to understand what is happening to the BME VCO sector, and the National BME Cancer Alliance within this, it is important to understand some of the wider context. Financial crisis and an ageing demography are driving change in public policy in the UK but there is also, arguably, a powerful ideological commitment to a wholescale restructuring of the welfare state to provide little more than basic services (Milbourne and Murray, 2014; Murray and Milbourne, 2014). This is leading to considerable change within the voluntary and community sector. Policy reforms claim to encourage VCOs to work with commissioners, to ensure contract opportunities

and to help the sector become competitive (OCS, 2010; HM Government, 2012, 2014). However, the drive to reduce state expenditure and extend the 'market state', and the policy changes necessary to effect these, impact heavily on community-based initiatives (Murray and Milbourne, 2014). The private sector, large VCOs such as housing associations which have widened their remit and new social entrepreneurs compete with traditional providers for health and social care (and other) contracts. In particular, the growth of a contract culture is having a detrimental effect on small VCOs.

Contracts

Contracts, privatisation and voluntary sector engagement are not new, but have moved apace under the neoliberal ideology of the current coalition government agenda (Ishkanian, 2014). The voluntary and community sector now relies on funding through service contracts rather than grants or donations in a highly competitive health and social care market. Public services are tendered out, bid for competitively and commissioned under contract from private providers, VCOs or social enterprises. VCOs are now expected to provide services previously delivered by the public sector (Aiken, 2014) and many large, national VCOs are already contracted to do so.

Smaller VCOs

Issues of size have become important (NCVO, 2013; Milbourne and Murray, 2014). While large and some medium-sized organisations are thriving, smaller locally based organisations are suffering disproportionately from a reduction in resources because they are generally unable to compete for contracts with the bigger players (Ishkanian, 2014). Partnerships between large and small organisations subcontracted to provide services are seen as an answer to funding but contracts are increasingly concentrated in a small number of large generic providers (Craig, 2011; Ware, 2013; Ishkanian, 2014). There are significant power imbalances between small agencies and large third sector organisations, which can pick the most profitable work and leave the rest to smaller VCOs to subcontract for fewer resources lower down the contracting chain (Rees et al, 2013; Aiken, 2014).

BME VCOs

There are particular difficulties for BME VCOs, which emerged decades ago to address the failings of statutory services, as well as institutional racism in policy and within the mainstream third sector (Craig, 2011). Although the BME sector continues to provide for the most marginalised in society, it struggles to compete with large third sector organisations in the current contract culture. Government policy appears to legitimate the neglect of minority ethnic disadvantage (Craig, 2011; Craig and O'Neill, 2013; Ishkanian, 2014). And BME VCOs continue to be marginalised by the statutory and mainstream third sectors (ROTA, 2009; Yeung, 2010; Ware, 2013), despite offering specialist services, cultural intelligence, self-help and a holistic understanding of their constituencies' needs (Cant and Taket, 2005; Voice 4 Change, 2012; Carr, 2014). BME VCOs additionally aim to empower disadvantaged communities, improving their employability and financial sustainability by enabling volunteers to gain skills, enhance

their curriculum vitae (CVs), and prepare for paid employment. In capturing the skills and energies of retired or unemployed people as volunteers, our organisations contribute to improving health, reducing isolation and enhancing self-esteem in those who might otherwise be socially isolated (Paylor, 2011; Nazroo and Matthews, 2012).

Experiences of feeling marginalised and exploited

We acknowledge that all sectors are under financial pressure and seeking different ways of sustaining the services they offer. However, experiences from our practice as eight BME VCO members of the Alliance and knowledge gathered through our various networks mirror existing evidence of a BME sector disproportionately under pressure (ROTA, 2009; Yeung, 2010; Abbas and Lachman, 2012).

We offer nine examples here that represent the kind of experiences that Alliance members have reported to us over the last three years.

First, one BME VCO involved in promoting health and addressing BME health inequalities closed in 2013, leaving major gaps in provision for the most vulnerable in society. So there is now a gap in advice and support for African, African-Caribbean and Asian people with mental health problems.

Second, an award-winning BME VCO in a city where over 35% of the population is of minority ethnic origin has relocated to Ghana due to funding cuts. This innovative social enterprise was based in the heart of an ethnically diverse, low-income area and succeeded in engaging diverse BME communities and new migrants. It offered English classes, health improvement activities, support to access employment and training and work opportunities for people from different cultures. This has further reduced employment opportunities in an already disadvantaged community and left a gap in services such as information and advocacy around welfare rights and access to healthcare and housing.

