

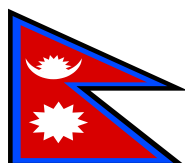
Health and Wellbeing of the Nepalese population: Access and experiences of health and social care services in the UK



UK-Nepal Friendship Society

www.uknfs.org

June 2015



LOTTERY FUNDED



BU
Bournemouth
University



Acknowledgements:

Big lottery Fund (*Project funder*)

University of Bournemouth, Faculty of Health & Social Sciences
(*Provider of ethical approval for the project*)

NHS England Equalities & Health Inequalities Team
(*Report review input at later and final stages*)

The Embassy of Nepal in London
&
Non-Residential Nepali Association UK [NRNA – UK]
(*Disseminating the project report to UK Nepali community groups*)

Research Team:

Dr Bibha Simkhada

Dr Rajeeb Kumar Sah

Mr Alan Mercel-Sanca

Prof. Edwin van Teijlingen

Prof. Bhimsen Devkota

Mr Yagya Murti Bhurtyal

Note: *This short report is prepared to highlight the key findings of this research. For further queries or detailed report, please contact the research team at bsimkhada@hotmail.com or rajebsah@hotmail.com*

Table of Contents

ACKNOWLEDGEMENTS:	2
RESEARCH TEAM:	2
BACKGROUND OF THE STUDY	4
METHODOLOGY	5
FINDINGS	6
CONCLUSIONS AND RECOMMENDATIONS	9
REFERENCES	12

Background of the study

It is estimated that 80,000 to 100,000 Nepali people reside in the UK (Adhikari, 2013). The Royal Borough of Greenwich in London has the second largest Nepali community (about 4000); that is 1.6% of the borough's total population (JSNA, 2012). Therefore, understanding health and wellbeing seeking behaviour, and health issues experienced by Nepali community living in the UK is important. Limited studies have been conducted on different health issues particularly chronic illness and lifestyle among the Nepali community in the UK (Casey, 2010; Adhikari *et al.*, 2008). Recently significant mental health problems have been reported in the Nepali population, presenting concerns for the NHS nationally and locally and social care providers at the local level.

The lack of medical and social care leaflets and brochures in Nepali language in the NHS presents another challenge (Casey, 2010). Moreover, the Nepali community's lack of understanding of the health system (NHS) restricts their access to general practitioners (GP) and other healthcare services. There is a need to create awareness among the Nepali communities about the available health services and empowering women and elderly to benefit from the health and social care services without restrictions.

This study is crucial as the NHS and social services have minimal awareness of the specific health and related social care needs of the UK Nepali community compared to other larger Black and Minority Ethnic (BME) communities. Therefore, this study aims to identify health and social care needs to promote positive health and wellbeing for the Nepali population in the UK. It also assesses health inequalities amongst the Nepali population focusing on the need for national level prioritisation to reduce these inequalities experienced by the broader UK Nepali population using NHS services.

Research questions:

1. Are health and social care services available and accessible for all Nepalese living in the UK?
2. What are the lifestyles factor affecting health and wellbeing of Nepalese population in the UK?
3. Do local health social care providers engage with the Nepali community [if so, how]? What are the gaps in NHS [Nepali] community engagement?

Aims:

The study aims to understand the access and experiences of the Nepalese population towards health and social care services in the UK.

Objectives:

1. To identify health and social care needs of the Nepali community and the response of the UK health and social care system to address them
2. To understand gaps and barriers in accessing the available sexual and mental health services in NHS healthcare provision.
3. To provide evidence based information for the NHS to engage effectively and comprehensively with the Nepali community in promoting positive healthcare for everyone.

Methodology

This study used mixed methods. The study was conducted in London Borough of Greenwich in May 2014. Quantitative information was collected using semi-structured questionnaires among the Nepali population aged 18 years and above. The data were collected from diverse group of Nepalese population that included elderly, young families, professionals and people from varied Nepalese sub-ethnic groups to obtain wide range of experiences and health related problems within the community. Participants completed 345 self-administered questionnaires and after quality assessment, 338 were included in the analysis.

