

# **Migrant Health Needs Assessment**

**February 2018**

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## 2 Executive summary

It is becoming increasingly important to understand how migration impacts health. In Hackney, nearly 100,000 residents were born outside of the UK. In the City of London, two in five residents migrated to the UK. This report assesses the health needs of this diverse and heterogeneous population.

Migrants can come to the UK for the purposes of work, study or familial relationships. Migrants can also be forced to leave their country against their will due to conflict or persecution and arrive in the UK seeking asylum. Undocumented migrants are those who lack a right of residence in the UK and may include those who have overstayed their visa, 'illegal' entrants, trafficked people, and refused asylum seekers.

This report found differences in the wider determinants of health between migrant and non-migrant populations. Migrants are more likely to depend on the Private Rental Sector and therefore are more likely to reside in substandard housing. Despite having higher levels of educational attainment, migrants are more likely to be in low-skilled work.

Health outcomes similarly differ between migrant and non-migrant groups. Although migrants overall may appear healthier upon arriving in the UK, over time this advantage is attenuated and migrant rates of morbidity and mortality equate or become worse than that of the UK born population. This report explores the differences in non-communicable diseases, communicable diseases, women's health, and mental health between migrant and non-migrant populations. For many of these indicators, evidence shows that migrants have worse outcomes than their UK born counterparts. The following conditions and behaviours are highlighted in the report:

### Non-communicable disease

- Cardiovascular disease
- Smoking
- Obesity
- Diabetes
- Cancer

### Communicable disease

- Tuberculosis
- HIV
- Sexual health

### Women's health

- Obstetric and postnatal care
- Maternal mental health
- Cervical screening

### Mental health

- Common mental health disorders
- Severe and enduring mental illness
- Substance abuse
- Suicidality

Poor health outcomes may be exacerbated by barriers to accessing health care services. The report explores the main barriers identified in the literature, as well as service-specific barriers for obstetric care, screening, and mental health services.

A policy review is presented highlighting the main immigration policies that impact the health and wellbeing of migrants in the UK. This is an area that is constantly

shifting and as a result the policy landscape will require continuous monitoring to keep informed.

National and local level data were collated exploring migration patterns, demographics, health outcomes, and the wider determinants of health. In some cases, local data did not reflect the health problems identified in the literature; this may be due to underreporting or the misidentification of certain health conditions. Interviews were conducted with local stakeholders exploring the main health issues that affect the local migrant population, barriers to accessing services, self-treatment of health conditions, and the outcomes of self-treatment.

Where information is available, local services for migrants are presented including advice and signposting services, language classes, and health and social care services.

The discussion and recommendations sections synthesise the evidence collated through the needs assessment and suggest how to tackle inequalities and unmet needs among this group. The recommendations are based on problems and issues identified through this needs assessment; we suggest a course of action and the responsible partner agencies. Broadly, we recommend:

- Key local stakeholders work together to address the health and wellbeing needs of migrant groups.
- Objectives for improving migrant health and wellbeing are embedded in Integrated Commissioning work streams with the aim of reducing health inequalities between migrant and non-migrant populations.
- Encouraging the development of champions in each stakeholder organisation whose focus is on improving the health and wellbeing of migrants living in Hackney and the City of London.

### 3 Introduction

The UK has 9 million migrant residents; one in six live in Inner London<sup>1</sup>. In Hackney, nearly 100,000 residents were born outside of the UK. In the City of London, two in five residents migrated to the UK. Those who migrate to high income countries have differing health outcomes compared to non-migrant residents. [1] By gaining a fuller picture of the health needs of migrant residents in Hackney and the City of London, we may help to foster more equal health and wellbeing outcomes between migrants and UK born residents. This needs assessment defines the term “migrant” as any individual who comes to reside in another country outside of their country of birth. [2] This document will focus on the needs of migrants in high income settings, particularly in the context of London and the UK.

The main challenge in accurately describing health and wellbeing among migrants is the heterogeneity of experiences. Not only do migrant residents have a range of differing health beliefs and socio-economic backgrounds but the principal cause behind initial migration may significantly affect future health and wellbeing. As a result, this report focuses on three categories of immigration status: general migrants, forced migrants, and undocumented migrants. Please see Box 1 for further information.

This needs assessment first focuses on the wider determinants of health inequalities between migrants and UK born individuals. Next, variations in health outcomes are discussed. Barriers to accessing health and social care services are also explored. A review of immigration policy and relevant policies affecting migrants is presented. This needs assessment has collated and analysed data on migrants, the wider determinants of the health of migrants, and migrant health outcomes. Interviews with stakeholders were undertaken and the themes that emerged are presented. Finally, known services available for migrants and refugees are summarised. The discussion and recommendations sections synthesise the evidence collated through the needs assessment and suggest how to tackle inequalities and unmet needs among this group.

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<sup>1</sup> The Inner London area includes the City of London and the London boroughs of Hackney, Camden, Greenwich, Hammersmith and Fulham, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth, Westminster. [222]



*Box 1: Definitions of 'migrant' based on immigration route***1. General Migrant**

An individual who leaves their country of origin to reside in another for the purposes of work, study or closer family ties.

**2. Forced Migrant**

An individual who has been forced to leave their country of origin due to war, conflict, persecution or natural disaster.

- **Asylum seeker**

An individual who has applied for asylum under the 1951 Refugee Convention on the Status of Refugees on the grounds of fear of persecution on account of race, religion, nationality, political belief or membership of a particular social group.

- **Refugee**

An individual upon whom the status of refugee has been conferred under the 1951 Refugee Convention on the Status of Refugees. This can be obtained either through successful application for asylum or by direct selection via the Gateway Protection Programme or Syrian Vulnerable Persons Resettlement Programme.

**3. Undocumented Migrant**

An individual who has entered the UK in a forced or unforced manner but has lost or never obtained a right of residence. This includes general migrants who have overstayed their visa, trafficked persons, irregular entrants, children of undocumented migrants, and refused asylum seekers who are not receiving Section 4 additional support (see Box 5 for further information on Section 4).

## 3.1 Methodology

### 3.1.1 Literature review

The literature search consisted of a two-staged approach. Firstly, a review of established literature was carried out by performing broad searches of the Cochrane library, NHS Evidence and Medline. The keywords and MeSH terms used in the search were: “immigrant” AND/OR “migrant” AND “health” AND/OR “migrant health” AND/OR “immigration and health”. Research studies and reviews published between 1980 and 2017 and written in English were included. Following the generation of a list of studies, the abstracts of each were reviewed in turn to ascertain whether the

content of the study aligned with the central focus of the needs assessment. A purposive literature search was also undertaken to supplement findings.

A review of grey literature was also conducted which included reports, papers and briefings from the Migration Observatory, the World Health Organisation (WHO), the Royal College of General Practitioners, and GOV.uk (including Public Health England), among other sources.

Findings from the literature review were collated and are presented in the Wider Determinants of Health chapter, the Health Outcomes in Migrants chapter, the Barriers to Health care Access chapter, and the Policy chapter.

### 3.1.2 Interviews

Stakeholder interviews were conducted between April and June 2017. The Public Health team contacted health professionals, migrant organisations, and the community and voluntary sector for participation in interviews. Participants who worked directly with migrant populations in Hackney and the City of London were purposely recruited. In total, nine 60 minute semi-structured interviews were conducted with participants working across a wide variety of professions. The interview questionnaire is available in the appendices. Interviews were recorded and transcribed. Themes were analysed using a grounded theory approach.

### 3.1.3 Quantitative data

Data regarding demographics in the UK, Hackney, and the City of London were derived from the Census 2011, the Office of National Statistics (ONS) and the Annual Population Survey (APS).

Clinical data for Hackney and the City of London were derived from GP coded clinical records held by the Clinical Effectiveness Group, Queen Mary University of London. Data from 273,473 records were filtered to extract records where country of birth was recorded. 14% of total patients had recorded country of origin. Country of birth data were further coded into 14 regions. These regions are the UK, Asia, Australia/New Zealand, Caribbean, Central and South America, Eastern Europe, Middle East, North Africa, North America, Oceania, South Asia, Sub-Saharan Africa, Turkey/Cypriot, and Western Europe. Please see the appendices for detailed information on regional coding.

## 3.2 Limitations

This report has focused on those who reside in Hackney and the City of London who were not born the UK. As a result, it may capture those who were raised in the UK and do not self-define as a migrant. It will also fail to capture those who were born in the UK but are the children or grandchildren of migrants to the UK. These groups will also have unique health needs that should be explored in future research.

Due to the rapid and limited nature of the literature review, this project did not have the capacity to assess evidence on health outcomes in children and young migrants, elderly care for migrants, and palliative care for migrants. These areas should be considered in future research.

Quantitative data were limited to individuals with country of birth coded. However, country of birth data were only available on 14% of patient records. Patients who have country of birth recorded may not necessarily be representative of the migrant and non-migrant populations in Hackney and the City of London.

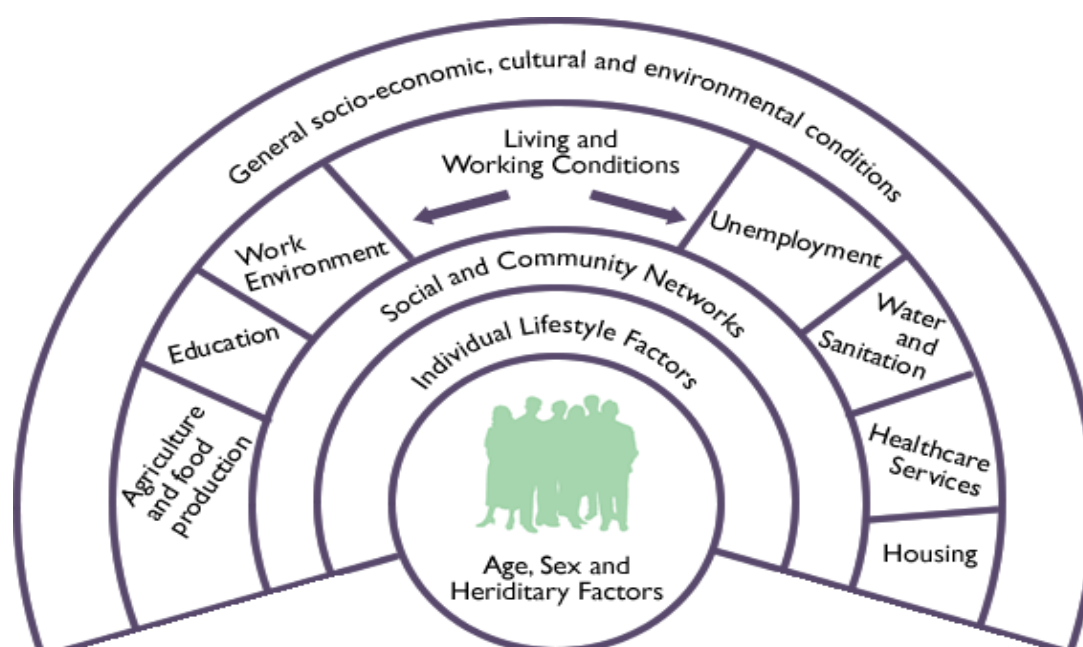
Where possible, this report has attempted to compare Hackney and the City of London to other local authorities and geographical areas. However, comparable data were not always available. Further research is necessary to understand how the health needs of migrants locally compare to other areas.

Services are presented where information is available but locations and times may change at any point. Please contact services directly for more information.

## 4 Wider determinants of health

The key wider determinants of health for an individual include housing quality, employment, and educational attainment as well as access to health care services. Please see Figure 1 for further information. The following will address how housing, employment and education impact the health of migrants. In section 6, barriers to accessing health care services will be explored.

Figure 1: The Wider Determinants of Health



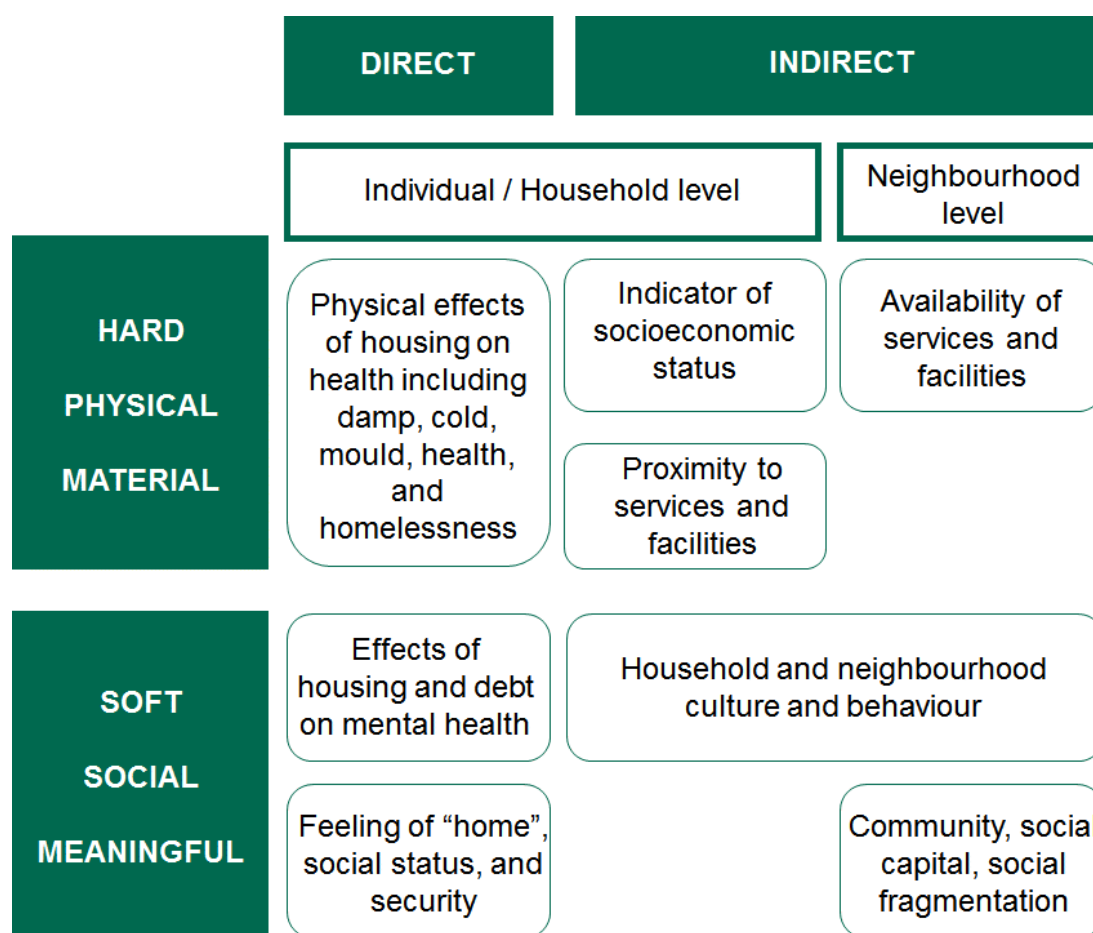
Source: Dahlgren and Whitehead, 1991 [3]

## 4.1 Housing

More than just a shelter, the home provides a haven of psychological and social security. [4] Housing quality affects health both directly and indirectly. If a house is damp, mouldy or cold, this can directly impact physical health. Poor housing can have direct impacts on mental ill health. A recent report commissioned for the housing charity Shelter examined the effect of housing standards and overcrowding on health and wellbeing. 'Bad housing' was defined as housing which was overcrowded or did not meet the Decent Homes Standard, while 'good housing' was all other types of housing. Those living in bad housing were found to be more likely to experience respiratory problems such as asthma, shortness of breath and disturbed sleep from wheezing, than individuals residing in good housing. Similarly, poor mental wellbeing was more likely to be reported in adults who lived in bad housing. [5] Overcrowded living conditions may affect the physical and psychological wellbeing of an individual. Among children, living in an overcrowded environment in the UK has been linked to both respiratory and gastrointestinal problems. [6] [7] [8] [9] More broadly, rates of drop out and behavioural problems at school have been associated with overcrowded conditions at home. [10] [11] Illnesses such as tuberculosis (TB) and influenza are known to spread more rapidly in overcrowded environments. [12]

There are number of indirect impacts housing has on health, including proximity to services and availability of social networks. Please see Figure 2 for further information.