Third, contracting processes have disadvantaged BME VCOs. Organisations want to continue to meet increasing demand, particularly as NHS cuts and welfare reforms impact heavily on BME communities. Although Alliance members are well positioned to access commissions because of cultural knowledge, community trust and professional skills, the commissioning process appears bureaucratic and unfair. There are situations where, despite having a track record of providing accessible, cost-effective services, BME VCOs are often prevented from bidding at the first stage because income streams or infrastructures are deemed inadequate. They do not have professional fundraisers and, unsurprisingly, services to vulnerable people invariably take precedence over bids (Radermacher et al, 2011; Ware, 2013).

Fourth, there are situations where we have found that contracting means that BME VCOs are faced with spending more time chasing funding, reducing the services available and potentially challenging the original mission of the BME sector. Hence, the Alliance concurs with Ishkanian (2014) in that awarding commissions to the cheapest rather than the best bidder has damaged the sustainability of the sector.

Fifth, the criteria by which funds are allocated has been raised as a concern. In one location, a university was given a significant sum of 'end-of-year' money by a health authority to undertake research without having to bid for it. Meanwhile, a local BME VCO was required to make an elaborate bid for £2,000 for a health improvement activity. While acknowledging the need to be accountable for public money, the

experience of Alliance members relayed to us is that they are required to meet more rigorous criteria than statutory organisations or mainstream VCOs.

Sixth, we point to Alliance members' experiences of partnership, which have taught them to recognise the value of partnerships while being cautious collaborators. This has been, not least, because BME communities report being suspicious of mainstream services. Alliance members have reported to us that they remain to be convinced that collaboration with big charities is right for BME VCOs or BME communities. They feel that they have been left to fill gaps in provision for decades and are therefore not confident that the mainstream is able to provide the quality that BME constituents deserve. Unless services are trusted, accessible and culturally acceptable, uptake will be low and vulnerable people will suffer. Alliance members have frequent requests for information from mainstream organisations with no expertise in BME provision, yet claiming to provide for and sometimes speak for all. For instance, we have many examples of being contacted late in a project when conventional methods of engagement failed or when staff find BME groups 'challenging'.

Seventh, past experiences suggest that BME VCO values and effective ways of working with BME communities do not sit comfortably with generic, bureaucratic, ethnocentric mainstream organisations, particularly when cost-based targets take precedence over what works for vulnerable constituents. Not surprisingly, BME VCOs fear incorporation or mainstreaming within large organisations and as such losing cultural specificity or diluting the community ethos and additionality that the BME sector provides. Alliance members worry that short-term generic goals detract from addressing the underlying causes of ethnic inequalities, enabling and empowering communities or campaigning on their behalf.

Eighth, Alliance members have found that even in agreed partnerships, the promised BME share of resources failed to materialise. Some were informed that there was no budget for the BME contribution but were still expected to undertake considerable parts of the work. For example, we have recently been informed of small organisations being required to pay value added tax (VAT) on (sub)contracts by larger contracting partners who were far better equipped to support such costs. We are also aware of an instance where one BME VCO was contacted by a university with partnership funding to investigate businesses within a particular ethnic community. The BME VCO was expected to disseminate information, recruit participants and conduct and translate interviews in community languages. When trying to establish the budget for this collaboration, it appeared that none had been ring-fenced for the BME contribution. The university is now paying external researchers with appropriate language and research skills.

Ninth, Alliance members who have engaged in partnerships have found this challenging because of a lack of understanding or respect for the BME VCO. Typical examples include the following:

- We are frequently approached when a commissioning proposal is almost complete rather than being involved from the start.
- Some members have even been named as partners by large voluntary organisations without prior permission, on the assumption that the VCO has much to gain from collaboration.
- Wealthy organisations often expect a free service and are surprised to be asked to contribute to the administrative, accommodation, staff or volunteer costs involved.

- Alliance members who have worked collaboratively with major charities feel that the BMEVCO contribution has not been adequately acknowledged, particularly when without their input, the engagement and research would not have happened.
- Alliance members have experiences of mainstream third sector organisations claiming credit for the contribution of BMEVCOs. One BMEVCO that helped a major charity to improve its performance exponentially by engaging BME donors, received minimal recognition for its efforts. Another, which contributed evidence and facilitated research access for a mainstream charity close to government, remains excluded from debates about major health inequalities for the community involved.