Qualitative information was collected using interviews and Focus Group Discussions (FGD). Interviews were conducted in English or Nepali. The data were tape-recorded and notes were taken as required. All Nepali language notes were transcribed and translated into English followed by coding and analysis. The data collection and analysis process was facilitated and monitored by the research team.

Quantitative Data	Qualitative Data	
Questionnaire survey 338 participants	Key informant interviews One Pharmacist One Pharmacist Manager One Volunteer Social Worker (Nepalese)	Focus group discussions Two mixed elderly groups One male group

Data Analysis and Quality Assurance

The data from self-administered questionnaire processed and analysed using SPSS v21. Qualitative data from interviews and FGDs were analysed manually using thematic approach. Transcripts were examined line by line for recurring themes, subthemes and categories. Qualitative and quantitative data sets were compared during analysis, and findings were triangulated to obtain major findings on access and experiences of health and social services in the Nepalese community.

The research lead and research assistant supervised and monitored the data collection and conducted FGDs and interviews with the key informants. The data were collected by trained volunteers, which was facilitated and monitored by the research lead and research assistant/field coordinator.

Ethical approval

Ethical approval was obtained from Bournemouth University and the research participants gave informed consent. Every precaution was taken to maintain and ensure the confidentiality and anonymity of the participant's privacy and identification.

Findings

This section describes all the findings from quantitative survey and incorporates the qualitative findings to explain the issues in depth.

Socio demographic Information:

The sample was as diverse as the Nepali Population residing in the UK. The survey was completed by 208 men (61%) and 130 women (39%). Most respondents (243 /72%), were employed, 155(46%) worked full time and 88(26%) part time), 39 (11%) were unemployed and 56 (17%) were retired. Most (68%) had a low income <£10,000 P/A. Only 88 (26%) respondents were graduated and majority 154 (46%) had education up to college level and 96 (28%) had primary school education. However, only one third were fluent in English language and the majority with poor English language were women and elderly. Two-thirds lived in rented accommodation and very few (6%) lived in council housing. Over half (58%) of respondents were permanent resident in UK. The qualitative information found that elderly people were living in very inappropriate accommodation especially who has poor mobility and with chronic health conditions. Participants expressed widespread abuse from landlords of basic rights and not providing proper living conditions.

I have seen majority of the elderly in this area are living in very poor houses most are in shared houses. Landlords are not treating very well as they are splitting one room into two rooms and charging same rent as bigger room for tiny room (Volunteer Social Worker).

It is difficult to live in a shared house. You have to share toilet with other people. Main problem is in using toilet. There is one toilet and many people are living in one house....a friend living in the shared house, she has one room upstairs. She has problem in her leg. She find difficult to walk upstairs. She has to cook food downstairs and take food upstairs to eat in her room. (FGD with Elderly Mixed 2).

Disability and poor health condition: In total, 4% had some kind of disability. The common medical problems were: high blood pressure 62 (18%), diabetes 43(13%), high cholesterol 23 (7%), asthma 14 (4%) and five people reported to have Tuberculosis.

Lifestyles:

Lifestyle-related behaviour covered four domains: physical activity and dietary habits, smoking and alcohol consumption. Walking was the most common form of exercise among both the young and the old, whereas younger people in general preferred going to gym compared to very few elderly.

About 28% of men smoked cigarettes compared to 8% of women, whereas 70% of males consumed alcohol compared to 46% of females. Few participants reported using drug, but one local pharmacist expressed concerns about widespread drug misuse among the younger Nepali population.

Almost half of the population consume five or more portions of fruit and vegetables. Educated people are more like to follow a healthy diet.

Health services use:

A majority of the participants (326) were registered with a GP. Twelve participants did not see a need for this until actually being unwell and they very limited or no understanding of the registration process and documents required. It was seen as a barrier to registering with a GP. It mainly affected students (7 out of 12) who were renting a room in a share house.

