MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT
ADULTS AND OLDER PEOPLE

Supplementary evidence based on engagement work carried out by TS4SE in support of JSNA topic on New Refugees and Migrant Groups

BACKGROUND

In 2017, TS4SE were commissioned by Manchester Health and Care Commissioning (MCC) to undertake some further engagement work with migrant communities in Manchester to provide additional evidence for the JSNA. The findings from this work are provided in this supplementary report, which is designed to be read alongside the main topic report.

The information below is based on the thoughts and opinions of refugee and migrant communities in Manchester. No attempt has been made to edit or validate the information supplied - the intention being to give a voice to the views and experiences of individual members of the communities who participated in the work.

Like many modern cities, Manchester boasts a diverse and dynamic population. Manchester's refugee and migrant communities include people from a wide range of backgrounds, nationalities and cultures. In developing this topic, TS4SE worked closely with some of the larger groups in the city, notably the Eritrean and Eastern European Roma communities.

In capturing this evidence, TS4SE worked directly with communities themselves, supporting them wherever possible to work directly with their own participants and report on their findings themselves. The evidence in this supplementary report highlights some of the common elements across each of the groups that were involved in the work, captures important community based priorities and identifies the high-priority cross-cutting recommendations the communities themselves thought would most efficiently and effectively begin to address their specific needs.

ERITREAN COMMUNITY

The Eritrean community in Manchester estimates its population to be around 4,000 to 5,000 people. They are from different ethnicities and backgrounds. However, the community is divided along political allegiances into the supporters of the only permitted political party and government in Eritrea, and those who oppose the party and government. By law, each Eritrean is compelled to serve 18 months in national service starting at 18 but, in practice, conscripts serve indefinitely, many for over a decade. In May 2016, a United Nations Commission of Inquiry concluded that conditions of national service rise to the crime of enslavement. Physical abuse, including torture, occurs frequently as does forced domestic servitude and sexual violence by commanders against female conscripts. This endless conscription remains a principal driver of migration.

In Manchester, there is an Eritrean Community Association office which is well run but not resourced. There are about three churches where Eritreans worship.

Eritreans seeking asylum can be found across Manchester in Home Office accommodation and refugees are homed across the city by Housing Associations. However, local populations are found in:

- Gorton (with the highest number of Eritreans);
- Longsight;
- Moss Side
- Hulme
- Rusholme and Cheetham Hill have a small number of people

Key issues

The Eritrean community in Manchester expressed concerns about communications from the NHS which were in English and which they struggled to understand:

> *"There is a problem of understanding letters from the NHS and by the time you manage to get through this language issue, your appointment day has already gone and getting another one is very difficult."*

Some people had frequently had appointments cancelled and several people felt that their GP did not take their health concerns seriously. Others felt it was difficult to get appointments when one is ill. Furthermore, interpretation was not always available, and not always of good quality:

> *"Sometimes the interpreter is not good"*

Eritrean women expressed a number of specific concerns about:

- **Interpreters** are not always available, and not always of good quality. Some of them are not qualified. There would be a more comfortable atmosphere if the interpreters were female. Some of the women had asked for female interpreters but they were told it is difficult to find one.
- **Female doctors** would be appreciated but the women felt that would be asking too much and there are a few of them. Many also said that the male doctors are very kind too.
- **Smear tests** should not be voluntary - one participant felt that it should be compulsory because, *"many of our sisters who come from the villages do not understand how important it is."* They do not trust the NHS because they do not get any results or letters. Putting a foreign object into your body could be dangerous. We do not have good understanding of how important it is because the nurses explain things briefly just before the test.
- **Sexually transmitted diseases:** It is unbecoming for a woman to discuss sex or sexually transmitted diseases among Eritreans. They know there are HIV infected Eritreans in Manchester.
- **Contraception, pregnancy and child delivery:** The general opinion among the women was that new arrivals are shy or afraid to ask for contraception of any kind. That is why before they even start learning the English language they get pregnant and give up hope of going any further in their education. Eritrean men here tend to be selfish. They want to have children. Most newly arrived Eritrean women do not go to the doctor for check-ups and examination when they become pregnant. It is because they do not know the advantages

and the risks involved in not being examined early in the pregnancy. During labour some pregnant women are turned away from the hospitals, especially St Mary's. They are told that they are far from delivering and have to come back later. Many have delivered in in their homes before the ambulances arrived. Some of them feel that it is because they are refugees or suspect racism.