This paper has focused on the difficulties we have learnt from members of the National BME Cancer Alliance in their experiences of working with the statutory and mainstream third sectors, but they nevertheless recognise the value of and need for partnerships. The welfare state and especially the health and social care sector have changed dramatically and will probably continue to change. We argue that while BME VCOs will continue to fight for a sustainable future, as the state is rolled back, we have to adapt to survive and meet the needs of disadvantaged communities. There is scope for greater collaboration between different BME VCOs, but there is merit in harnessing the strength of mainstream third sector organisations. The nine examples above show why Alliance members have reservations about funding relations and partnerships. Despite this, we accept and understand the importance of collaboration in addressing health and other inequalities experienced by BME communities. The next section highlights what our members consider to be the value of the BME sector and suggests some of the ways in which partnerships with larger organisations could be fairer and more effective.

Towards fairness and respectful partnerships

The experience of Alliance members, as discussed above, shows that thoughtlessness, social and organisational ethnocentricity and the lack of incentives to take ethnic inequalities seriously play a part in the marginalisation of BMEVCOs. Our practice in working with very marginalised communities suggests that government, local authorities and funders need to address funding inequalities experienced by BME VCOs. Commitment to ensuring infrastructure support and cascading funding down to BMEVCOs has the potential to be effective and cost saving in the long term. Our experience suggests that policy makers and commissioners currently underestimate the impact the loss of specialist services will have on already disadvantaged BME communities.

We can use our experience in the cancer field as one example, to show where the failure to recognise the value of the BME VCOs in the Alliance could lead to:

- increasing levels of cancer;
- late detection (or crisis intervention) requiring costly, invasive investigation;
- treatment with higher mortality and morbidity.

There is evidence that BME communities lack knowledge about cancer (and other health issues), are reluctant to access screening and present late for treatment, with

poorer and more costly outcomes (NCAT, 2012). BME VCOs are trusted more by their communities and have a track record in reaching those referred to as 'hard to reach'.

We argue that there are wide-ranging benefits that VCOs in the Alliance and other BME VCOs offer, which are not easily provided by mainstream organisations. For example, the value of staff or volunteers representative of the groups to be engaged with, who are trusted by those suspicious of mainstream services and who speak the language of the community literally and metaphorically should not be underestimated. BME VCOs reach out to their communities, meet them where they assemble and work with local groups, faith communities and ethnic media. They seek to be innovative, addressing health issues through music, films, food, fitness and beauty, and history projects, as well as incorporating them into social, cultural or religious occasions. In particular, they understand sensitivities around particular illnesses, health beliefs and behaviours that might be ridiculed and the fears and experiences that prevent or delay help-seeking.

Capturing the expertise of BME VCOs holds out the promise of offering important gains for policy makers and public services. It can:

- help in the early detection of illness;
- increase the uptake of screening;
- encourage the adoption of preventive strategies at a time when the government's focus is on improving cancer survival rates through early detection.

Reducing the need for late or crisis interventions with better health outcomes is more likely when culturally appropriate ways of engaging and working with minority ethnic communities are adopted. Even with the best intentions, our members argue that it is unlikely that mainstream bodies can provide this with the same degree of detail and sensitivity that BME VCOs can.

Our experience with Alliance members suggests to us that they welcome proactive consultation about BME health inequalities. They have also valued early consultation so that BME issues are embedded throughout a proposal rather than tacked on as an afterthought. Statutory and mainstream bodies have much to gain from broadening their BME contacts, engaging with diverse communities and hearing sometimes challenging viewpoints. However, it is important that organisations with adequate budgets should not expect a free service from BME VCOs for facilitating consultations, research or health interventions. Mainstream partners are welcome to participate in cultural events or community activities but a realistic contribution is always appreciated. Our experience leads us to argue that partnership arrangements should ensure that the BME contribution is adequately funded and that monies are disbursed in an equitable and timely manner. We also believe that, in some instances, money may not be necessary and reciprocity in kind may be easier for both partners. The role and contribution of the BME VCO needs to be adequately acknowledged and communities concerned should be provided with feedback on engagement, involvement and actions.

Conclusion

The experiences of National BME Cancer Alliance members have highlighted how BME VCOs have been affected by recession, facing or having faced closure,

with reductions in provision, which leave gaps in information, advice and support to very vulnerable people. We have recounted in this paper how welfare reforms disproportionately disadvantage our BME VCOs in the current competitive contracting culture. We have discussed the funding difficulties faced by small BME VCOs and the challenges of partnerships with larger players who do not understand BME communities or value the expertise of the VCOs that serve them. We have outlined the skills and expertise that have the potential to afford cost-effective and accessible services for some of the most disadvantaged in society, but which will be lost if BME VCOs are side-lined.