About 38% respondents had some kind of wellbeing check-up such as screening, blood sugar monitoring and cholesterol measurement. The uptake of disease screening was very low (28%). Only 25% of the total number of female participants had undergone smear test. Only 35% had travel vaccines before travelling to Nepal.

Satisfied with the health service: Almost half of participants (49%) were satisfied with the health services, a third had no opinion whilst a minority was unsatisfied. The major issues reported for dissatisfaction was: unfriendly staff, no arrangement for future treatment, and doctor not listening properly.

Focus groups reported many positive experiences towards medical staff and they valued the care and treatment received, however many expressed language barriers.

We are satisfied with the doctor's service as we are getting the services. The main problem we are facing is to access the doctors, most of the doctors are good they check well and behave well. if we can speak English we would not have much problem. Our main problem is communication... We need someone who can speak Nepali and explain our problems for us (FGD with mix elderly 1).

A majority of elderly participants had negative experiences, the major issues being delayed appointment, expensive medicine, prescription issues and language barriers. Similarly services providers such as the pharmacists also expressed similar barriers leading to dissatisfaction: poor language skills, poor knowledge and understanding about NHS and social care.

This study also highlights that cultural issues around accessing health services (in Nepal) may play a big role in the expectations of the elderly. Most may be used to the system of immediate access to private health services in Nepal.

Other community health services:

Dental Services: Only 45% were registered with a dentist, the main barriers were costs and not perceiving a need.

Alternative medicine: It was not uncommon to use herbal/Ayurveda medicine as a first choice in many illnesses, as 16% had used herbal/Ayurvedic or any alternative treatment. The popularity of herbal medicine is due to lack of quick appointments with GPs and language barriers. There was little use of other [non-herbal] alternative therapies, such as acupuncture, yoga, or meditation.

Interpreters at health care facilities: Only one in five (19%) used a translator or interpreter services at health facilities. The FGDs and interviews showed poor knowledge about and use of interpreter services while accessing health and social care service. Many were unaware about accessing interpreters.

Reproductive and Sexual Health:

Most of the participants were very uncomfortable with talking about sexual and reproductive health, only 6% reported to have sexual health problems and only 2% of participants (all males) reported to have more than one sexual partner. All reported to be heterosexual, indicating a cultural taboo on homosexuality. Concerns about privacy and confidentiality were highlighted as barriers in using sexual health service. The qualitative interviews also highlighted taboo about sexual health as participants were reluctant to use sexual health services unless in an emergency.

Sexual health is like drug addiction, I heard it has some taboo in this society. I think they are not using the sexual health services until very late as it has got taboo (Pharmacist).

Mental Health:

About 17% (57) of all respondents reported having experienced poor mental or emotional health in the last 12 months. The main reasons were; economic hardship, family/relationship problems, and the extreme weather in the UK. Ten percent especially elderly had experienced poor mental or emotional health as a result of feeling isolated due to language barriers or cultural differences. About 8 % of total population were aware of local mental health support and services and only two out of these 57 had used mental health services.

Pharmacists commented on under-reporting of mental health issues, due to the traditional cultural taboo associations with it that exist with those sections of the community most influenced by same. Many mental health issues are only revealed after an attempted suicide or in advanced state of mental problems: this is a very important and serious matter that the NHS needs to address in sensitive culturally appropriate ways. The findings indicate that people are not very open about mental health problems, and that there exists a cultural taboo about acknowledging the need for mental health services.

Experience of bullying, violence, abusive and degrading behaviour: Eighteen people (5%) had been bullied or experienced violence by non-Nepali people in the UK and nine people had suffered sexual or gender-based violence [GBV] or degrading behaviour, mainly at work. Very few (n=9) had ever used a social worker, indicating the concept of and services of social workers was little understood.

Community/ social services:

Most (90%) has used community services and facilities in last 12 months, such as parks, religious places, leisure centre and community centres. Majority of participants were receiving some sorts of social security benefits.