*Figure 2: Effects of poor housing*



Source: Adapted from Shaw M, 2004 [13]

There are key differences between the housing characteristics of migrant residents and UK born residents. In London, migrants who have come to the country in the past five years overwhelmingly use the Private Rented Sector (PRS) for accommodation, with eight in ten recent migrants residing in PRS housing. Only a third of migrants own their own homes, in contrast with over half of UK born residents. [14] Private rentals are associated with higher rates of substandard housing quality than either self-owned or social housing. Social housing, however, is linked to higher rates of overcrowding. [5]

Health outcomes are not only affected by the quality of housing but also by the frequency of movement between accommodation. As a result of migrants relying on the PRS they may experience an increased degree of transience as they move through a succession of private tenancies. [14] Similarly, many asylum seekers experience a higher degree of transience as a result of the dispersal housing policy<sup>2</sup>. [15] Asylum seekers may be accommodated in housing which is far from other community members and may potentially be rehoused several times. [16]

Increased residential mobility between boroughs is very likely to affect GP registration and wider health service utilisation. Several studies reported that individuals who move frequently in the UK are less likely to be registered with a GP.

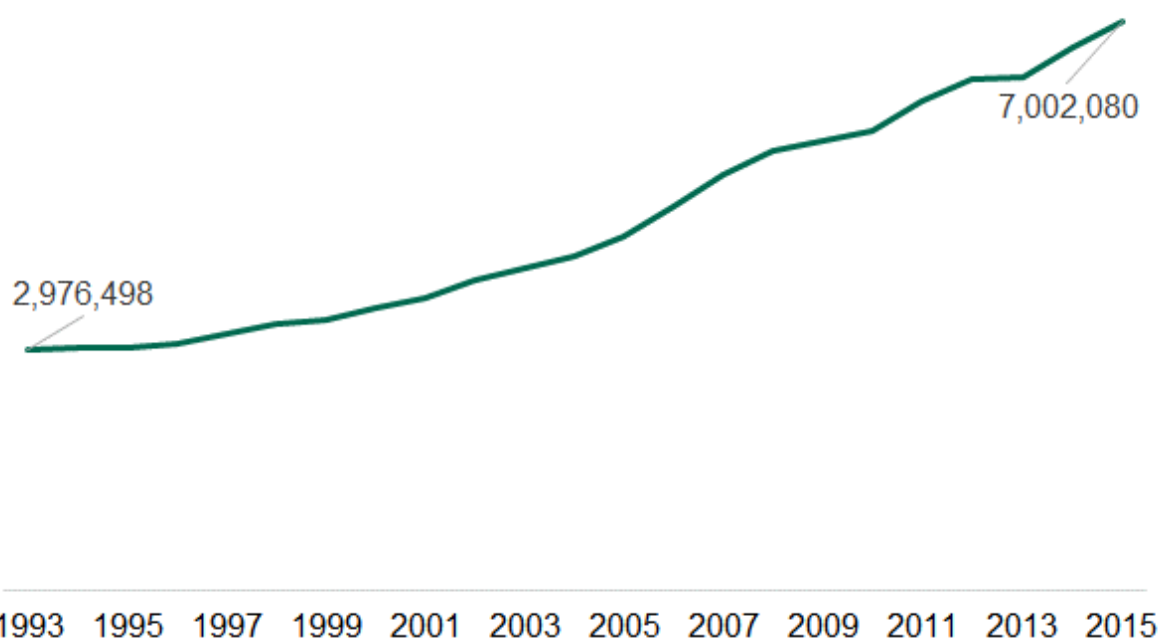
<sup>2</sup> This policy was implemented to ensure that local authorities would not become overstrained through providing refugee support.

[17] Similarly, some studies have reported a significant negative effect on health service utilisation and mental health from a phenomenon known as ‘malign residential mobility’. [16] [18] This describes a state of excessive residential transience caused by repeated moves from one temporary accommodation to the next. This may lead to social isolation, loneliness, poorer physical and mental health and greater insecurity. [19]

## 4.2 Employment

In the recent past the numbers of migrants of working age in the UK has increased (Figure 3). However, the proportion of migrant workers in low-skilled work sectors has grown over the past 15 years. [20] Despite having a higher proportion of degree level qualifications on average, younger migrants are more likely to be in low-skilled jobs than UK born employees. [21] A higher proportion of migrants aged 20-29 work in the lowest-skilled occupations compared to UK born residents. [21]

Figure 3: Numbers of migrants of working age in the UK, 1993-2015



Source: Rienzo, Migrants and the UK Labour Market: An Overview, 2016 [20]

Table 1: All Migrants: Top 10 Occupations by Workforce Share 2015

Occupation	% Of Total Workforce
Elementary Process Plant Occupation	42
Process Operatives	36
Cleaning and Housekeeping Manager	35

<b>Elementary Cleaning Occupations</b>	31
<b>Food Preparation and Hospitality</b>	30
<b>Textiles and Garment Trades</b>	28
<b>Health Professional</b>	26
<b>Elementary Storage Occupations</b>	26
<b>IT and Telecommunications Professionals</b>	25
<b>Assemblers and Routine Operatives</b>	25

Source: Rienzo, Migrants and the UK Labour Market: An Overview, 2016 [20]

In Europe, occupational accidents are approximately twice as likely to occur in migrant workers as non-migrant workers. [22] Several factors may contribute to this. Migrants carry out a disproportionate number of challenging, unhygienic or dangerous jobs. [20] This form of work may often be ineffectively supervised and regulated. Recent migrants with a limited experience of English may face challenges understanding safety warnings or machine operating instructions designed to reduce the risk of harm. [23]

### 4.3 Education

Education has been shown to be an important wider determinant of health outcomes. [24] [25] [26] Migrants to the UK have been shown on average to have a greater level of higher educational attainment than the UK born population. [21]

Younger migrants appear not to be at the same disadvantage as those arriving to the UK after school age. Among young people with English as an additional language (EAL), progress in school tends to be below average in comparison to UK born children but this disparity is largely eliminated by the age of 16. [27] Individuals who join the UK school system before the age of 11 have been shown to have better educational outcomes than those who arrive later. [21] Other factors that have been shown to affect the educational outcomes of EAL children are similar to that of the UK born population: transition between schools, having special educational needs, and living in a deprived area. [21]

## 5 Health outcomes in migrants

### 5.1 General health

Evidence suggests that general migrants entering the UK may have a better baseline health level than UK born individuals of a similar age and gender. The theory of the 'healthy migrant effect' suggests that, in general, migrants arriving to high income countries such as the UK, US, Canada and Australia appear healthier at first but over time this health advantage is attenuated and rates of mortality, morbidity and other negative health predictors equate or become worse than that of the overall population. [28] [29] [30] [31] [32]

Once the individual has emigrated from their country of origin, life may begin to change. Acculturation is the process of the gradual exchange of a migrant's original attitudes and behaviours for those of the host culture and may be one of the factors explaining the diminishment of migrant health over time. [51] Factors such as reduced income and poorer working and living conditions may begin to erode positive health characteristics. Isolation, reduced psychological support from a social network, differences in the host nation's health beliefs, and changes in diet, may all play a role in diminishing the health of a migrant over time. [29] [33]

The reasons behind the healthy migrant effect and its attenuation are complex. Several explanations have been put forward to try and explain why the phenomenon exists. Firstly, it has been suggested that individuals – particularly general migrants – choosing to immigrate come from more socio-economically privileged backgrounds and as a result have better health outcomes than both the general population of their country of birth and those of their country of residence. Secondly, the stricter immigration policies (see Policy section) of economically developed countries require potential immigrants to have greater levels of socio-economic and educational privilege in order to apply. Lastly, the most common reason for migration globally is work. Work is, in general, not only a preserver of good health but also requires a minimum standard of health to partake in. [33]

It has been suggested that the relative good health of new migrants may be because they choose to not fully disclose current health problems for fear of losing their residency status or having difficulties finding work. [34] However, the healthy migrant effect is observed in lower recorded rates of mortality and measures of health outcomes which are not self-reported. [28] [29] Another explanation put forward for the observed difference is that newer migrants, whose health declines significantly, may return to their country of origin. [29] While this is likely to be the case for some migrants, this pattern is not common. [29]

It should also be clearly noted that while general migrants appear to be healthier on arrival to the UK, forced migrants report worse health outcomes on arrival. [29]

## 5.2 Non-communicable disease

Wider determinants of health are likely to play a role in the development of many non-communicable diseases such as cardiovascular disease, diabetes and cancer. Low socio-economic status, separation from family and friends, and structural discrimination are among many factors which may explain why migrants appear to experience a greater burden of non-communicable disease than UK born residents. [35]

### 5.2.1 Cardiovascular disease

European and UK research into cardiovascular disease among different groups of migrants has shown widely varying patterns in different groups. [23] [36] However more consistent evidence appears when a distinction is made between stroke and cardiovascular disease. [37]



In England between 1999 and 2003, mortality from stroke was almost three times as high among male migrants from West Africa and twice as high among men from the Caribbean compared to those born in England. However during the same period, mortality from coronary heart disease was significantly lower in these groups when compared to men born in England. [38] This is likely to be caused by the slightly different physiological processes behind the development of the two illness which in turn will be in part affected by the individual's genetic background.

In the UK, male and female migrants from Bangladesh, Pakistan, India and the Republic of Ireland show an increased prevalence of both stroke and coronary heart disease relative to individuals born in England. [38] Notably, individuals from the Indian subcontinent have not experienced a similar rate of decline in the occurrence of coronary heart disease as individuals born in England. This has meant that their risk of acquiring the illness has actually increased over time relative to England born individuals. [38] An explanation for this has been sought through examining whether individuals from these groups have higher rates of the principal factors behind cardiovascular disease: smoking, obesity, hypertension and diabetes. [37]

### 5.2.2 Smoking

Evidence regarding tobacco use and country of birth remains scarce and most data present smoking rates by ethnicity. Men from Bangladeshi, Pakistani and Irish backgrounds have been shown to have higher smoking rates in comparison to men born in the UK. [39] However, one study showed that after controlling for socio-economic status, individuals of Bangladeshi ethnicity are less likely than UK born individuals to smoke. [40]

Among female migrants, an analysis of the Millennium Cohort Study found that among mothers, ethnicity was a better predictor of both cigarette smoking and alcohol consumption than the length of time they had stayed in the UK. [41] This suggests that, in terms of smoking and alcohol consumption, individuals may retain cultural norms to a greater degree than they are affected by the process of acculturation.

### 5.2.3 Obesity

As with smoking, data related to country of birth and obesity are unavailable. The best available evidence is currently from studies examining disparities between different ethnic groups. Higher levels of obesity are found in Black African or African-Caribbean groups, while among adults of South Asian ethnicity, evidence is currently equivocal. [42] [43] Some UK studies have shown an increase in obesity in South Asians [44] [42] [45] while others indicate the opposite. [46] [47] [43] In contrast, several studies have indicated that those of Chinese ethnic origin have a lower body mass index (BMI) and other indicators of obesity than those who identify as White. [48] [49] [50]

Obesity has been shown to be positively associated with the process of acculturation among certain groups of migrants. One systematic review showed that greater degrees of acculturation are associated with an increase in BMI among male

migrants but a lower or similar BMI among female migrants when compared to non-migrants. [51]

#### 5.2.4 Diabetes

In Western Europe, with few exceptions, the prevalence, incidence and mortality rates for Type 2 diabetes are higher in migrants than non-migrant residents. [52] [53] [54] [55] [56] [23] [57] [58] In the UK, one in five migrants of South Asian origin has Type 2 diabetes. Among this group, diabetes onset occurs 5-10 years earlier which in turn results in worse chronic complications. [59] [35] A long term follow-up study from the UK has reported an incidence of type 2 diabetes almost three times higher in migrants from India and more than twice as high in those who identify as Black Caribbean, compared to UK born individuals. [35] The reasons behind these differences are complex. Specific groups of migrants such as those from South Asia may have a tendency to develop a resistance to insulin and truncal obesity which are linked to the development of diabetes. [60] Lifestyle factors such as an increased tendency towards sedentary behaviour have also been associated with UK migrants from South Asia. [61]

#### 5.2.5 Cancer

Certain types of cancer are known to be more common in individuals from particular ethnic or cultural backgrounds. Several European countries have produced large scale studies reporting that both cancer incidence and mortality are lower among migrants than non-migrant residents. [37] Migrants have a marked decreased incidence and mortality rate in most common cancer types: lung, breast, ovary, prostate, colon, kidney and bladder cancer. [37] [62] [63] [64] [65] [66] [67]

While total cancer risk is lower in migrants as a whole, incidence varies considerably between different groups. A commonality between many European studies is the finding that some groups of migrants have much higher incidence and mortality rates for cancers associated with infectious disease. Examples of these include gastric cancer, which is associated with *Helicobacter pylori*, nasopharyngeal cancer (Epstein Barr virus (EBV)), hepatic cancer (Hepatitis B and C), Kaposi's sarcoma (HIV), cervical cancer (human papillomavirus), and some forms of lymphoma (EBV and HIV). [37] [62] [68] Migrants may experience a higher prevalence of these conditions if they occupy home and work settings that are more amenable to the spread of infectious disease.

The reduced incidence of cancer in migrants has prompted some to question if diagnoses may be reduced because of a reduced uptake of available screening programmes. Studies from the UK and Europe have shown that among certain groups of migrants, breast, cervical and colorectal cancer are diagnosed at a later stage. [69] [37] [70] [71] [72] [73]

## 5.3 Communicable illnesses

### 5.3.1 Tuberculosis

Migrants have a higher incidence of infectious diseases such as tuberculosis (TB), HIV and hepatitis B and C compared to the UK born population. [74] Since May 2012, the UK has operated a national pre-entry screening programme which selects individuals on the basis of the TB prevalence in their country of origin. Currently all individuals applying for visas of more than six months who are from 101 countries with a TB incidence rate of at least 40 per 100,000 are now pre-screened in their country of origin. [75] Visa applications from these countries are only processed once the applicant has been issued with a certificate of clearance, indicating they are free from active pulmonary TB.

The detection rate of the pre-entry TB screening programme has risen significantly from 2006 to 2015. This is thought to be due to the overall improved quality of the screening programme. [75] A 2016 study has shown that migrants screened in the programme pose a negligible risk of spreading the infection to others but are at an increased risk of acquiring TB themselves later in life. [76]

While the current process of pre-screening high risk migrant groups may be more cost effective than universal port of entry screening, it may have resulted in infected individuals arriving from countries with a TB prevalence below screening cut off. The increasing trend of TB diagnosis and antibiotic resistance among migrants is of significant concern given the lack of availability of alternative antibiotic treatment, prevalence of alternative health beliefs, and stigma surrounding the illness. [77]

### 5.3.2 HIV

In 2015, over six thousand people were diagnosed with HIV in the UK. [78] As with TB, the incidence of individuals diagnosed with HIV has fallen year on year since 2005, however the prevalence of HIV in men who have sex with men (MSM) has risen during this period. [77] The overall decline in HIV incidence may be largely due to increased disease awareness, and better availability of antiretroviral treatment and barrier contraception in high income countries.