Lessons from the deliberations of Alliance members suggest that there is considerable scope for policy makers and commissioners to capture the creativity of the BME sector either alone or in partnerships. Having grown outside the mainstream in response to our communities, we have developed innovative, cost-effective and sometimes unconventional ways of working. This has resulted in accessible, acceptable, culturally sensitive services and many models of excellence in practice. We have many volunteers helping us to support those in need, while they in turn enhance skills, confidence and self-esteem and contribute to resilient, cohesive communities. In an era of financial constraint, there are efficiencies and cost savings to be gained if the work of mainstream and third sectors is complemented by BME VCOs, thus enabling accessible services for vulnerable communities while making funding go further.

References

Abbas, M, Lachman, R, 2012, *The Big Society: The big divide?*, Bradford: JUST West Yorkshire

Aiken, M, 2014, *The changing shape of voluntary services: How this affects volunteer based community groups*, London: National Coalition for Independent Action

Cant, B, Taket, A, 2005, Promoting social support and social networks among Irish pensioners in South London UK, *Diversity in Health and Social Care*, 2, 263–70

Carr, S, 2014, *Social care for marginalised communities: Balancing self-organisation, microprovision and mainstream support*, Policy Paper 18, Birmingham: Health Services Management Centre, University of Birmingham

Craig, G, 2011, Forward to the past: can the UK black and minority ethnic third sector survive?, *Voluntary Sector Review*, 2, 3, 367–89

Craig, G, O'Neill, M, 2013, 'It's time to move on from race': the official 'invisibilisation' of ethnic disadvantage, *Social Policy Review*, 25, 93–112

HM Government, 2012, *Making it easier for civil society to work with the state*, London: The Stationery Office

HM Government, 2014, *Making it easier for civil society to work with the state*, Progress Update, March, London: The Stationery Office

Institute of Race Relations, 2014, Definitions, www.irr.org.uk/research/statistics/definitions/

Ishkanian, A, 2014, Neoliberalism and violence: the Big Society and the changing politics of domestic violence in England, *Critical Social Policy*, doi: 10.1177/0261018313515973

McCabe, A, Phillimore, J, 2012, *All change? Surviving 'below the radar': Community groups and activities in a Big Society*, Working Paper 87, Birmingham: Third Sector Research Centre, University of Birmingham

Mayblin, L, Soteri-Proctor, A, 2011, *The black and minority third sector: A resource paper*, Working Paper 58, Birmingham: Third Sector Research Centre, University of Birmingham

Milbourne, L, Murray, U, 2014, *The state of the voluntary sector: Does size matter?*, Paper 2, London: National Coalition for Independent Action

Murray, U, Milbourne, L, 2014, *The state of the voluntary sector: Does size matter?*, Paper 1, London: National Coalition for Independent Action

Nazroo, J, Matthews, K, 2012, *The impact of volunteering on wellbeing in later life: A report to WRVS*, Cardiff: Women's Royal Voluntary Service

NCAT (National Cancer Action Team), 2012, *Cancer does not discriminate*, London: NCAT

NCVO (National Council for Voluntary Organisations), 2013, *Counting the cuts: The impact of spending cuts on the UK voluntary and community sector − 2013 update*, London: NCVO

Paylor, J, 2011, *Volunteering and health: Evidence of impact and implications for policy and practice*, London: Institute for Volunteering Research

OCS (Office for Civil Society), 2010, *Building a stronger civil society: A strategy for voluntary and community groups, charities and social enterprises*, London: OCS

Radermacher, H, Karunarathna, Y, Grace N, Feldman S, 2011, Partner or perish? Exploring interorganisational partnerships in the multicultural community aged sector, *Health and Social Care in the Community*, 19, 5, 550–60

Rees, J, Taylor, R, Damm, C, 2013, *Does sector matter? The experiences of providers in the Work Programme*, Working Paper 92, Birmingham: Third Sector Research Centre, University of Birmingham

ROTA (Race On The Agenda), 2009, *The economic downturn and the black, Asian and minority ethnic (BAME) third sector*, London: ROTA

Voice 4 Change, 2012, *Personalisation and the BME voluntary sector and social entrepreneurship*, London: Voice for Change/School for Social Entrepreneurs

Ware, P, 2013, '*Very small, very quiet, a whisper ….': Black and minority ethnic groups: Voice and influence*, Working Paper 13, Birmingham: Third Sector Research Centre, University of Birmingham

Yeung, W, 2010, *Report on the impact of the economic downturn on black and minority third sector organisations*, London: Council of Ethnic Minority Voluntary Organisations