Conclusions and Recommendations

Understanding health and social care needs of migrant populations is an important initiative to reduce health and social care inequalities. There are various social, cultural and lifestyle factors that determines health and wellbeing of the population. This study demonstrated that majority of Nepalese population is on low income even if they are educated. This low income leads to adoption of and entrapment in poor lifestyles that eventually has negative impact on health. Housing issues has been another challenge for this community, as majority of elderly people lives in poor quality rented and shared accommodation. Stress related to housing/rented accommodation possesses a significant health risks for elderly and those with long-term health conditions. Majority of elderly population are dissatisfied with the housing arrangements from their local authority. The study suggests that housing authority should assess the housing situation to authenticate the suitability for the vulnerable people.

The study found that only a third was fluent in English language and this tends to be a key barrier to accessing health and social care services. Findings also suggest that health and social care needs of the Nepali community needs to be practically understood through engaging with local communities and health and social care service providers. This must be seen from wider perspectives such as age gender, sexual orientation, degree of cultural acclimatisation and ease in understanding and communicating English language.

More than half of the participants drink alcohol and a third recognise that their alcohol intake level is harmful for their health. The reported use of illegal drugs was very low, although pharmacists suggested otherwise, suggesting it was higher in the Nepali community than in the general community. This low number could be because of, as indicated, their willingness to hide this habit/dependency from their family, friends and society.

The study found that most elderly population suffered from chronic health conditions such as high blood pressure, diabetes, high cholesterol, asthma and tuberculosis. It is essential to make those suffering from these medical conditions/illnesses, aware about the available health facilities on prevention and treatment. Older people seem less likely to access community facilities for physical fitness due to lack of knowledge and information. Walking is the most common form of exercise among all ages; however it is more popular amongst the elderly population. More attention needs to be given to help increasing engagement in different forms of physical exercise in the community, and of NHS programmes that support exercise for those with health conditions.

The findings showed that use of dental service is poor in this Nepali community. Part of the reason could be that most people are on low income and not being able to afford a dentist, whilst some perceive that they do not need dental services. The use of wellbeing check such as available screening services is generally low and men appear to be poor in using free screening services that are available through the NHS. Only a third of population had travel vaccinations before they travelled to Nepal with men were more likely to use this service. Therefore awareness on the importance of wellbeing checks, vaccination and oral hygiene are necessary in this community.

A majority of the Nepali population are registered with a GP but they were not happy with the limited information provided by the GPs about the available services. Most importantly, this research revealed that the main reason for dissatisfaction of the Nepali community

toward NHS services is poor communication and the actual or perceived poor [unfriendly] attitude of health service providers [HSP's] and HSP administrative staff. This finding indicates that the NHS Equality Delivery Standard has yet to be implemented at local level and applied in effective ways. The survey indicated that a small number of participants were not registered due to required housing related documentation and also their perception of not requiring services until actually being unwell. The findings also suggest that most elderly expects immediate access and recovery, which may be frustrating toward health services in the UK. Nepali community demonstrated poor knowledge and understanding of the UK health and social care system and it is important to explain them about the availability and accessibility of health and social care services in the UK.

Also importantly, findings of the research indicate that those over the age of 40 are more likely to experience poor mental health because of the social isolation and feeling of loneliness. Addressing the issue of loneliness is necessary, as qualitative findings suggested that loneliness was very common amongst the elderly. The language barriers and cultural differences aid to this problem. The findings also suggested that cultural issues in sexual health in Nepali community are big problem as many people only come to use the services when they are really struggling to cope with it. Mental and Sexual health are complex issues as participants were not very open to discuss about it. The fear of disclosing confidential information related to sexual and mental health was seen as major barrier. Only few participants were aware of mental and sexual health services and hardly few had used the available services, possibly due to cultural taboo and stigma. Cultural integration and the issues of privacy and confidentiality need to be considered while delivering services on these sensitive issues.