Despite the overall fall in incidence, HIV among migrants in the UK remains considerably more common than in the general population. Data from 2001 to 2010 have shown that individuals from Sub-Saharan Africa account for three quarters of cases among migrants. [77] Those from Sub-Saharan Africa who carry HIV are also significantly more likely to be from a heterosexual background than UK born carriers of the infection and may be missed by screening programmes targeted at MSM. [79]

Despite having a higher incidence of the illness, migrants are known to have a higher incidence of delayed HIV diagnosis suggesting that more work needs to be done in raising awareness and tackling barriers to health access. [80]

### 5.3.3 Sexual health

Reporting on usage of sexual health services in London, one group found that migrants from Ascension 10<sup>3</sup> (A10) countries reported twice the number of sexual partners in the previous year in comparison to the general population and were three times more likely to have paid for sex than the general population. [81] However, A10 migrants were also more likely to report more consistent condom use and had lower reported diagnoses of sexually transmitted infections (STIs). This may indicate that while certain migrant groups in the UK engage in more risky sexual behaviour, they may be more familiar with risk prevention information and as a result have better sexual health than the general population. [81]

The sexual behaviour characteristics of recent male gay and bisexual migrants living in London may be particularly influenced by the process of migration. One study found that MSM from Central and Eastern Europe living in the UK had an increased tendency towards risky sexual activity such as unprotected sex or group sex. [82] The authors suggested that by extricating themselves from the more conservative social norms of their home societies, migrants who are MSM may allow themselves greater access to venues frequented by MSM in London. [82] This may, in turn, result in an increased tendency towards risky sexual activity. However, over time there was a reduction in sexual risk taking behaviours suggesting that recent migrants may be worth targeting in future preventative strategies. [82]

## 5.4 Women's health

*“Most of the theoretical models used in health promotion today are grounded in majority culture-based research and may not be appropriate for diverse subgroups in the population, such as new immigrant women.” Hyman and Guruge, 2002 [83]*

### 5.4.1 Obstetric and postnatal care

While there is currently only limited direct research on the quality of obstetric care for migrants in the UK, a recent large scale national study found discrepancies between maternal mortality outcomes by ethnicity. [84] Between 2009 and 2012 the maternal mortality rate was three times higher in Indian women and twice as high in Black African women in comparison with White British women. Further to this more than two thirds of women in the study who died as a result of pregnancy or childbirth did not receive the nationally recommended level of antenatal care. [84] Previous research has also indicated that the infant mortality among migrants from the Caribbean and Pakistan is around twice that of the UK born population. [23] [85]

These findings were echoed by a study investigating obstetric care in Eastern European migrants living in Scotland. [86] Almost double the proportion of women in

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<sup>3</sup> Describes the 10 countries granted ascension to the EU in 2004: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, and Slovenia.

the migrant group did not meet Scotland's antenatal booking standard of 14 weeks<sup>4</sup> in comparison to the general population. [86]

Within undocumented migrant and forced migrant groups, obstetric outcomes are likely to be considerably worse than the national average due to late booking, language difficulties, lack of clarity around entitlements, fear of being charged and a propensity toward more complex maternal health needs. [87] Doctors of the World examined the outcomes of 35 pregnant undocumented migrants, asylum seekers, and refugees, who presented at their drop-in clinic between 2013 and 2014. Only 40% of individuals had their first antenatal appointment in the first 12 weeks of pregnancy and a third of the women only began to access antenatal care after 20 weeks. Notably, among the group of 35 participants there was one reported late stillbirth and one newborn death. The national average for stillbirth and newborn deaths in 2012 was 7 deaths per 1,000. [87]

### 5.4.2 Maternal mental health

Reported rates of postnatal depression (PND) among migrant women have been shown to be similar to that of the general population. [88] [89] However, migrants as a whole are known to have higher rates of depression and other common mental health disorders suggesting that PND may currently be underdiagnosed by frontline medical staff. [90] Research into the approach of health care staff to migrant women suggests that they are not screened for mental illness as frequently as UK born women and, as a result, may not receive the same level of psychological support. [90] [91] [92] [93] The reasons behind this are multifaceted. Comparative research into postnatal depression has shown that women from many non-Western cultures are more likely to present with somatic symptoms of depression (such as back pain) which may be misdiagnosed by health care staff or over investigated. [94] Recently arrived African migrant women in London have reported that postnatal depression was particularly stigmatised both in their country of origin and within their communities in the UK. [90] [95] Within certain groups of migrants, greater somatisation of depressive symptoms may occur due to cultural stigma preventing the overt manifestation of mental illness. [90]

### 5.4.3 Cervical screening

In recent years, uptake of the NHS cervical screening programme in England has fallen slightly. It has been suggested that this may be in part because of poorer rates of uptake among the growing migrant population. [96] Understanding barriers to screening uptake is important because it may be the first significant interaction with the NHS for many younger migrant woman.

Several studies from the UK have indicated that women from Black and Asian minority ethnic (BAME) backgrounds are less inclined to take up cervical screening. [97] [98] [99] One large UK study found that 12% of women who identified as White British had not attended their cervical screening appointments in comparison to 62%

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<sup>4</sup> Current NICE guidelines recommend that antenatal care booking and blood screening should ideally take place by 10 weeks gestation with no antenatal appointments missed.

of Caribbean, 44% of African, 66% of Indian, 62% of Pakistani and 71% of Bangladeshi women. [100] The study also examined the effect of migration status on different reasons for non-attendance. Non-attendance was divided into either being disengaged or overdue. Disengaged referred to those who reported that they had never heard of the test or had not received a letter; overdue referred to those who had received a letter but not attended or who had a cervical smear more than five years previously. Migrants were more likely to not attend screening due to disengagement rather than being overdue. This finding suggests that there may be difficulties in raising awareness of screening programmes among migrants rather than migrants choosing not to be tested.

## 5.5 Mental health

### 5.5.1 Common mental health disorders

Migrants on the whole experience poorer mental health outcomes than UK born residents. [88] Most studies describe higher rates of depression among migrants than in the general population. [88] There are also considerably higher rates of post-traumatic stress disorder (PTSD) and anxiety among migrants. [88] [101]

Rates for both depression and anxiety are twice as high among refugees compared to general migrants. It is reported that nearly half of all refugees are recorded as having PTSD. [101] As well as experiencing the psychological impact of war, torture and persecution, asylum seekers and refugees may undergo unique mental health stressors following arrival to the UK which are specific to their uncertain future and poor socio-economic position. [102] Outcomes for depression and anxiety disorders among forced migrants may require a more targeted approach compared to general migrants due to these marked differences.

Two studies from the UK have noted significantly poorer mental health outcomes among Somali asylum seekers living in London compared to UK born residents. [102] [103] In one small qualitative study of Somali asylum seekers all participants reported experiencing some form of mental distress such as 'nightmares, feeling stress, anger, loneliness and anxiety'. [102]

Levels of self-reported discrimination have been shown to have an effect on the occurrence of common mental health disorders, particularly among those who have migrated more recently and individuals from Black African and Black Caribbean groups. [104] One study reported that the rates of depression or anxiety<sup>5</sup> among recent migrants were twice as high in those reporting major discrimination as in UK born individuals who also reported experiencing major discrimination. [104]

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<sup>5</sup> As defined by a score of  $\geq 12$  on the Clinical Interview Schedule – Revised (CIS-R), a validated questionnaire commonly used to aid diagnosis of common mental health disorders.

### 5.5.2 Severe and enduring mental illness

In higher income countries, clinically diagnosed psychotic disorders occur more than twice as often in migrant residents compared to non-migrant residents. [88] [105] [106] Within the UK, Black African and Caribbean migrants have been consistently found to be at a much greater risk of psychotic disorders than the general population. Black African and Caribbean migrants are almost five times more likely to suffer from a psychotic disorder than the White British population. [88] [107] [108] [107]

As well as multifactorial genetic susceptibility, these findings may be explained, in part, by the combined effects of disproportionate poverty and social exclusion, institutionalised racism in health services, implicit bias and high exposure to discrimination. [108]

A number of studies from the UK have investigated the effects of discrimination on the prevalence of severe mental health issues in ethnic minorities. Individuals from minority groups who reported high levels of discrimination against them were significantly more likely to be diagnosed with schizophrenic disorders than those exposed to lower levels of discrimination. [109]

A study found that an individual from an ethnic minority background who lives in a district with a lower density of people from the same ethnic background has a significantly increased risk of developing schizophrenia than if they were living in an area with a higher density of people from the same background. The authors found that higher exposure to racial discrimination in the less ethnically dense areas largely accounted for the observed difference between groups. [110]

### 5.5.3 Substance abuse

Alcohol and illicit drug use are important causes of morbidity and mortality globally, accounting for five million deaths worldwide in 2010. [111] In the general population, social isolation and decreased self-esteem have well established associations with increased risk-taking behaviour such as drug and alcohol abuse. However, there is some evidence to suggest a lower prevalence of substance abuse among migrant populations. [112] This may be due to protective effects of social, religious and cultural norms discouraging drug and alcohol use. [113]

However, there is considerable variation in the occurrence of substance misuse behaviour among migrant groups. One review found that the prevalence of harmful alcohol use among different migrant groups ranged from 4% to 36%, alcohol dependence between 1% and 42% and drug dependence from 1% to 20%. [112] In one London-based study of clients attending a sexual health clinic, Eastern European migrants were twice as likely to report injecting drugs compared to participants from the general population. [81]

#### 5.5.4 Suicidality

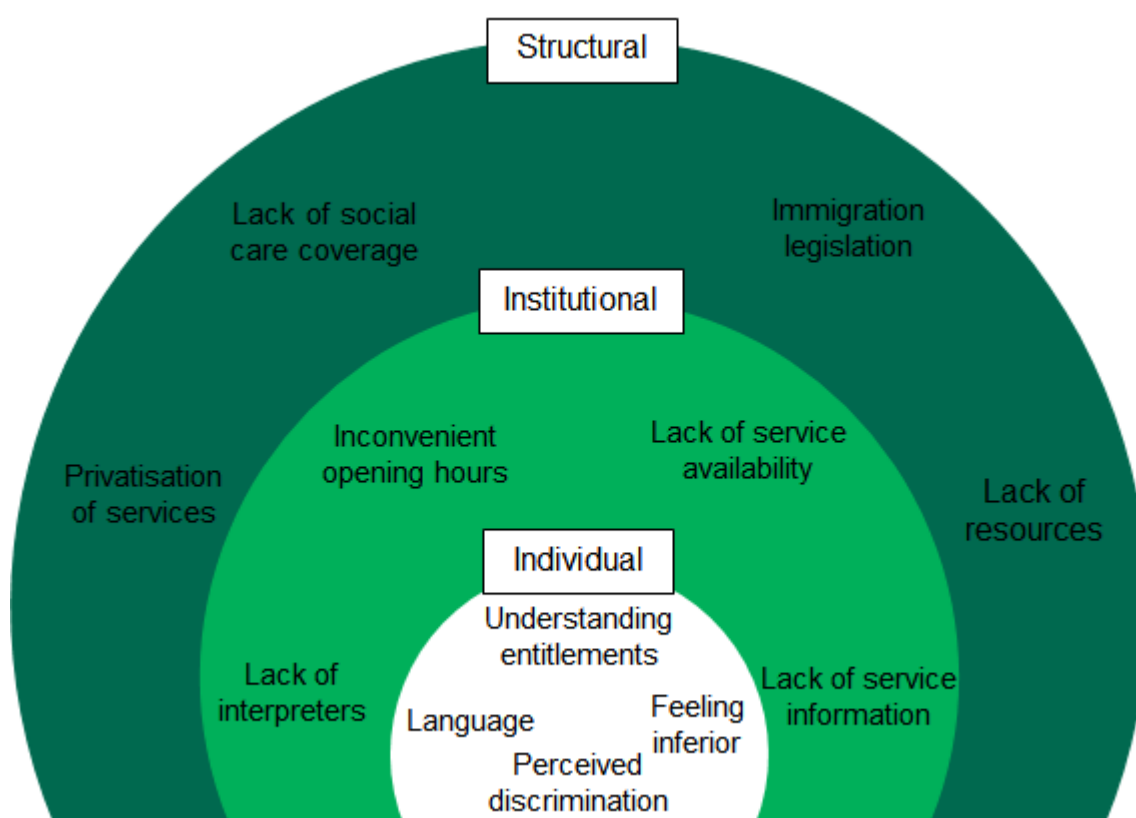
While severe mental ill-health is a significant risk factor for suicide, it is unclear if this pattern is seen in migrants. A large systematic review of several European studies showed no increased risk of suicide among migrants as a whole, however a higher risk of suicide was found in certain sub-groups of migrants. [114] Young female migrants from Turkey, East Africa and South Asia were found to be at risk groups. Initial suicide risk was strongly influenced by the suicide rate of country of origin indicating that migrants 'bring along' their suicide risk in the initial period of migration to a new country. However, the study did not examine the particular risks of asylum seekers and refugees who are known to have worse mental health outcomes. [114]



## 6 Barriers to health care access

Common barriers migrants face in accessing health care can be considered on an individual, institutional and structural level. [115] At the structural level, barriers include poverty and deprivation. For example, if migrants lack financial resources, they may not have the ability to take time off work to access care or enough money to fill a prescription. At the institutional level, the lack of translation services, accessible information, or opening hours may form a barrier to migrants accessing care. At the individual level, migrants may not understand what they are entitled to and may not have the language skills to access services. The WHO argues that 'existing health services have been developed with the needs of the majority population in mind and they may need to be adapted to provide high-quality, accessible and appropriate health services to migrants and ethnic minorities.' [23]

Figure 4: Self-reported barriers to health access by migrants



Source: Adapted from Agudelo-Suarez et al 2012 [115]

Barriers to accessing and using primary and secondary health care services in the UK are multifactorial. The NHS health care system is notably complex and vulnerable migrants may struggle to comprehend the role and scope of both primary and secondary care without proper support and advice. [116] Language barriers may impair registration with primary care services and with booking or attending appointments. In particular, migrants may have misconceptions or be misinformed by staff that they require proof of address or other documentation to register at a GP practice. [87] Several studies allude to poor comprehension among migrants

regarding the role of NHS primary care services. [117] A study of Eastern European migrants in London reported that over a third were not registered with a GP at the time of the study. There is limited large scale research on the rate at which primary care services are taken up by migrants. [81] In one study examining obstetric patients from undocumented, refugee and asylum seeker backgrounds, only one out of thirty five had registered with a GP at the point of first consultation despite the average period of residency in the UK being around four and a half years. [87] Around 40% of the participants reported previously trying to register with a GP, but being unable to do so largely because of being unable to provide appropriate paperwork. These findings are troubling given that no proof of address is required in order to register with an NHS primary care centre.

A recent large study of adult migrants registered with GPs in England found that migrants were admitted to NHS hospitals considerably less frequently than UK born residents. [118] Secondary health care utilisation by migrants may be significantly lower than that of the UK born population due to the barriers discussed in Figure 4. [118]

Mistrust of health care professionals and the health care system may also act as a barrier. In a recent local survey, 74% of individuals from the Turkish community reported that they did not feel they trusted their GP and 66% did not trust hospital care. [119] This was mirrored in the results from stakeholder interviews which will be explored later in this report.

Implicit bias refers to the unconscious attitudes or stereotypes that affect individual understanding, actions, and decisions. The role that subconscious or implicit bias plays in the relative health discrepancies seen between migrants and non-migrants has gained traction in recent years. Implicit bias tends to operate to the disadvantage of individuals who are already more vulnerable. [120] While the methodology for measuring implicit bias remains a subject of debate there have been over 30 recent studies documenting the influence of implicit bias among health care workers and its effect on health outcomes of minority groups. [120] A recent review of these studies found that health care professionals exhibit the same levels of implicit bias as the wider population and suggested that more work must be done to educate health care workers around its effects. [120]

As well as general barriers to access health care services, specific barriers exist which are unique to accessing different forms of care. These are discussed below.

## 6.1 Barriers to accessing obstetric care

Understanding the obstetric experiences of migrant women may help tackle emerging health inequalities. Migrants describe unsuccessful communication and lack of connection to health care professionals. They also report not receiving the information they need, leading to nutritional problems and diminished access to maternity services during pregnancy. [121] Feelings of stigmatisation are frequently reported alongside communication problems. In addition, several studies report migrant women and asylum seekers lacking the confidence to discuss their obstetric concerns. [121] [122] [123] Real or perceived costs of maternity care may also act as

a barrier. In a recent London-based study of pregnant migrant women from vulnerable backgrounds, the most common reason cited for non-attendance at antenatal clinics was fear of incurred cost. [87] Together these findings highlight the barriers that migrants – particularly undocumented migrants, refugees, and asylum seekers – face during pregnancy.

## 6.2 Barriers to accessing screening

Within the migrant community, barriers to accessing screening programmes for TB, breast, and cervical cancer centre around the following: [124] [41] [115] [125]

- Lack of knowledge about screening programmes
- A low perceived risk of the illness
- Fear of stigmatisation
- Language difficulties
- Embarrassment or fear of screening
- Negative past experiences with screening or the NHS
- Transport and time constraints

### 6.2.1 Cervical screening

Migrants and women from BAME groups have a reduced uptake of the cervical screening programme in the UK. Lack of awareness of the importance of screening appears to be considerably more common in women from BAME backgrounds. One study reported that women from BAME backgrounds were ten times more likely than White British women to believe that they did not need a smear test if they did not have any symptoms of cervical cancer. [124]

In a study of Polish, Slovakian and Romanian migrants living in London, decreased uptake of the service was noted in women who also reported a lack of confidence in the service. [96] Migrant participants reported doubt and confusion about the differences in the screening programmes between the UK and their own countries in regard to the age of commencing screening and the intervals of follow-up. [126] Several Polish women in the study reported that although they resided in the UK they preferred to see a gynaecologist in their home country. This may impact continuity of care over time in the UK.