- **Children's health:** "Many Eritrean children suffer from skin diseases and illnesses related to cold, but their parents are frustrated because the doctors always tell them that the children are fine. They do not recognise the severity of the children's illness enough. So we (those whose children may have the same problem) consult and advise each other."
- One woman stated that **FGM "**is not practiced at all in Manchester."
- Eritrean people's understanding of **mental health** is very different from that of UK health professionals. A diagnosis of 'mental health problem' carries a lot of stigma and is regarded as something that is permanent and cannot be recovered from. Most Eritreans believe that medication for depression and mental health only makes the patient gain more weight and does not help. Therefore, they do not actually take the medication prescribed by GP. They believe that mental health problems come from bad experiences that have disturbed your soul. Instead they turn to religious practices such as washing with or drinking holy water, and Holy Communion.
- **Skin problems**: Many Eritreans have skin rashes they believe developed in their journey. They itch a lot but the instead of referring them to dermatologist they (GPs) give them different creams.
- **Dental treatment:** Some of the women were registered with a dentist, but they do not go because they think that the enamel of their teeth is thinned by the metal screeching while the dentists clean their teeth. So they use the traditional small piece of twig to brush their teeth.
- **Accident and Emergency services:** Community members expressed their concerns about the waiting time. For some A&E is where they go to see doctors who specialise in the area they want because their GP is reluctant to refer them to specialist doctors in the first place.

Recommendations

More work is needed to educate and inform the community about NHS. This is an ongoing issue as the community is still growing each month.

High numbers of people still waiting for their papers. Mental health issues are paramount but background health culture is still an issue that acts as a barrier to seeking help.

Many in the community still need cultural orientation. The UK is very alien culturally and social norms vary tremendously from Eritrea, there are still examples of clash of cultures. Cultural isolation is a particular issues, especially among those with asylum decisions (positive or negative) who are homeless is still huge, background well-being is not good, even if people aren't "ill".

GPs need to be more inclusive when it comes to children's health and should explain things to the mothers. Mothers should not go back home with questions and worries still in their minds.

More education is needed for Eritrean women in the areas of:

- When is the right time to see a doctor;
- Contraceptives;
- The advantage of seeking medical attention as soon as they suspect pregnancy;
- Is depression different from mental health?
- Is depression curable?
- Some basics about diabetics;
- Dental health because there are people who believe that cleaning scrapes off the enamel, and so they do not go for routine cleaning at their dentist's;
- Diet – what is healthy and what is dangerous for health;
- Hygiene advice and assistance for new arrivals.

EASTERN EUROPEAN ROMA COMMUNITY

The Eastern European Roma community in Manchester is now an established part of Manchester's rich multi-cultural community. Today, Roma from countries like Poland, Romania, Hungary, Slovakia, Czech Republic, Latvia, Lithuania and Bulgaria have established communities across Manchester, specifically in Gorton, Levenshulme, Rusholme, Longsight, Cheetham Hill, Crumpsall, Moss Side, and Moston. Outside of Manchester, Roma communities are also found in Oldham, Chadderton, Bolton, Eccles and Salford.

Community work undertaken by TS4SE Co-operative as well as work by the Universities of Manchester and Salford have identified Romanian Roma as the largest population, followed by Slovak, Hungarian, Bulgarian and Czech, with smaller numbers of Polish, Lithuanian and Russian. There is no official data on the number of Roma in the City of Manchester city. However, estimates from local universities place the numbers at about 5,000. Additionally, Manchester's Roma communities are dynamic and trans-national, meaning that people will arrive, work, move, return and settle, stay with relatives or friends and travel. While there are established and settled communities, these local communities will include a proportion of people who are not settled residents. This means population estimates may be inaccurate.