Recommendations:

The research suggests three levels of recommendations on the basis of its findings.

1) Policy recommendations

Tackling health inequalities and language barriers: Improving language skills and overcoming language barrier is essential to improve access to available services. The NHS should, in conjunction with the Nepali community, develop a strategy and allocate appropriate funding to reduce the health inequalities by targeting vulnerable /isolated groups. For example, language barriers among the elderly could be improved by employing interpreters in GP practices and hospital. Volunteer interpreters could, perhaps, be employed to tackle high demand for interpreters and reduce NHS costs. Collaboration with Nepali national organisation such as NRNA, UK Nepali Doctors Association, and Nurses Association could help interpreters to support the Nepali community.

Promoting Health and Wellbeing: An educational initiative creating awareness about the structure of health and social care services, on the uses of services, with a lead by and support from national organisations like Public Health England and NHS England is required. Services should be sensitive to the needs of the Nepali community and promote awareness about their physical and mental health issues. It should further include support for Nepali lesbians, gays, bi-sexual and transgender people (LGBT) who are very restricted within their culture, impacting their sexual and mental health.

Social services: Social service organisations need to work closely with Nepalese community to identify and understand problems related to housing, which negatively impact health and

social wellbeing. They should support local authorities in developing effective policies on safety issues and local authorities should take a more proactive supportive position to assist both landlords and tenants.

2) Programme recommendations

The health and social care policies need to be implemented with a prospective of culture appropriate at local level. Community engagement programme should be developed in collaboration with the local community and supported by local authorities. Such programmes could tackle loneliness and social isolation among elderly Nepali population by bringing together the Nepalese community. It may also help to interact and integrate with other communities and the wider society, which could in turn improve mental health and general wellbeing. Social clubs could offer an entertainment and educational programmes on health related information in Nepali and could run health promotion campaign to promote positive health and wellbeing among the population. Health promotion programs to address long term conditions as well as sexual and mental health should be the top priority in order to improve access to counselling, and to make these much more publicised in culturally sensitive language especially for those with minimal English language skills. Similarly, Health promotion programmes creating awareness about the availability and accessibility health and social care services are necessary to address the health and wellbeing issues of the Nepalese population.

3) Research recommendations

- There is a need for a national level research to map the different needs of sub groups and appropriate interventions to reduce health and social care inequalities in the Nepali community.
- Further research is essential to understand lifestyle related alcohol drinking, smoking trends and culture and its negative impact on health and on the family and society.
- Research is needed on mental health to identify the factors that lead to loneliness and social isolation among elderly population.
- More research on sexual health behaviour and related issues to understand the needs of people living in this bicultural society, including for UK Nepali LGBT populations.
- Further study is essential to explore the ways and trends of social integration of sub groups into UK society. This would clearly benefit NHS in terms of outreach and effective engagement to and service provision for the UK Nepali NHS services users, but potentially other UK South Asian population groups.

References

Adhikari K (2013) *Adjusting Estimated Nepali Population in the UK*. Available online: www.cnsuk.org.uk/?option=articles&id=14 (Accessed: Jan, 2014).

Adhikari P, Simkhada PP, van Teijlingen ER and Raja AE (2008) Health and Lifestyle of Nepalese migrant in the UK. *BMC International Health & Human Rights*, 8(6).

Casey M (2010) *Health needs assessment of the Nepali community in Rushmoor*. Available online: www.gov.uk/government/uploads/system/uploads/attachment_data/file/28116/NepaliHealthNeedsAssessmentOct2010.pdf (Accessed: Jan, 2014).

JSNA (2012) *Joint Strategic Needs Assessment: An Update for 2012 of the Impact of Deprivation on Health and Well-Being in Greenwich*. Available online: www.royalgreenwich.gov.uk/downloads/file/1377/joint_strategic_needs_assessment_2012_part_1_introduction_and_chapter_1 (Accessed: Jan, 2014).