Opportunities for promotion of screening may be being missed in primary care. One recent study of GP surgeries in East London showed that the majority of individuals who had not attended cervical screening had seen their GP in the previous year. [127]

### 6.2.2 Infectious disease screening

Several studies point to stigma as a significant barrier preventing migrants from accessing screening for TB and HIV. [128] Migrant participants in one qualitative London-based study unanimously agreed that they felt current infectious screening

models were not widely accessible to them. Stigma from within their own community was reported as one of the main barriers to access. However, among migrants who had used screening services, many reported that services were felt to be not 'migrant friendly' and they felt stigmatised by health care workers. [128] One approach proposed by migrant participants was a community-based package combining screening for key infectious diseases into one general health check-up. Their main reason behind this was the perception that combining services would lessen the associated stigma of being screened for particularly taboo illnesses by creating an element of ambiguity about the reasons for attendance. [128]

Lack of knowledge around infectious illnesses, particularly TB, appears to be a common feature in many migrant communities which may slow health care seeking behaviour. A lack of clarity around the cause of TB was very commonly reported. Migrants throughout the studies were largely unaware of the existence of latent TB and often attributed the cause of TB not to a bacteria but to factors such as leading an 'irresponsible' lifestyle, the weather, or excessive work or stress. [129]

### 6.3 Barriers to accessing mental health services

Mental health presents many unique barriers to health care in addition to the common barriers seen across specialities. Studies in this area tend to report challenges particularly around language fluency, stigmatisation and cultural mismatch in the understanding of mental ill health. [114]

There may be limited time in a short GP consultation for a migrant with low English fluency to adequately explain the complexities of their current emotional state. Indeed, certain emotional states may not have a direct equivalent in English, resulting in misunderstandings. [130] [131] Information provided may be in language which is too complex or technical while effective delivery of talking therapies may meet similar challenges. [132] Use of interpretation services may help to overcome some of these barriers, however, some migrants have reported a reluctance to use interpretation services due to concerns that they may be judged by the interpreter who may be a member of their community. [133] [134] [135]

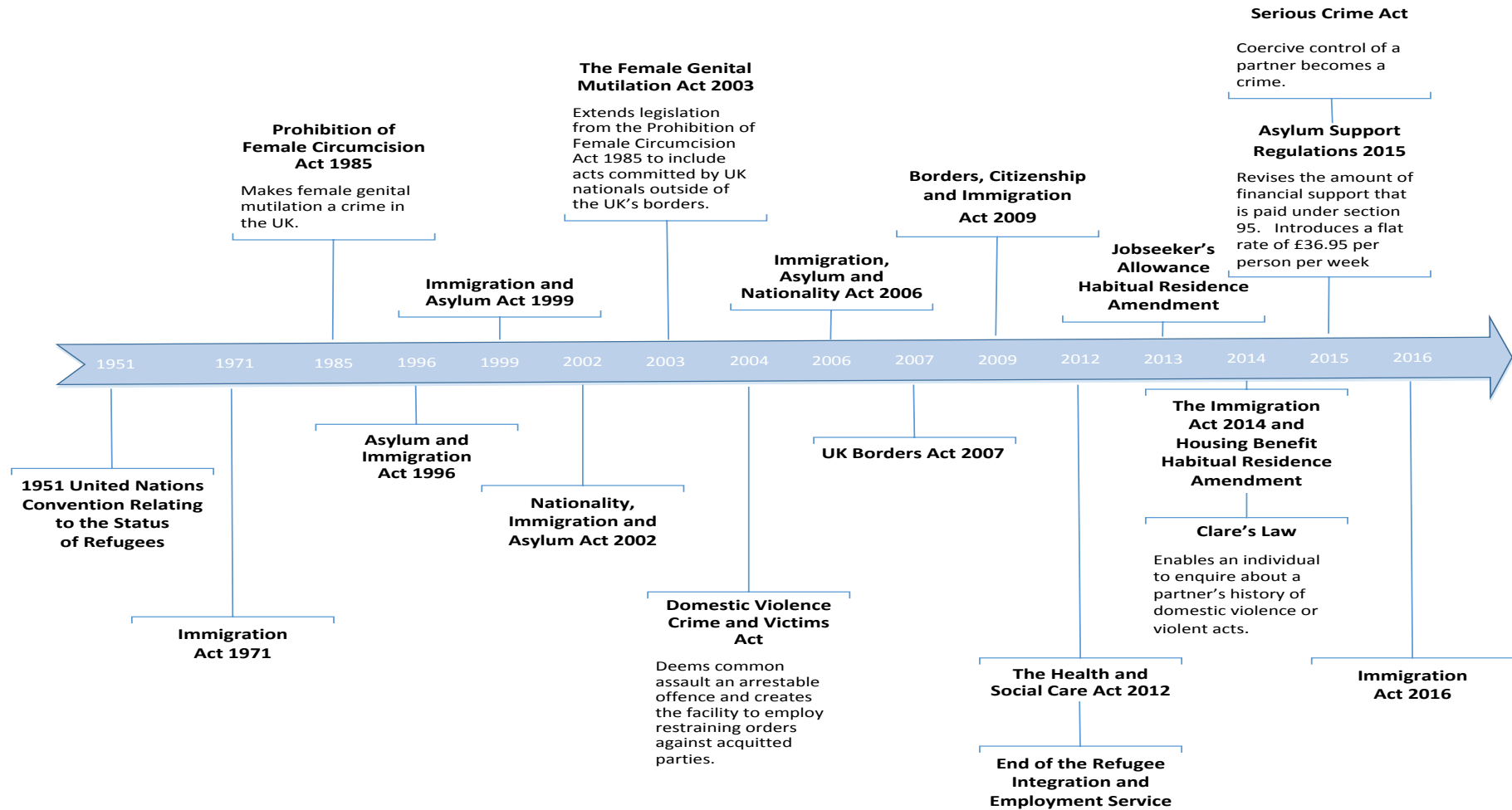
Migrants may also have different or contradictory notions about the origin and meaning of mental ill health. For instance, some Chinese migrants may understand health as a holistic state of equilibrium involving both body and mind, and as a result report having difficulty with a separate service for mental health. [114] Other migrants may regard mental ill health as a form of punishment from a higher power. [114]

Variations in social interpretations of mental illness may not only impede treatment but also diagnosis of conditions. Differing cultural understandings of mental illness may result in atypical presentation at the level of primary care, for instance, in the form of somatisation. This may go unrecognised as a symptom of declining mental health or be mistakenly over investigated. It has been suggested that the lower prevalence of postnatal depression among migrant women may be due to underdiagnosis. [136]

A large systematic review has found that among migrants as a whole, adoption of the language and cultural norms of a host country is associated with a more positive attitude around seeking psychological assistance. [114] However, Polish migrants living in the UK showed an inverse relationship between identification with British culture and willingness to seek psychological help suggesting that interaction with psychological health services may be due to more complex factors than cultural integration alone. [137] As well as acculturation, the review showed that migrants who were female, older, better educated, and of a higher socio-economic level were more likely to seek psychological help. [114]

## 7 Policy

### 7.1 Timeline of selected immigration policy



## 7.2 Immigration policy

It has been estimated that since 2010 there have been approximately 45,000 changes to immigration law. [138] Many of these modifications have sought to develop and modernise national policy regarding refugees and asylum seekers. Changes have also centred on making it more difficult for individuals without ‘legal status’ to stay in the country. This may in part be due to the difficulties and costs of locating and removing undocumented migrants. A recent report has estimated the national cost of seeking out and removing all undocumented migrants in the UK may be upwards of £1.4 billion annually. [139] Speaking in October 2013 in regards to the 2014 Immigration Act the Home Secretary said that the Government wished to: “create a really hostile environment for illegal migrants [because] what we don’t want is a situation where people think that they can come here and overstay because they’re able to access everything they need.” [140]

### 7.2.1 The European Union and European Economic Area

The EU is an economic and political union made up of 28 countries<sup>6</sup>. It operates a single market which allows the free movement of goods, capital, services and people between its members. The European Economic Area (EEA) allows European countries to enter into the EU single market. It includes all EU countries as well as Iceland, Norway, and Lichtenstein. Switzerland is not part of the EEA Agreement, but has a set of bilateral agreements with the EU allowing it to integrate with the single market. As a result Swiss residents have the same rights and privileges in the UK as EEA citizens.

On Thursday 23<sup>rd</sup> June 2016 the UK voted to leave the European Union. EU regulations currently allow EEA nationals to live freely in any EEA country, and permit them to visit and seek employment in the UK without work permits. The effect of ‘Brexit’ on immigration is currently difficult to predict. [141] Since work is the main reason for EU migration to the UK, labour migration policies are likely to change following the UK exit from the EU. [142]

The Government is likely to create new legislation determining which jobs EU workers and employers would be eligible for as well as the conditions surrounding these. One commentator has suggested in the short term, a future labour migration system is likely to allow continued migration for work in high-paid, higher skilled jobs with the greatest shift in policy among low- and middle-skilled work such as skilled trades occupations in the construction industry and relatively low-paid work in social care or hospitality. [142]

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<sup>6</sup> The EU includes Austria, Belgium, Bulgaria, Croatia, Republic of Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK.

## 7.2.2 Non-EEA migrant working visas

UK immigration policy began to take a more selective approach to immigration in 1971 when the Immigration Act of 1971 removed the automatic right of Commonwealth citizens to remain in the UK. The Immigration, Asylum and Nationality Act 2006 created the legal framework behind a tiered points system for awarding entry visas to non-EEA migrants. As of 2008, potential migrants from non-EEA countries are required to pass a scored assessment before they are given permission to enter the UK. [143] Broadly, applications for non-EEA migrants are now classed as one of four 'tiers' with several sub-tiers within each. An additional tier (Tier 3) was originally intended to be a pathway for unskilled migrants, but this was later removed. The current tiers are: [142]

- Tier 1: Visas for entrepreneurs and investors with significant business funds available to set up or invest in a UK business.
- Tier 2: Constitutes the vast majority of visa applications. This comprises skilled workers for jobs that cannot be fulfilled by UK or EEA workers, intra-company transfers, ministers of religion and sportspeople. Workers being recruited by a new employer on a Tier 2 visa must usually be taking up a graduate job meeting a minimum salary threshold. Exceptions to the higher salary threshold apply to under-26 year olds, as well as certain jobs in public sector occupations on the shortage occupation list.<sup>7</sup> Currently the UK holds reciprocal agreements with countries such as Australia, Canada and New Zealand which permit individuals who are 18-30 years of age to engage in most forms of work for up to 2 years. Tier 2 workers are eligible for indefinite leave to remain in the UK after 5 years if they have an income of at least £35,000 or are in a job that is on the shortage occupation list.
- Tier 4: Student visas at school, college, or university level.
- Tier 5: Temporary work visas for charity workers, entertainers, diplomatic staff, and sportspeople.

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<sup>7</sup> This is a list of areas of employment in the UK which are in higher demand of applicants.



*Box 2: Different forms of residency status in the UK [144]***Humanitarian protection**

Humanitarian protection is granted to a person who is deemed to have a need for protection but who does not meet the criteria for refugee status. To qualify, a person must show that there are substantial grounds for believing that if they return to their country of origin they will face a real risk of suffering serious harm.

**Discretionary leave**

Discretionary leave is granted to a person who does not qualify for refugee status or humanitarian protection but presents other accepted reasons why they need to stay in the UK temporarily.

**Indefinite leave to remain**

Indefinite leave to remain (ILR) which is also called 'permanent residence' or 'settled status' gives permission to stay in the UK without any time limit. Indefinite leave can lapse if the holder has remained outside the UK for a continuous period of 2 years.

**Limited leave to remain**

Limited leave to remain is the permission to enter the UK for a limited period defined on many visas e.g. visitor, spousal and student visas. Individuals may apply for an extension to their permit if they wish to stay longer.

**British citizenship**

British citizenship can be applied for by adults who have held ILR for 12 months and who have remained in the UK for 5 years.

**7.2.3 No recourse to public funds**

The condition of having 'no recourse to public funds' (NRPF) was stipulated in the Immigration Act of 1999. This set out that individuals who are subject to immigration control would no longer have access to most public benefits. Being subject to immigration control refers to individuals who:

- Do not have leave to enter and/or leave the UK i.e. refused asylum seekers, visa overstayers and irregular entrants
- Are from non-EEA countries and whose visa is for limited leave to enter or remain in the UK such as work permit, student and spousal visas.

Social security, tax credits or housing assistance benefits claimable in the UK:

- Income-based Jobseeker's Allowance
- Income Support
- Income-related Employment
- Support Allowance
- Pension Credit
- Housing Benefit

- Child Tax Credit and Working Tax Credit
- Universal Credit
- Child Benefit
- Social Fund payments
- Council Tax reduction
- Domestic rate relief (Northern Ireland)
- Disability Living Allowance
- Attendance Allowance
- Personal Independence Payment
- Carer's Allowance
- Allocation of local authority housing
- Local authority homelessness assistance

#### 7.2.4 Asylum seekers and refugees

In law, the UK derives its framework for conferring the status of “refugee” from the 1951 United Nations Convention Relating to the Status of Refugees. This is a multilateral UN treaty that outlines which persons are considered to hold refugee status, and explains the rights of individuals who are granted asylum (Box 3). The Refugee Convention built on Article 14 of the 1948 Universal Declaration of Human Rights, which describes the right of individuals to seek asylum from persecution in other countries. [145]

##### *Box 3: Legal definition of "refugee"*

A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. [140]

Article 31 of the Convention provides that refugees should not have any penalties imposed upon them as a consequence of illegally entering or being present in the country of refuge illegally in order to seek sanctuary, provided that they travel to the country of refuge directly from the territory where they feared persecution, present themselves to the domestic authorities without delay, and show good cause for their illegal entry or presence. [145]

In the UK, individuals are afforded the status of refugee in one of three ways. The majority are granted refugee status by progressing through the asylum process. This may take many years to complete if the initial application is rejected and subsequent appeals take place. In some cases, asylum seekers are able to make new claims for asylum or humanitarian protection if their circumstances change. For example, if the applicant has children born in the UK, new claims can be made under Article 8 of the Human Rights Act of 1998. [146]

A smaller number of individuals are granted refugee status by acceptance onto the Gateway Protection Programme and Syrian Vulnerable Person Resettlement Programme (VPR). Created in the Nationality, Immigration and Asylum Act 2002, the Gateway Protection Programme was launched in 2004 and operates in partnership with the United Nations High Commissioner for Refugees (UNHCR) being currently co-funded by the EU. [147] [148] The programme offers a legal route for a yearly quota of 750 UNHCR-identified refugees to be resettled in the UK from their home country. Refugees are assessed for eligibility under the 1951 Convention Relating to the Status of Refugees. [145] If accepted they are transferred to the UK and granted indefinite leave to remain.

The VPR is a scheme set up in 2015 which seeks to resettle 20,000 Syrian's fleeing conflict by the year 2020. Initially, resettled Syrians were given the status of 'humanitarian protection' for a period of five years, after which they could apply for indefinite leave to remain. From July 2017 all those admitted to the UK under the VPR have been conferred refugee status. Between October 2015 and December 2016, 5,454 Syrians were resettled in the UK under the VPR. [149]

However, significant reform of immigration law did not come about for a further thirty years. The Immigration and Asylum Act of 1999 sought to overhaul the UK's immigration system in several ways. First, it streamlined the asylum process to increase the rate that applications were dealt with. Second, it created legal provision to decrease the number of individuals who sought to enter or remain in the UK illegally. Third, it enabled the Government to undertake a dispersal policy for newly arriving asylum seekers. This was done to reduce the concentration of asylum claimants living and working in London and the south-east of England and led, in turn, to the creation of the National Asylum Support Service (NASS) which administers the system. [15] Finally, changes to the manner that asylum seekers and refused asylum seekers received state welfare were implemented. [15] Asylum seekers were no longer able to directly access the majority of the UK benefits system but were instead given access to a separate welfare payment detailed in Section 95 of the Act (see Box 4). Asylum seekers who have had their application refused are entitled to apply for Section 4 support (see Box 5).

#### *Box 4: Section 95 Support*

Section 95 of the Immigration and Asylum Act 1999 describes that once an asylum seeker has submitted their claim for asylum, support is provided in the form of monetary support and/or accommodation. As of August 2015, a flat rate of £36.95 per person per week is now paid rather than a tiered payment related to age and dependants. Following a refused claim, asylum support under section 95 is terminated after 28 days in individuals with no dependent children.

### Box 5: Section 4 Support

Section 4 of the Immigration and Asylum Act 1999 entitles refused asylum seekers meeting one of a number of conditions (such as inability to leave the country on health grounds) to receive a payment of £35.39 per person per week received on a pre-paid card. Small increases in Section 4 payments may be given in certain circumstances such as for pregnant females and children under the age of three. In some cases, full board accommodation may be provided in lieu of payment.

### 7.2.5 Modern slavery and human trafficking

In November 2014, the UK Government published its Modern Slavery Strategy, which outlines a cross-government approach to tackling the issue. Modern slavery includes victims of slavery, victims of servitude, victims of forced or compulsory labour and can include victims of trafficking. Trafficking in persons is defined as the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purposes of exploitation.

