

## Merging insights about research with Indigenous and migrant communities

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Born in Bradford is a new birth cohort study of 10,000 families<sup>1</sup>. Babies are studied over time to allow the circumstances of their birth to be related to subsequent health. Half the babies mothers are either new or second generation Muslim migrants from the rural province of Mirpur in Pakistan<sup>2</sup>. The spur to the study's establishment was the high rate of infant mortality, highest in migrant families. (Between 1996 and 2003 UK infant mortality was 5.3/1000, overall in Bradford it was 9.1, and in mothers of Pakistani origin 12.9/1000)<sup>3</sup>. Morbidity including levels of obesity, an indicator of later diabetes and heart disease, and genetic disorders<sup>4,5</sup> was also highest in children of Pakistani origin.

Bradford's Pakistani community retains close links with its homeland. Marriage between UK and Pakistan based members of the same extended families and travel for lengthy visits in both directions are common. Many of the traditional practices of Pakistan are evident in Bradford. These are migrants who are part of a community defined by identity not geography, one community across two continents. Such a hybrid is a world-wide phenomenon, a feature of the coming together of the dispersal of communities and of modern communication possibilities. There are many more examples including Pacific Islanders in New Zealand and Asian migrants in Australia.

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<sup>1</sup> For more details about Born in Bradford see study website: [www.borninbradford.nhs.uk](http://www.borninbradford.nhs.uk).

<sup>2</sup> Born in Bradford, a cohort study of babies born in Bradford and their parents: Protocol for the recruitment phase. Pauline Raynor and Born in Bradford Collaborative Group. *BMC Public Health* 2008, 8: 327 doi 10.1186/1471-2458-8-327.

<sup>3</sup> The Bradford and District Infant Mortality Commission. <http://www.bdimc.bradford.nhs.uk>.

<sup>4</sup>Whincup, PH, Gilg JA, Papacosta, O, Seymour C, Miller GJ, Alberti, KG, Cook DG: Early evidence of ethnic differences in cardiovascular risk: cross sectional comparison of British South Asian and white children. *BMJ* (Clinical research ed) 2002, 324(7338): 635.

<sup>5</sup> Corry PC: Intellectual disability and cerebral palsy in a UK community. *Community Genetics* 2002, 5(3): 201-4

The challenge for improving migrant health is how to engage with communities to build on their health sustaining practices and encourage change where practices are detrimental in their new environment. For example infant feeding may need to change as families move from resource poor to resource rich countries<sup>6</sup>. The Ninth Global Forum on Bioethics in Research's focus on indigenous health underlined the importance of recognising that any proposed change will not be effective unless it goes beyond a Western ethic of individualism and builds on community ethics of mutual obligation to family, ancestors, community and land. This approach to ethics is not procedural but ontological, it is not required just to engage people, it relates to the essence of how a person conceptualises themselves and frames their motives for behavior.

What researchers on migrant communities can offer to those with a focus on indigenous health is to prompt them to consider a more dynamic and contested conceptualisation of community and identity, one shaped by social change and geographic dispersal and to demonstrate that respecting community ethics does not preclude a need to challenge traditional practices when circumstances change.

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<sup>6</sup> Lawlor DA, Chaturvedi N: Treatment and prevention of obesity – are there critical periods for intervention? *International journal of epidemiology* 2006, 35 (1): 3-9.