Key Issues

The Eastern European Roma community in Manchester report that the largest issues uncovered related to access to GP services and registration; people felt their health concerns were to easily dismissed by GPs, and that a lack of language support in NHS registration, consultations, and when booking appointments led to their health needs or worries not being addressed. NHS ambulance calls, A&E emergencies and dentists were also problematic as Roma patients struggled to engage NHS staff without interpreters and a lack of information and knowledge about how the NHS worked and the role of GPs and when to present to A&E.

For several participants, language barriers were their only identified issues with UK health care. One interviewee said some hospitals do not offer interpreting services when they think patients could cope with English, even though that person had

requested an interpreter. Several people spoke of the difficulties encountered at the GP Practice arising from the lack of language support when they make appointments and at consultations.

About half of the people we spoke with said they are registered with a GP and those that were that were said they found it easy because they had help from a friend who spoke good English, knew about registration process and who had helped them to register. There was one respondent who said they could not immediately register with a GP, though they had all required documents in advance, because GP practices refused to do so by verbally telling them there was no vacant places within their services. The GP practice has not offered or provided them with an official letter stating the reasons behind their refusal.

The other half of the people we interviewed stated they are not registered because:

- they had no national insurance number;
- poor or non-existent English;
- no friends who speak good English and know about GP registration process;
- no interpreters;
- no financial means to pay for interpreting services themselves;
- unaware of existing interpreting and translation services in Romani language;
- no serious medical conditions requiring a special medical attention.

Several people spoke about the difficulty getting an appointment, even if it was urgent, the short duration of appointments, lack of consistency in treatment and review, and the difficulty getting specialist referrals.

Although five of the people we spoke with had a general understanding of the need to register with a GP, this seemed to be not linked to an understanding of how the NHS works and knowledge about access to other services. Several people had dental problems and no dentist, but were not aware of how to register with a dentist or access emergency dental services:

> *"I had to go to private dental services that are very expensive – I paid £240 GBP for an examination and tooth pulling. I have a dentist, but my dentist does not work on Saturday and I had to use private dental services. I did not have access to my dental clinic on the weekend."*

Three people had also presented to A&E as they did not have a GP or because they were ill. One person appeared frustrated when he said:

> *"I had a breathing problem and had a cold. I went to A&E first in North Manchester where a doctor told me I got to have breathing problems resulting of my cold, given that I am a smoker. He prescribed a paracetamol."*

Whilst not in a majority of those interviewed, the absence of a clear understanding of the role of the GP, a lack of a GP willing to register a Roma patient, together with frustration in appointments had led to people presenting to A&E in North Manchester.

UK health services were seen as slow (GP appointments and A&E and ambulance waiting times) and Dentists as expensive and difficult to see. Several people spoke about encountering difficulties with NHS ambulance services, one was clear that felt he had faced discrimination while another was concerned about a long wait for an emergency ambulance, however the nature of the condition was not disclosed.

Recommendations
Full health screening on arrival and registration with a practice to gather a comprehensive health history, this approach would save time and build trust, identifying any underlying conditions early.

Language support needs to be improved, professional Romani language interpreters are needed, but it should also be noted that language is not the only communication issue: respect is also important. Training existing community members with good English as interpreters would engender trust and mutual respect.

While Romani is a common language, there are regional and national variations in dialect that can affect understanding, where possible interpreters should be used from the same linguistic background as a patient.

Signposting:

- to translated information (e.g. Choose Well) and wider translations for the range of languages spoken by Roma communities about where to go for different types of care, and rights regarding healthcare, as well as preventative healthcare and early access to services such as Well Woman Clinics;
- to disseminate complaints information and procedures to ensure people have the ability to raise issues and get them heard

Develop and share accurate and up to date information about the Roma communities with health and social care providers: find out who is here, what are their strengths, what are their questions and concerns, what are their recommendations?