### 7.2.6 Working illegally

Greater checks have been applied to the eligibility criteria required of migrant workers in the UK. Currently, asylum seekers are required to wait for a period of 12 months before access to employment on the shortage occupation list is granted. The Asylum and Immigration Act 1996 made it a criminal offence for the first time to employ an individual unless they had permission to live and work in the UK. [150] A decade later the Immigration, Asylum and Nationality Act 2006 brought in on-the-spot fines of £2,000 for employers found to be hiring an employee without residency status. [143] The Immigration Act 2016 established extensive laws on working illegally: from July 2016, individuals who knowingly or negligently employ people not permitted to work may now be incarcerated for up to five years and illegal workers for a period of 51 weeks. [151]

## 7.3 Policy on migrant health

### 7.3.1 NHS charges for migrants

The Health and Social Care Act 2012 [152] and the Immigration Act 2014 further adapted how non-EEA migrants accessed NHS services by introducing the Visitor and Migrant Cost Recovery Programme. This ended free secondary care for short term visitors to the UK and implemented tracking of NHS registration. The purpose of these changes was to discourage the perceived rise of 'health tourism' and recoup

costs incurred by migrants who use the NHS without having paid into the service through taxation. [153] [154]

The services that are free at the point of access regardless of residency status include:

- Primary care
- Dental care in the community
- Treatment in accident and emergency
- Immediately necessary or urgent care in hospital
- Compulsory psychiatric treatment
- Treatment for some communicable diseases, such as HIV, tuberculosis, cholera, food poisoning, malaria, meningitis and influenza
- Diagnosis and treatment of sexually transmitted infections
- Family planning services excluding abortion and fertility
- Treatment provided to victims of violence including torture, female genital mutilation, domestic violence and sexual violence
- Treatment under a court order

From April 6 2015, a new Immigration Health Surcharge came into action under the Act. This requires all non-EEA nationals residing in Britain for more than 6 months to pay a £200 surcharge annually (£150 for students) in order to use the majority of NHS secondary health care services including secondary dental care. [153]

In 2015/2016, in its first year of implementation, the Health Surcharge generated £164 million. The government has set a yearly target of regaining £500 million in funds through the program as a whole. [154] To help to achieve this, the government has recently proposed widening the net of chargeable services to include NHS secondary care services provided outside hospitals, obtaining free prescriptions, dental care and optical vouchers. [154] From 23<sup>rd</sup> October 2017 it became a requirement for hospitals to check whether patients are eligible for free care on the NHS. It has also become mandatory for hospitals and NHS bodies to identify patients and flag up those who are chargeable so that other parts of the NHS can readily recoup costs. [155]

Currently, the act allows for free secondary health care for the following individuals:

- British citizens and residents of EEA/Switzerland who are ordinarily resident in the UK
- Nationals of other countries who have indefinite leave to remain in the UK
- Nationals of non-EEA countries with a reciprocal health agreement with the UK
- Refugees (granted asylum, humanitarian protection or temporary protection)
- Asylum seekers whose claims or appeals have not yet been determined
- Refused asylum seekers receiving either Section 4 support, Local Authority support under Section 21 of the National Assistance Act 1948 or Part 1 (care and support) of the Care Act 2014

- Looked after children by a Local Authority
- Victims of human trafficking
- Prisoners and immigration detainees

A number of individuals are not entitled to free secondary care provision. Currently, the groups that are charged for care at 1.5 times baseline costs include:

- Non-EEA/Swiss nationals with visitor visas or those with visas lasting less than 6 months
- Refused asylum seekers who are not in receipt of asylum support (unless they are receiving local authority support that started prior to 1 April 2015)
- Visa overstayers
- Illegal entrants

### 7.3.2 Information sharing

The second major policy change which may affect migrant health was implemented through the Health and Social Care Act 2012 and relates to the sharing of health information with the Home Office. Under Section 261(5) of the Act, NHS Digital may disclose information from a patient's medical record to the police or Home Office when the disclosure is made in connection with the investigation of a criminal offence or to expedite protecting the welfare of the individual. [152] In practice, this permits the Home Office to access the GP registration data (such as patient address details) of individuals whom the Home Office may want to trace such as undocumented migrants or refused asylum seekers. As the data is accessed through NHS Digital, the Home Office do not require the consent of the patient's GP.

## 7.4 Housing policy

### 7.4.1 Housing benefits and allocation

Housing benefit and allocation varies widely between migrants depending on their country of origin and residency status. EEA nationals who have resided in UK for more than five years are now subject to the 'Habitual Residence Test' to determine their eligibility for housing benefit and social housing. In general, only migrants who are in work are eligible. In comparison, non-EEA migrants with permanent residence or 'indefinite leave to remain' can apply for housing benefit and social housing, but those with temporary or 'limited leave to remain' cannot. [156]

Asylum seekers are entitled to housing provided by the Home Office while their asylum claim is processed. Asylum seeking children who are alone in the UK are housed and supported by their local authority under the care of social services. [156] For refugees, once their asylum claim has been accepted they are no longer entitled to Home Office support after 28 days but are granted the same housing and benefit rights as UK citizens. Homeless refugees are entitled to apply for social housing from the local authority in which they received accommodation as an asylum seeker. [156]

### 7.4.2 Tenancy

Several changes to legislation have been made to combat a rise in individuals without residency status accessing private lets. [153] The Immigration Act 2014 introduced penalties of £3000 per occupant for landlords who knowingly allow an individual without residency status to rent from them. The more recent Immigration Act 2016 extended this. Landlords can now be fined for not checking the residency status of their tenants, while landlords who knowingly rent premises to illegal migrants the landlord can face up to five years imprisonment. Landlords have in turn been granted powers to issue 28 day eviction notices to illegal tenants without the requirement for a court order. [151]

## 7.5 Social security and tax credits for migrants

Benefit entitlements vary considerably between various groups of migrants. Most of these differences depend on the residency status of the individual. A simplified table of current benefits is presented in Table 2 which migrants may currently access:

Table 2: Social security, tax credit and work related benefits for migrants

Residency Status	Social security and Tax Credit Entitlements	Work Related Benefits	Additional Sources of Support
<b>Refugee</b>	Entitled to claim	Entitled to claim if permitted to work	Local councils, voluntary organisations, governmental programmes (limited access)
<b>Asylum seeker</b>	Not entitled to claim	Entitled to claim if permitted to work	Can claim Section 95 asylum support.
<b>Refused Asylum seeker</b>	Not entitled to claim	Not entitled to claim	Can claim Section 4 asylum support. <sup>8</sup>
<b>EEA/Swiss National with permanent right of residence</b>	Entitled to claim	Entitled to claim if permitted to work	
<b>EEA/Swiss National without permanent right of residence</b>	Restricted entitlement <sup>9</sup>	Entitled to claim if permitted to work	
<b>Non-EEA National with Indefinite leave to remain<sup>10</sup></b>	Entitled to claim	Entitled to claim if permitted to work	
<b>Non-EEA National without Indefinite leave to remain</b>	Not entitled to claim	Entitled to claim if permitted to work	
<b>Person subject to immigration control</b>	Not entitled to claim <sup>11</sup>	Entitled to claim if permitted to work	

Source: Kennedy [156]

<sup>8</sup> Section 4 support is due to be replaced by Section 95A support in 2017/2018.

<sup>9</sup> EEA/Swiss nationals have restricted access to certain benefits and require a 'right to reside' to access. Right to reside is conferred to EEA/Swiss nationals who are in work, self-employed or students. Since 2014 individuals whose right to reside is based on being a jobseeker cannot access housing benefits or universal credit. EEA residence without permanent right of residence must also pass the Habitual Residence Test.

<sup>10</sup> Individuals whose right to remain has been awarded as a result of another person formally undertaking to maintain and accommodate them are not entitled to social security and tax benefit.

<sup>11</sup> Can claim council tax reduction, local authority housing allocation and local authority homelessness assistance.

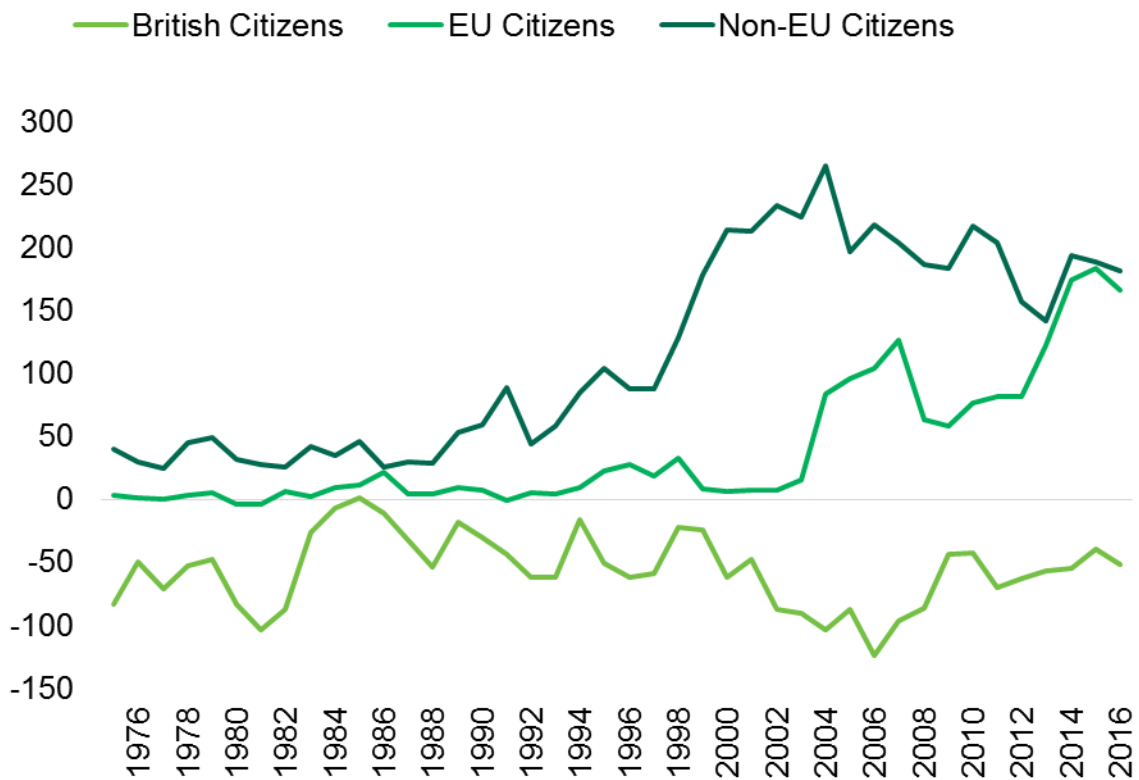


## 8 National data

In 2016, net long-term international migration was estimated by the ONS as 248,000 with 588,000 individuals coming to reside in the UK and 339,000 emigrating. Over the past four decades, annual estimates of net migration have risen substantially. [157] Net immigration to the UK peaked at 335,000 in 2015-16. However, latest estimates show that in the latter half of 2016, net immigration fell. [157]

General migrants employed in the UK currently constitute the largest share of international migrants. This is followed by those wishing to study and those accompanying or joining family. [157]

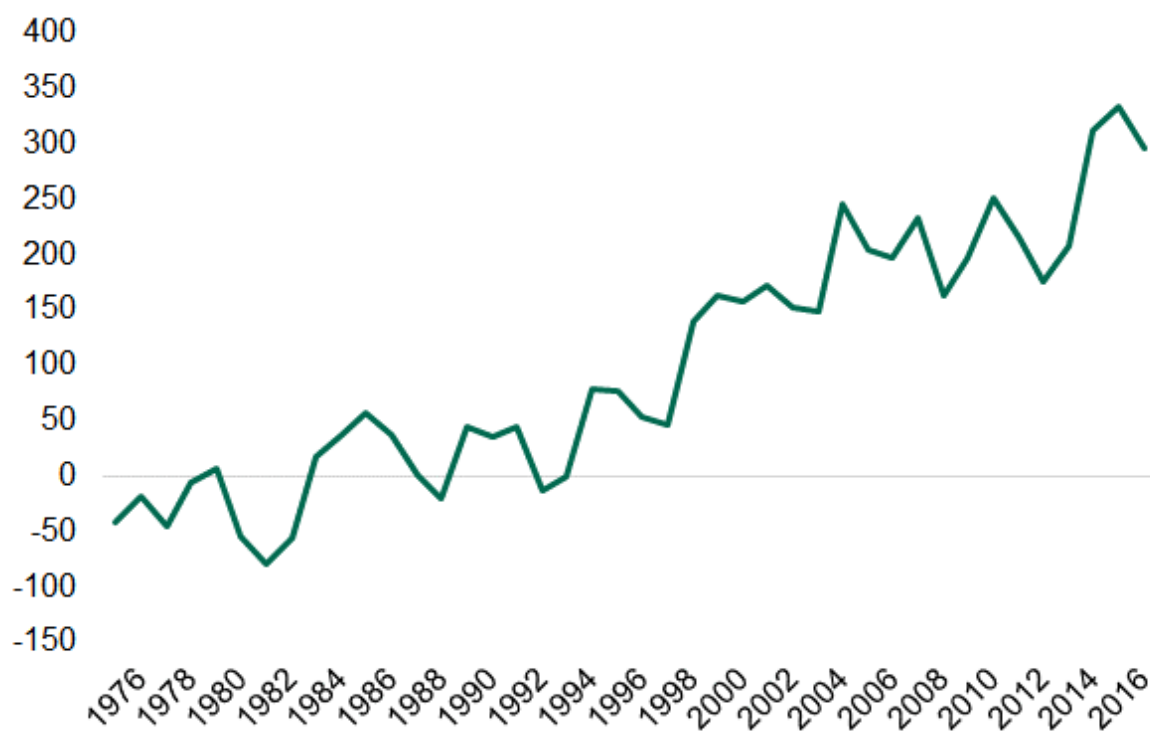
Figure 5: UK migration by citizenship, (in thousands, 1976 – 2016)



Source: ONS 2017

Note: Confidence intervals are not available.

Figure 6: UK net migration (in thousands, 1976 – 2016)



Source: ONS 2017

Note: Confidence intervals are not available.

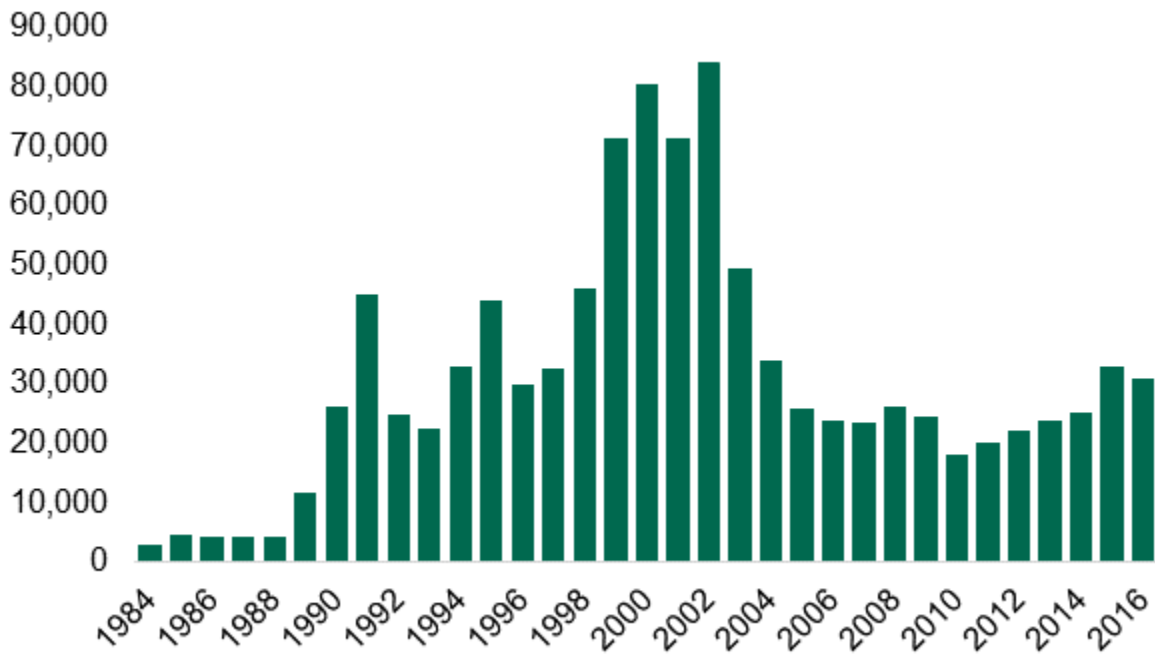
## 8.1 Forced migrants

Forced migrants make up a minority of migrants coming to the UK. In 2015, asylum seekers comprised 5.3% of migrants to the UK. In 2016-17, a total of 9,634 people were granted asylum or an alternative form of protection from 36,846 applications. [158] The overall number of asylum applications has varied considerably. Following a peak between 1999 and 2002 of around 70-80,000 asylum applications per year, the number of applications (excluding other forms of protection) has now fallen to between 20-30,000 a year. See Figure 7 for further information. [157]

In 2016, 37% of UK asylum applicants were nationals of Asian countries, 29% were nationals of Middle Eastern countries, 23% were nationals of African countries, and 7% were from Europe. [158] In 2016 individuals from Iran, Pakistan, Iraq, Afghanistan and Bangladesh made up the largest groups applying for asylum; in 2015, Eritreans were the largest group of applicants. [158]

In addition to asylum seekers who apply in the UK, resettlement schemes are also offered to those who have been referred to the Home Office by United Nations High Commissioner for Refugees (UNHCR). These include the Syrian Vulnerable Person Resettlement (SVPR) program and the Gateway Protection program. In 2016, 5,453 people were granted humanitarian protection under the SVPR scheme. [157] These individuals will be granted refugee status as of July 2017 as part of the government's plan to settle 20,000 Syrian refugees in the UK by 2020.

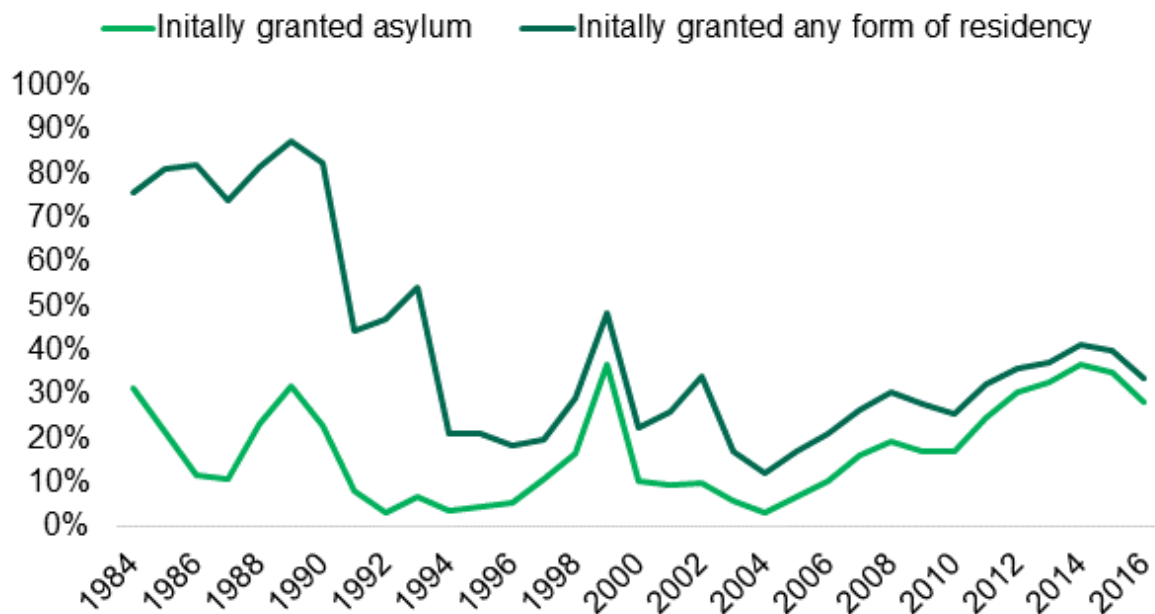
Figure 7: Number of asylum applications to the UK (1984 – 2016)



Source: ONS 2017

Note: The numbers included in the figure excludes dependents.

Figure 8: Proportion of asylum applications granted on initial request (1984 – 2016)



Source: ONS

The process of applying for asylum in the UK can take a considerable amount of time. This is because of the large number of applications received and the subsequent appeals that occur in refused cases. Though a small majority of cases are now resolved in under 6 months, at the end of 2016, the total number of pending cases received for asylum since 2006 was 24,903. [158] Rates of final outcome

acceptance of asylum applications have fluctuated since 1984. Rates of acceptance vary widely depending on country of origin. [158]

The Syrian refugee crisis has caused a marked rise in the number of asylum applications received by EU countries since 2014. In 2015, the UK had the 9<sup>th</sup> highest rate of asylum applications amongst the 28 EU member states and the 19<sup>th</sup> highest per head of the population. [159] In 2016, Germany received 476,500 requests for asylum, the majority of which were from Syrians. In comparison, the UK had 36,846 applications. [158]

## 8.2 Undocumented migrants

Determining the total number of undocumented migrants in the UK is extremely challenging given that the ONS does not routinely produce data on this. Furthermore, individuals who do not have residency status are very unlikely to disclose this information to any governmental agency given the potential personal repercussions.

In 2005 the Home Office estimated, using data from the 2001 Census, that the population of undocumented migrants in the UK was approximately 430,000 excluding children. [160] Eight years later, in 2009, the London School of Economics produced an estimate of 618,000 undocumented migrants using data from 2001 to 2007; an estimated 442,000 individuals (72%) are thought to live in London. [161] The report also suggests that 62% of undocumented migrants will have remained in the UK for at least five years. [161] In 2017, Civitas estimated that the number of undocumented migrants in the UK is likely to exceed 1.2 million.<sup>12</sup> [139] [162]

Undocumented migrants may occasionally have their immigration status regularised, meaning that they are given temporary or indefinite leave to remain in the UK. Most applications are made under Article 8 of the European Convention on Human Rights, which describes the right to a family life and a private life. [162]

## 8.3 Housing

The Migration Observatory has reported that data from the Labour Force Survey (2016) indicate that there is a marked difference in the types of accommodation that migrants occupy in comparison to UK born individuals [14]:

- Recent migrants to the UK (those in the UK for 5 years or less) overwhelmingly use the private rented sector for accommodation with close to 80% in private lets.

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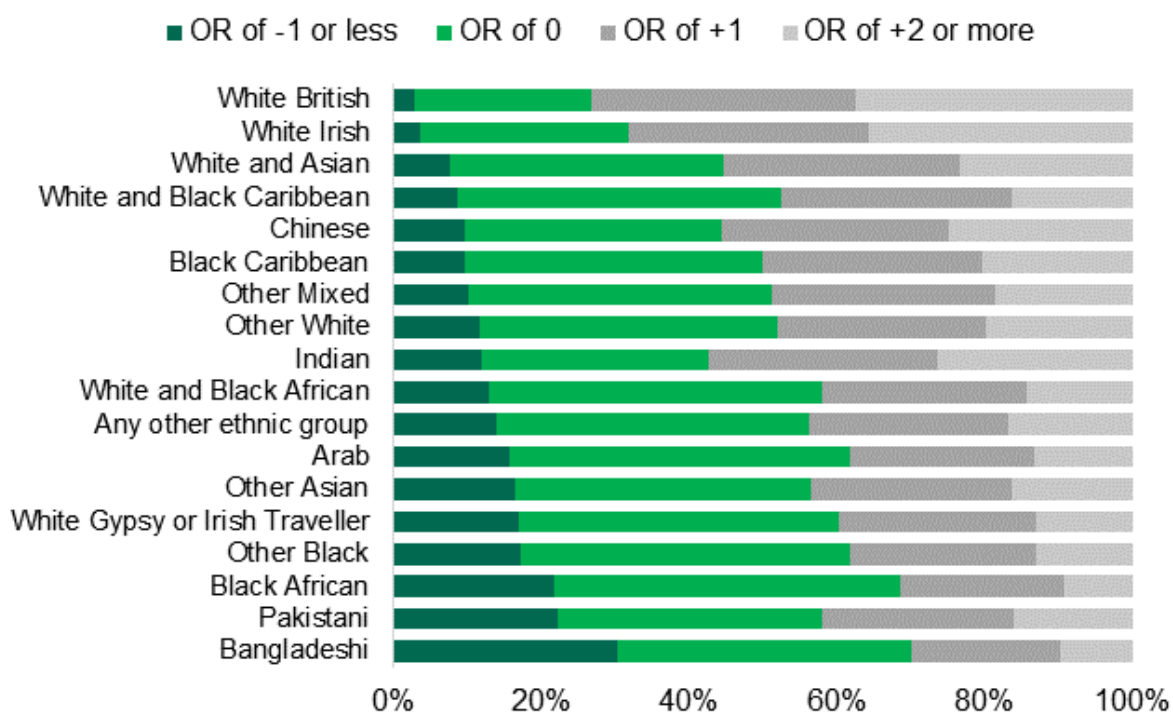
<sup>12</sup> In June 2017, a report published by Civitas, critiqued previous estimates, suggesting that they significantly underestimated the numbers of migrants who overstay their work or travel visas. The UK currently issues around 2 million visas annually to students, visitors and spouses. The report from LSE estimated that around 0.5% of those issued these visas overstayed however the Civitas reports contests that the proportion is likely to be considerably higher. [146]

- Within London, 44% of all migrants rented in comparison to 17% of UK born residents.
- 26% of migrants lived in social housing in London in comparison to 22% of the UK born population. These figures are 17% and 18% respectively for the UK as a whole.
- Only 34% of migrants in London owned their own homes, in contrast with 57% of UK born residents. In the UK, 46% of migrants owned their own homes compared to 69% of UK born residents.

One study has indicated that up to 15% of households in London are overcrowded, considerably higher than the rest of the UK where rates are between 3-6%. [5] While there is limited national evidence surrounding first generation migrants, overcrowding has been noted to be most severe among Pakistani, Bangladeshi and Black African communities. [163] [164]

The 2011 Census recorded that 30% of UK households with a Household Reference Person (HRP) from the Bangladeshi ethnic group were overcrowded, followed by 22% from the Pakistani ethnic group, and 22% from the Black African ethnic group.

Figure 9: Household occupancy rate (OR) by ethnicity (2011)



Source: Census 2011

Note: Occupancy rates (OR) describe the number of free bedrooms per household where -1 indicates that a household has at least one bedroom too few for the number of people in the household. -1 or less is considered overcrowded by the bedroom standard.

## 8.4 Employment

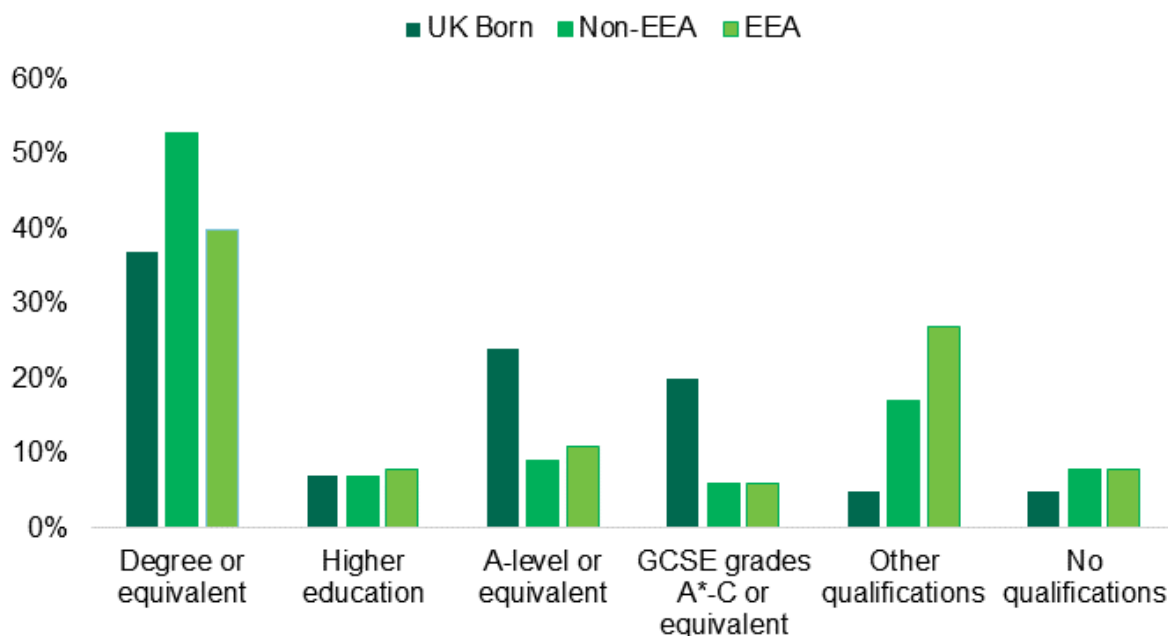
Employment characteristics in UK migrants have been shown to vary according to their region of origin. Young European Economic Area (EEA) born migrants have higher employment rates (86%) but a smaller proportion of high-skilled workers (26%) than UK born residents. In contrast, young non-EEA born migrants are less likely to be in employment (69%), but a higher proportion are in high-skilled jobs. [21]

## 8.5 Education

Around eight out of ten recent migrants to the UK are under the age of 35. [21] According to data from the Labour Force Survey (2015), among individuals aged 25-35 years, migrants are more likely to have attained a degree or equivalent qualification than UK born individuals. [21]

In 2015, 53% of non-EEA and 40% of EEA migrants aged 25-35 years were recorded as having attained a degree compared to 37% of the UK born population. [21] While young migrant residents may have a larger proportion of higher educational achievement, they also have a larger proportion with no qualifications (8%) or hold other types of qualifications (17% of non EEA and 27% of EEA hold qualifications which may not be recognised in the UK). 5% of the UK born group do not hold any qualifications. [21]

Figure 10: Highest qualification received by place of birth (aged 25-35, 2015)



Source: Labour Force Survey 2015

## 9 Local data

In 2015, the Annual Population Survey (APS) estimated the rate of non-UK born residents in the Borough of Hackney to be 358.2 per 1,000 resident population, or approximately 96,000 residents. The Census (2011) found that 96,240 Hackney residents (39% of total residents) were born outside of the UK. Unlike Hackney, the APS does not provide equivalent estimates for the City of London however the Census (2011) found that 2,705 City of London residents (37% of total residents) were born outside the UK.

In 2015, the Office of National Statistics estimated the long-term international inflow of Hackney residents to be 22.6 per 1,000 population. In the City of London, the rate is estimated to be 93.0 per 1,000. This indicator refers to those intending to reside in the UK for at least 12 months. In 2014, the Office of National Statistics estimated the short-term international inflow of Hackney residents to be 6.3 per 1,000 population. In the City of London, the rate is estimated to be 26.0 per 1,000. This indicator refers to those intending to reside in the UK for 3-12 months.

As of 2017, Hackney received 19 refugees and the City of London received 7 refugees as part of the Syrian Vulnerable Person Resettlement Program. There were 51 asylum seekers in Hackney and 0 asylum seekers in the City of London in receipt of Section 95 support at the end of 2016. [157] Please see Box 4 for further information on Section 95 support.

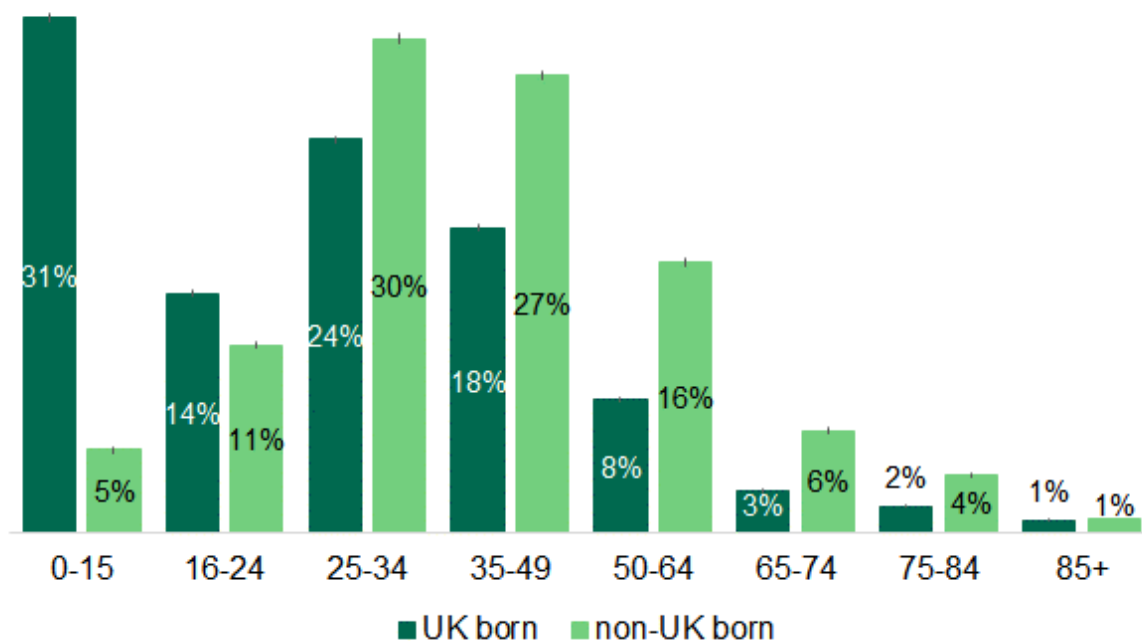
### 9.1 Inequalities

#### 9.1.1 Age

Only 5% of non-UK born Hackney residents were aged 15 and under, compared to 31% of UK born Hackney residents. The non-UK born population was more likely to be of working age: 30% were aged 25-34 and 27% were aged 35-49 compared to 24% and 18% of the UK born population, respectively.