Training to providers to better understand how to share health care messages with Roma community members, based on an understanding of their cultural concepts and expectations of health.

There remains a great reluctance to use UK based health services, many are travelling for treatment back to Europe.

Often families and communities will seek medical assistance across local authority borders, so any plans should consider how support across these boundaries can be coordinated.

There are people willing and able to volunteer in the Roma community, the notion that Roma will only do things when paid is a falsehood.

Language and dialect interpretation/brokerage remain big issues in the community with several incidents of interpreters struggling to communicate raised in the discussions. Establish a community-led health initiative to provide support, signposting and information to the community and social care providers and share health and social care messages with the community.

Employ Roma community members as receptionists, health assistants or trainers so that they could provide advice and support to both GPs and community members.

OTHER REFUGEES COMMUNITIES IN MANCHESTER

TS4SE Cooperative was also asked by Manchester CCGs to undertake a short piece of reportage on the health priorities identified by individuals from a range of refugee communities in Manchester. These communities were:

- Kurdish
- Somali
- Syrian
- Women asylum seekers
- Anglophone (English speaking) Africans
- Francophone (French speaking) Africans

TSF4SE found that across the groups they interviewed there were some community specific issues. These are described below. It is also important to note that Kurdish, Somali, Syrian and Francophone Africans feature highly in Freedom from Torture's experience of having a high percentage of survivors of torture from these countries.

WOMEN ASYLUM SEEKERS
GPs understand and abide by the NHS England guidelines on registration.
GPs understand the asylum system and the likely effect on health and wellbeing, and should treat asylum seekers with understanding, patience and listening

"They need to handle us with care."

GP Practices have a better understanding of the rules around Overseas Visitors charging regulations

"They should treat first and bill later."

Access to good quality interpreting

The NHS should work with voluntary sector organisations such as Women Asylum Seekers Together (WAST) and support them, as these groups provide invaluable social contact as well as support, hot food, advice, classes, volunteering opportunities and a purpose in life. The women understand very well that the warmth and support of organisations such as WAST has a huge impact on their mental health.

FRANCOPHONE AFRICAN REFUGEES (self-reported)
Health centres should employ more GPs and staff with medical knowledge; staff with medical knowledge would be more suited to assessing the urgency in which a patient needs to be attended to, rather than the receptionist.

There should be an understandable and user-friendly system with which to book an appointment. Those with no IT knowledge or no internet access should be able to make an appointment or apply for repeat prescriptions with the receptionist directly. Also, receptionists should have the right to re-arrange booked appointments in order of urgency.

A&E departments should have staff with medical knowledge to quickly assess people in the waiting area to determine who should referred to their GPs and who should wait, to cut down on the time wasted by the doctors and the patients in A&E. GPs should spend sufficient time checking up a patient with a hands-on approach (physical examination) rather than searching up information on a computer and

giving it to patient to read, to assure patients that they are being properly taken care of and not neglected.

GPs should explain the treatment they are giving to the patients and the reasons why any changes to treatment were made. If language barrier is an issue, Health Centres should employ interpreters with medical knowledge to relay the information to the patient to avoid communication breakdown.

Leaflets and information available to patients should be translated into more African languages, especially in clinics in areas that have very diverse communities.
NHS should educate, train more people and work with people speaking different languages that are helpful for the benefit of the patients.

Key health issues in the community remain Mental Health and HIV. The key barriers are language and culture and lack of training and insight by NHS/Social care staff on refugee issues. From a community perspective, the overall issue remains access to funds and resources to continue good work.

ZIMBABWEAN EXILES (self-reported)

Health staff should be made aware of the psychological and mental health problems faced by refugees and people seeking asylum and have appropriate referral and support for work with refugees.

Reception staff should receive training on communication and also asylum and refugee awareness.

The information shared shows the need to provide community based support that works with existing resources to improve immigrants' health and well-being. These services need support, training and resourcing to assist the NHS.