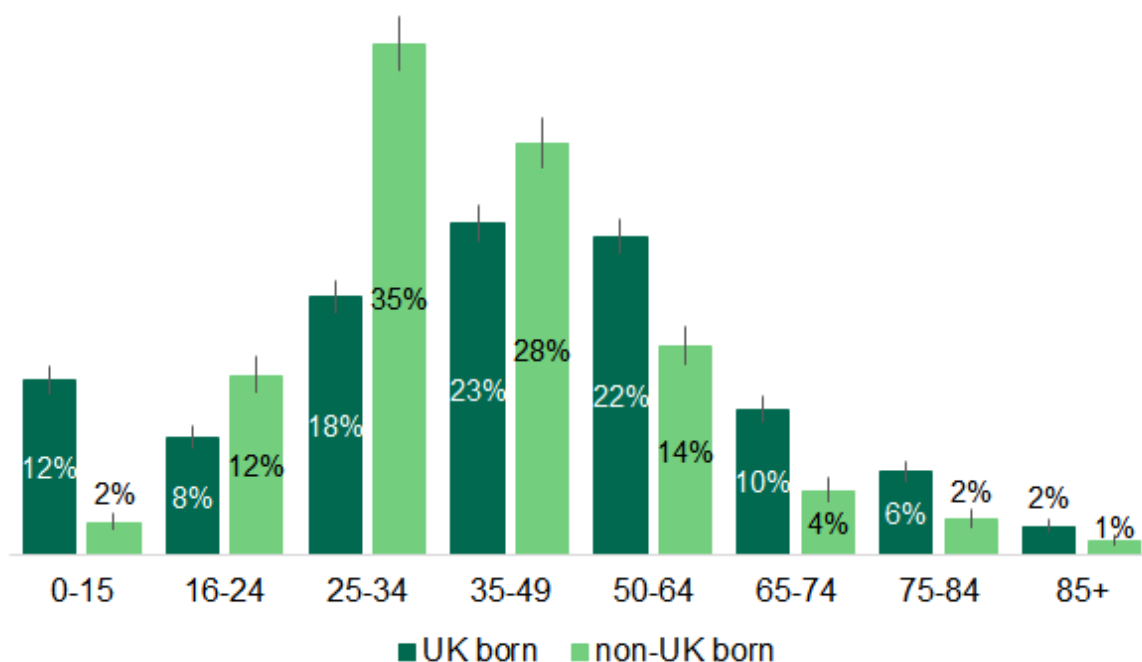
In the City of London, the non-UK born population were more likely to be younger working age while the UK born population were more likely to be older working age.

Figure 11: Percentage of UK and non-born Hackney residents, by age (2011)



Source: Census 2011

Figure 12: Percentage of UK and non-born City of London residents, by age (2011)



Source: Census 2011

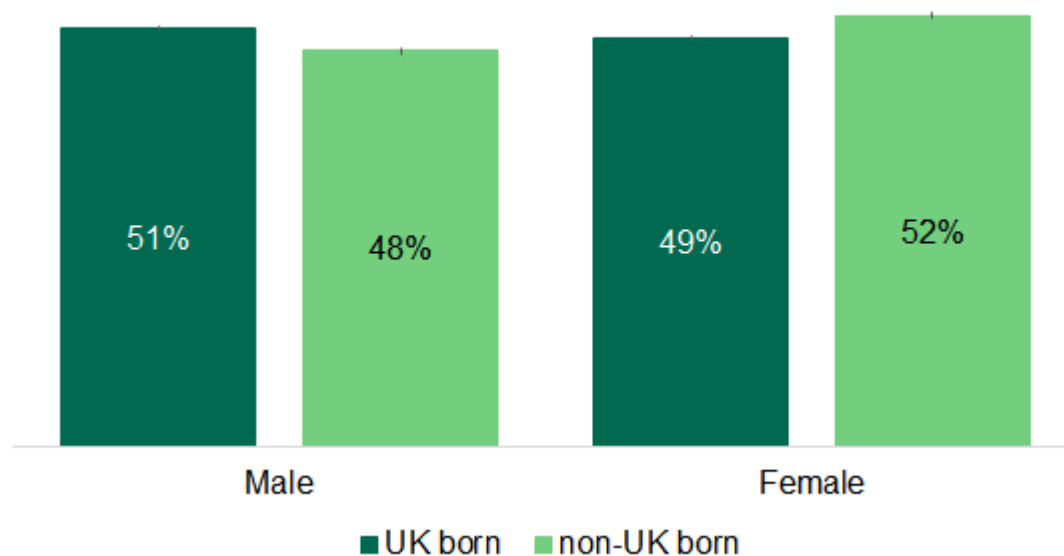


### 9.1.2 Gender

The non-UK born Hackney population has a higher percentage of female residents (52% compared to 49% of UK born residents). In 2011, there were over 4000 more female non-UK born residents than male non-UK born residents (50,153 vs. 46,087).

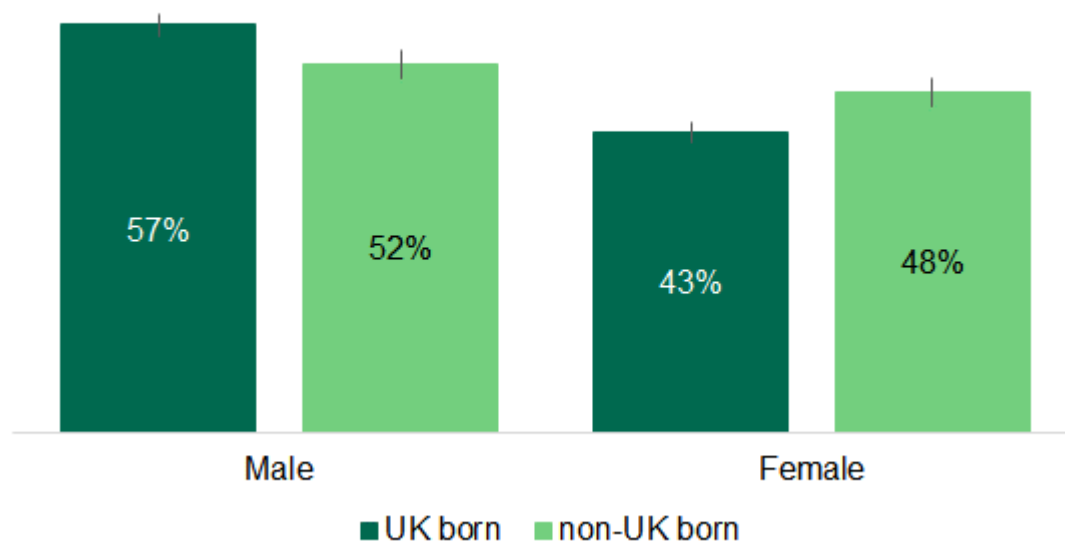
In the City of London, there is a higher percentage of male UK born residents compared to male non-UK born residents, but there is a higher percentage of non-UK born female residents compared to UK born female residents.

Figure 13: Percentage of UK and non-born Hackney residents, by gender (2011)



Source: Census 2011

Figure 14: Percentage of UK and non-born City of London residents, by gender (2011)



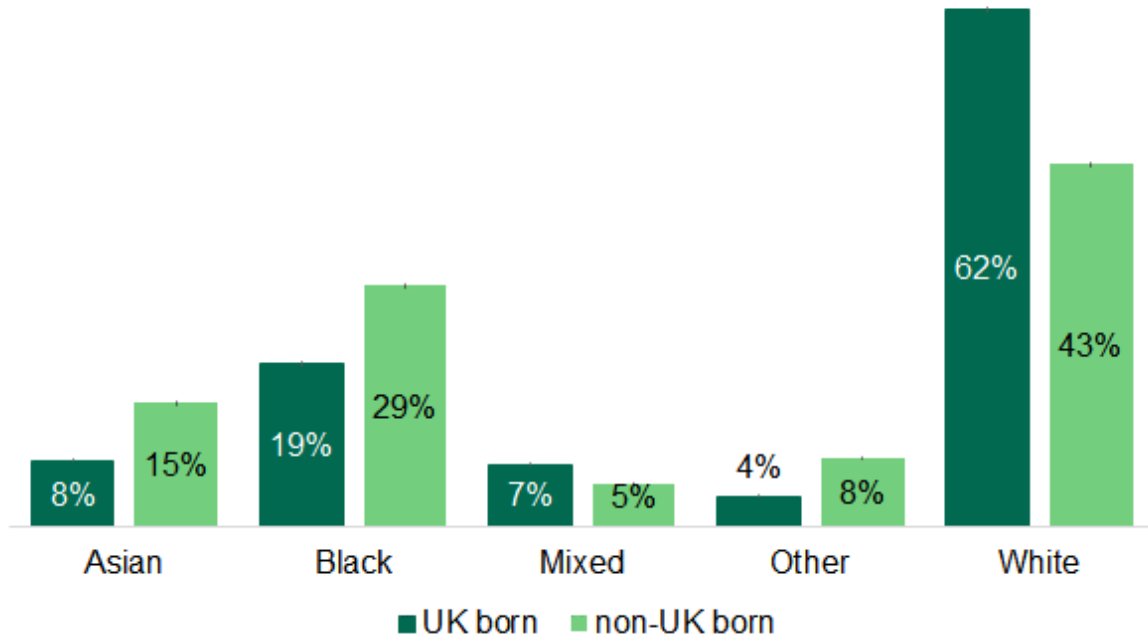
Source: Census 2011

### 9.1.3 Ethnicity

In the non-UK born Hackney population, residents are more likely to identify as Asian, Black or Other ethnicity compared to the UK born population. The UK born population are more likely to identify as White or Mixed ethnicity than the non-UK born population.

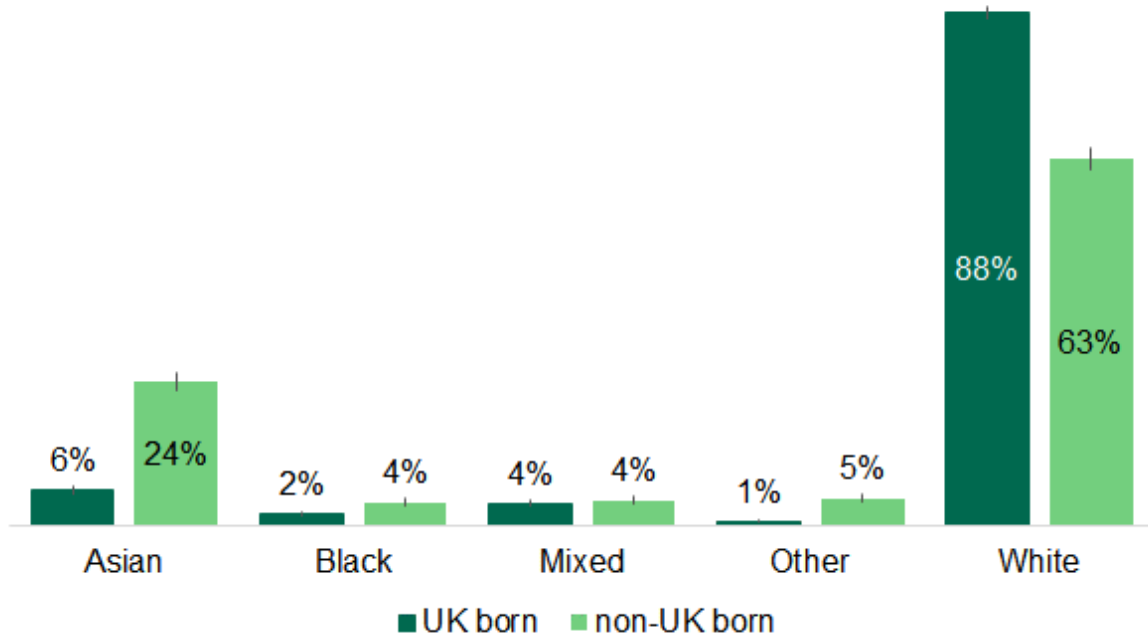
In the City of London, non-UK born residents are more likely to identify as Asian whereas UK born residents are more likely to identify as White.

Figure 15: Percentage of UK and non-born Hackney residents, by ethnicity (2011)



Source: Census 2011

Figure 16: Percentage of UK and non-born City of London residents, by ethnicity (2011)

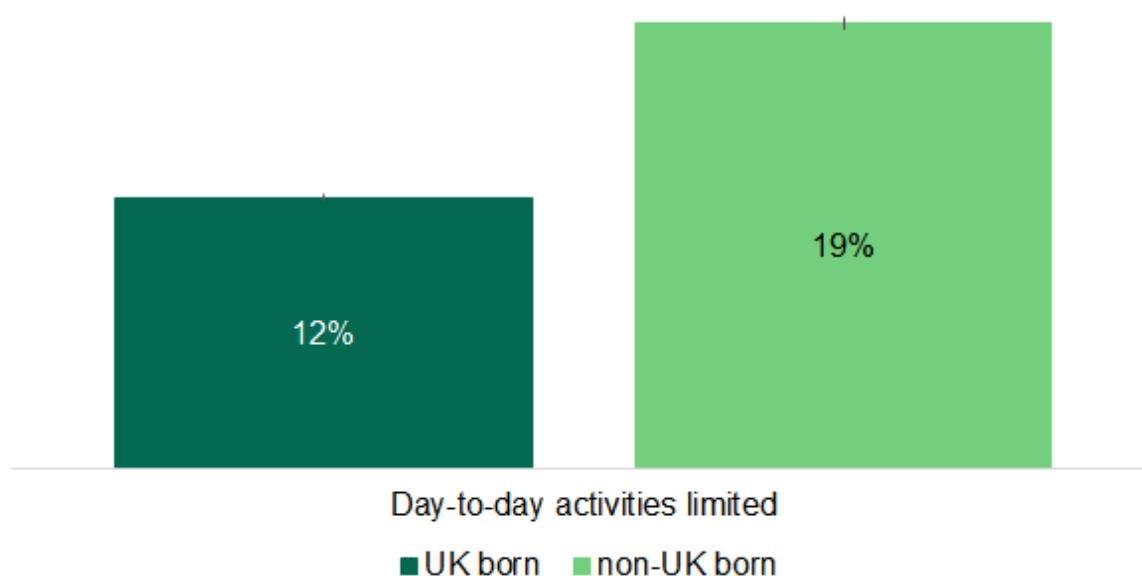


Source: Census 2011

### 9.1.4 Disability

Migrants in Hackney are significantly more likely to report having a disability than non-migrant residents. 19% of non-UK born Hackney residents reported that they had a long-term health problem or disability to the point that their day-to-day activities were limited compared to 12% of UK born Hackney residents. [29]

Figure 17: Percentage of UK and non-born Hackney residents, by disability (2011)



Source: Census 2011

### 9.1.5 Sexuality

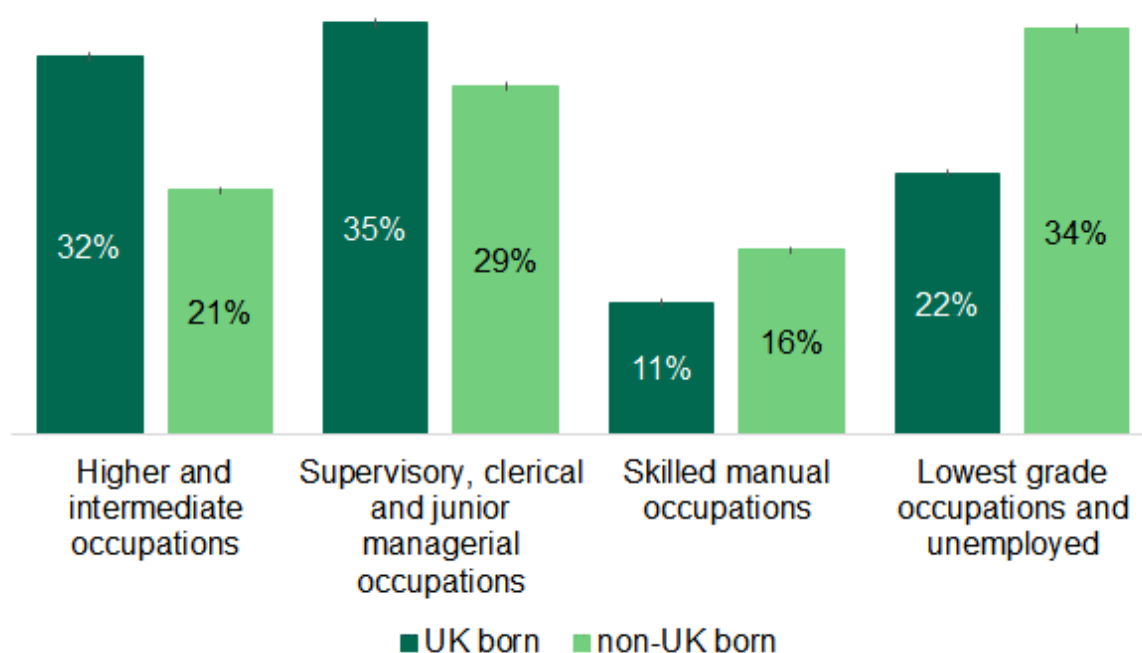
PHE estimates 8.5% of Hackney and the City's population are lesbian, gay or bisexual (LGB). [165] Figures for UK born and non-UK born are not available.