HIV treatment information for African refugees and asylum seekers should be widely available, and information about confidential voluntary sector services (such as the George House Trust) should be made available.

Community members should receive information about how the NHS works, who does what and why and treatment information should be provided to patients so they understand why a doctor or health professional has chosen a particular treatment.

GP staff and health professionals need an awareness of cultural health beliefs and practices and need to understand how these impact on women's health; women patients should be made aware that they can speak to women doctors about sexual health, appointments need to be handled with sensitivity and understanding, treatments explained to avoid complications arising from traditional treatments.

Social media should be explored as a means of propagating health information, advice and support for women in the Zimbabwean Community.

There should be a clear and consistent message from the NHS and social care professionals on labia elongation and FGM.

SYRIAN REFUGEES

Refugees need easy access to information about finding a GP and how the NHS works, replacing expired HC2 (entitlement to free NHS care) certificates and using NHS services. This could usefully be provided through community groups and services as often these will be the main initial source about services in an area.

Full medical histories should be taken by the GP because information shared on registration forms may not be complete or accurate.

Parents need information about inoculation and vaccination, vitamin supplements (Vitamin D) and background health issues. GPs need to ensure they take full medical histories of children.

Patients should always be offered interpreter support, interpreters should be qualified and DBS checked and dialect/standard Arabic should always be provided.The language needs of patients visiting hospital, especially in-patients, needs to be carefully considered and interpreters offered during all consultations.

NHS ambulance call centres require support and training to assist non-English speaking patients and how and when to use interpreters.

NHS staff should receive training on refugee and asylum awareness and have access and information on particular communities and conflicts.

IRAQI AND IRANIAN KURDISH EXILES

Effective communication requires skilled interpreting, time and understanding by both the medical professional and the patients:

NHS interpreters need to be assessed and to speak good English and understand medical language;

All NHS staff need to know how to work with interpreters.

Gender appropriate interpreters should be used.

Interpreters should speak the right Kurdish language for the patient. This information should be part of the referral and assessment information.

NHS staff and NHS Ambulance staff need to receive training on refugee and asylum awareness and have access to specific background information on the Kurdish community's health and well-being needs, the experiences of women in war and their experiences during the escape from traumatic situations.

Mental health and well-being is a serious issue in the community, GPs need access to appropriate support, training and referral/signposting options for specialist services.

The community needs to understand the role of GPs and other health professionals and how to access and use the NHS, community groups play an important role in this and should be supported to ensure this information reaches the communities. Women in the communities face specific cultural and social barriers to good health care. Specific projects or outreach initiatives should be considered to improve their health and well-being.

SOMALI REFUGEES

All refugees and people seeking asylum should be assessed by their GP for wider social and emotional problems arising from forced exile and migration.

Language needs should be fully assessed by GPs practices, good practice should be shared across the city, and women refugee patients should be offered both women GP appointments and women interpreters.

GP and other health services should plan for appointments that involve interpreting as these can take longer and short appointments may be a false economy if the patient has to return several times and use interpreters each time.

The NHS and the role of the GP needs to be understood by the community. Accessible information should be provided at the GP surgery to patients to explain the important role and skills of the GP and their staff.

Refugees need to be supported, signposted or assisted to find GPs when they have been forced to leave Home Office accommodation. Social workers have been important to several people in finding a GP, community groups could have a role too. Health staff should receive training and support to develop a broad understanding of what it means to be a refugee, health needs etc. and to access specific health information about each refugee producing country/situation.

SUMMARY

There were core common issues consistent across all six groups. The common core priorities were:

- Support for refugees to identify and register with a GP
- Interpreting at the GP Practice and during GP and hospital appointments
- Gender specific interpreting and consultations
- Mental health support and well-being

Additionally, specific priorities were identified on:

- Provision of information on Vitamin D
- Information on inoculations and vaccinations
- HIV treatment and access
- Women's health (information on specific FGM practices)