### 9.1.6 Socio-economic disadvantage

Non-UK born Hackney residents are less likely than UK born Hackney residents to be in higher and intermediate occupations (21% vs 32%) as well as supervisory, clerical and junior managerial occupations (29% vs 35%). Non-UK born Hackney residents are more likely than UK born residents to be in skilled manual occupations (16% vs 11%) and the lowest grade occupations/unemployment (34% vs 22%).

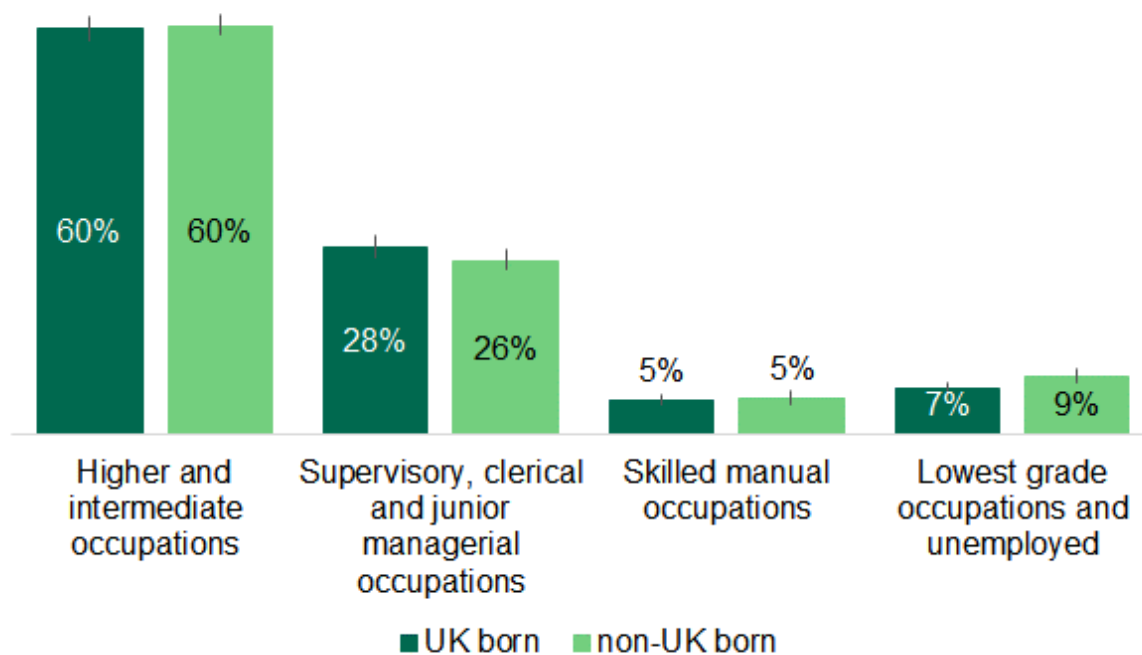
In the City of London, UK born and non-UK born residents are equally represented across higher and intermediate occupations and skilled manual occupations.

Figure 18: Percentage of UK and non-born Hackney residents, by social grade (aged 16-64; 2011)



Source: Census 2011

Figure 19: Percentage of UK and non-born City of London residents, by social grade (aged 16-64; 2011)

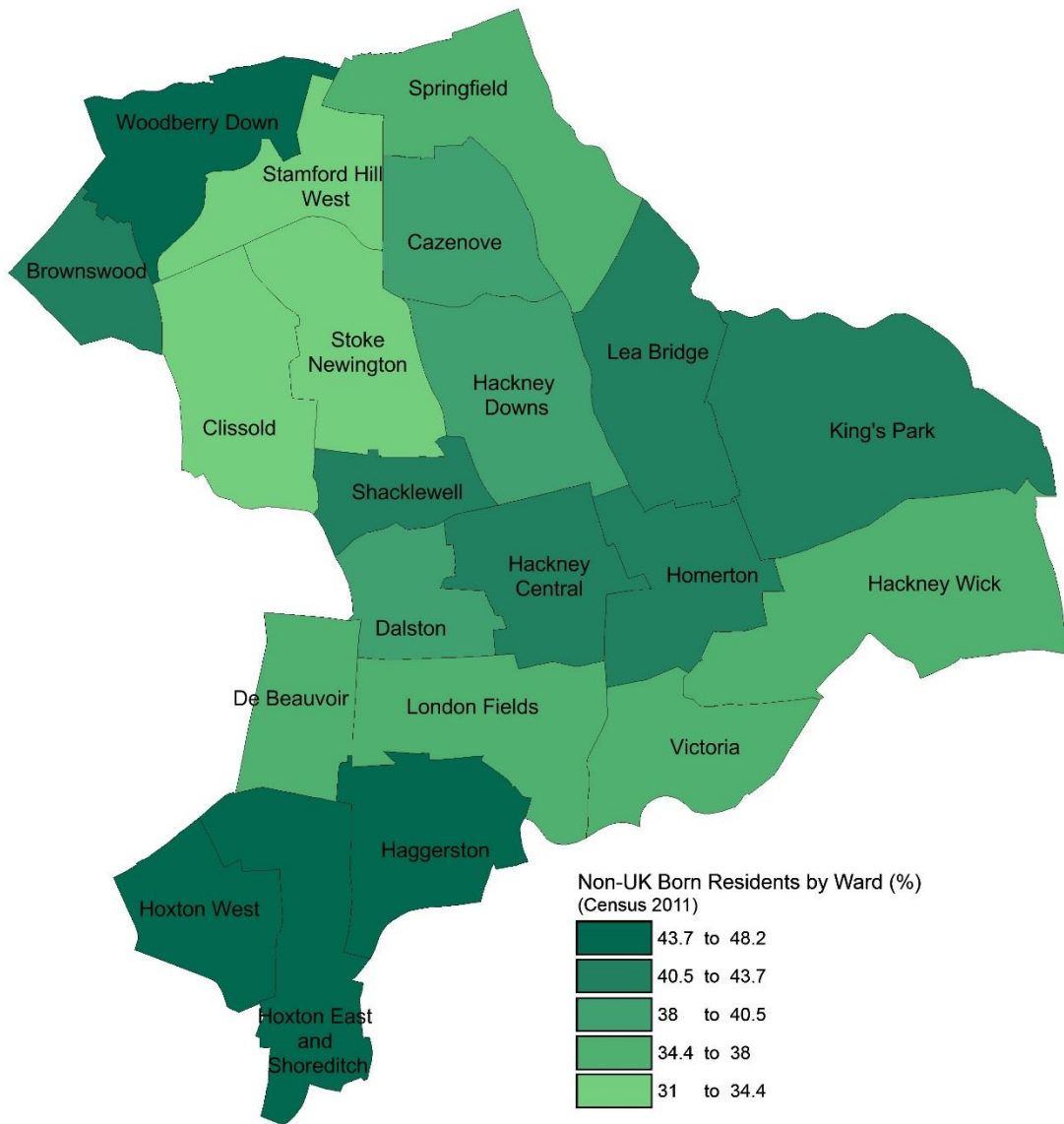


Source: Census 2011

### 9.1.7 Location within Hackney

There is a moderate degree of variation in the density of migrants in Hackney. The Woodberry Down ward has the highest proportion of non-UK born residents while the Stamford Hill West ward has the lowest proportion of non-UK born residents.

Figure 20: Percentage of UK and non-born Hackney residents, by ward (2011)



Source: Census 2011

## 9.2 Comparisons with other areas and over time

Table 3 compares the annual estimated rates of the non-UK born population per 1,000 resident population in Hackney. There are no statistically significant differences year on year.

*Table 3: Estimated rate of non-UK born per 1,000 resident population*

Local Authority	2011	2012	2013	2014	2015
Hackney	386.2	378.5	390.6	383.1	358.2

Source: Annual Population Survey (APS)

Notes: The APS does not provide equivalent estimates for the City of London. These are modelled estimates based on national survey data therefore results should be interpreted with caution.

Table 4 compares the estimated rates of long-term international migration inflow per 1,000 resident population in Hackney and the City of London by year. Since 2012, there has been an increase in the inflow of international long-term migration to Hackney, however, as these are modelled estimates presented without confidence intervals, changes in rates should be interpreted with caution.

Changes in the rate of long-term international inflow in the City of London is based on small numbers and does not represent significant changes year on year.

*Table 4: Estimated rate of long-term international inflow per 1,000 resident population*

Local Authority	2011	2012	2013	2014	2015
Hackney	18.4	17.9	18.9	20.1	22.6
City of London	121.3	91.8	81.6	86.5	93.0

Source: Annual Population Survey (APS)

Notes: Confidence intervals are not available for this data. These are modelled estimates based on national survey data therefore results should be interpreted with caution.

Table 5 compares the estimated rates of short-term international migration inflow per 1,000 resident population in Hackney and the City of London by year.

*Table 5: Estimated rate of short-term international inflow per 1,000 resident population*

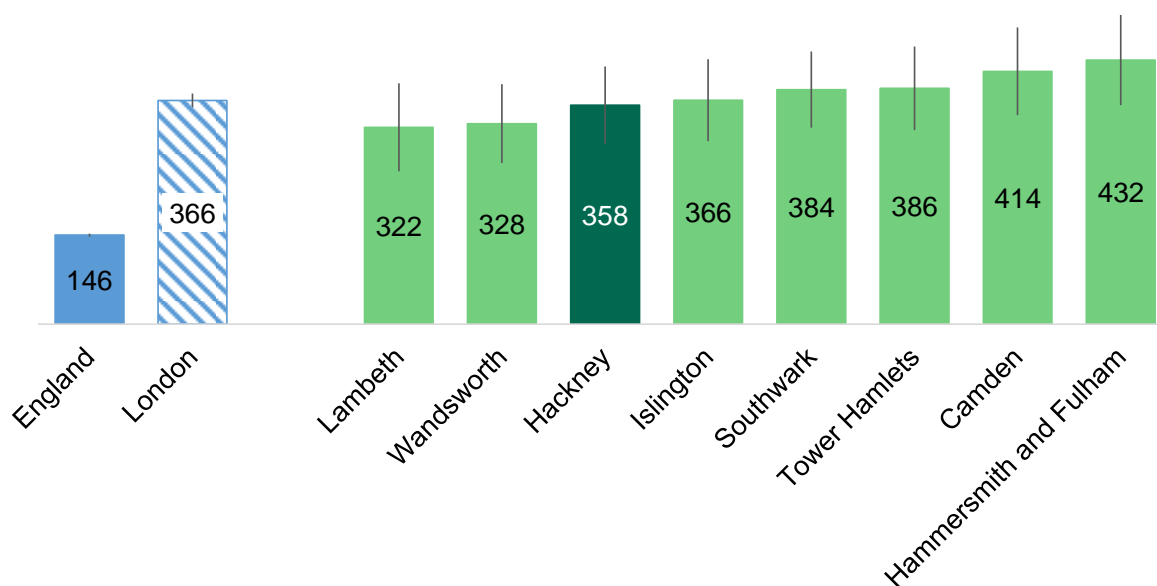
Local Authority	2011	2012	2013	2014
Hackney	3.6	3.8	4.6	6.3
City of London	20.9	23.7	16.0	26.0

Source: Annual Population Survey (APS)

Notes: Confidence intervals are not available for this data. These are modelled estimates based on national survey data therefore results should be interpreted with caution.

Figure 21 compares the estimated rates of non-UK born residents per 1,000 resident population. There is no statistically significant difference between Hackney and the local authority comparison group. London has significantly higher rates of non-UK born residents compared to England.

Figure 21: Estimated rate of non-UK born per 1,000 resident population (2015)

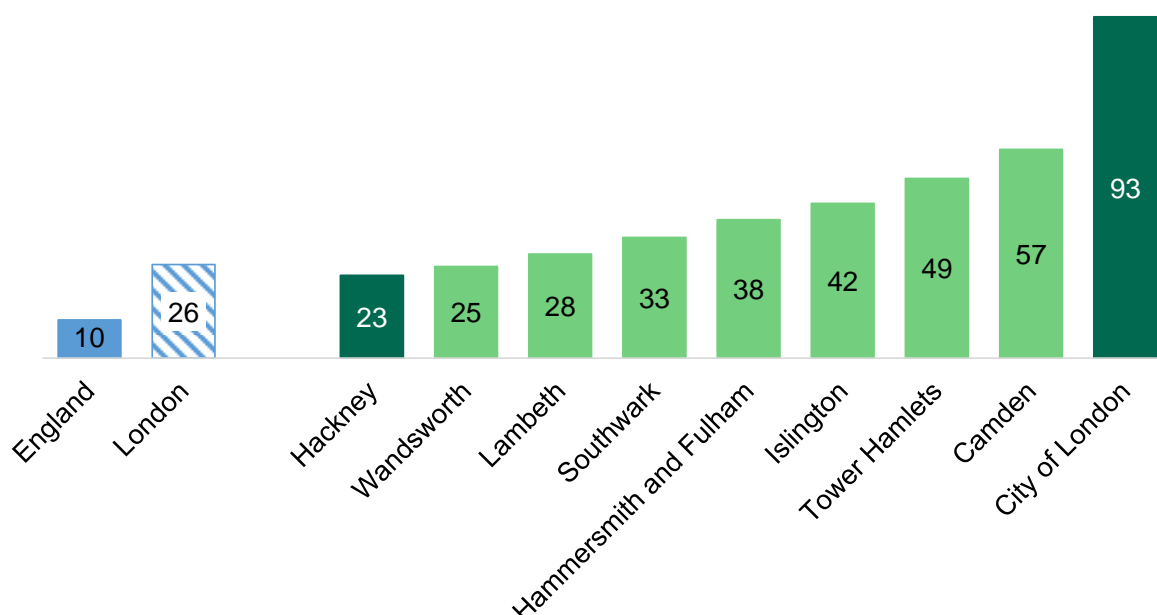


Source: Annual Population Survey (APS) 2015

Note: Data not available for the City of London

Figure 22 compares the estimated rates of long-term international migration inflow per 1,000 resident population.

Figure 22: Estimated rate of long-term international inflow per 1,000 resident population (2015)



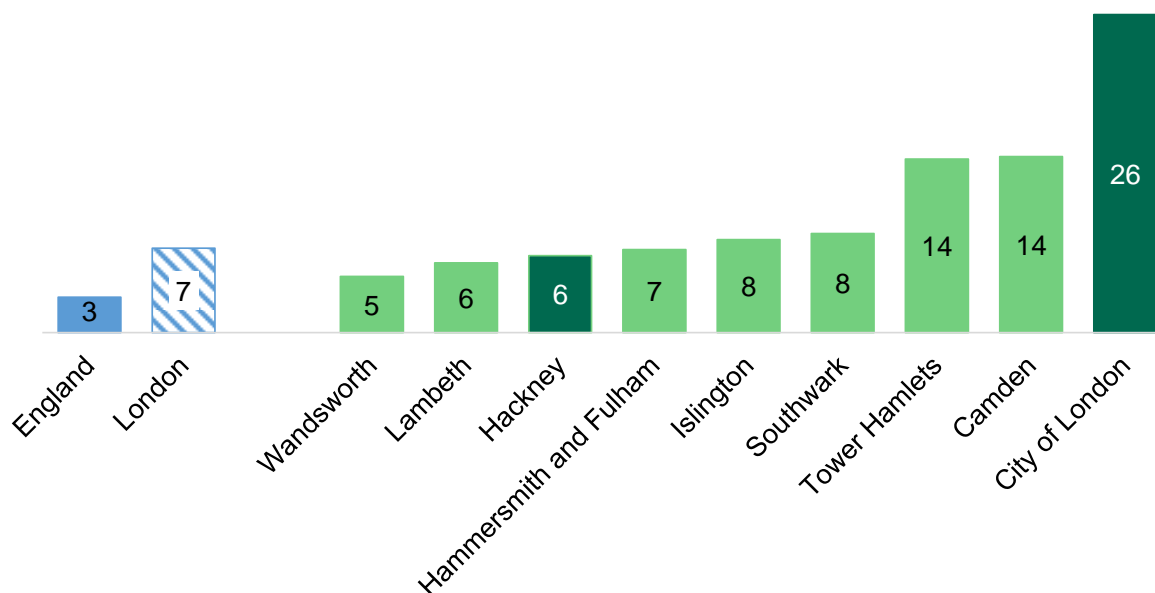
Source: Annual Population Survey (APS) 2015

Note: Confidence intervals are not available for this data. These are modelled estimates based on national survey data therefore results should be interpreted with caution.



Figure 23 compares the estimated rates of short-term international migration inflow per 1,000 resident population.

Figure 23: Estimated rate of short-term international inflow per 1,000 resident population (2014)



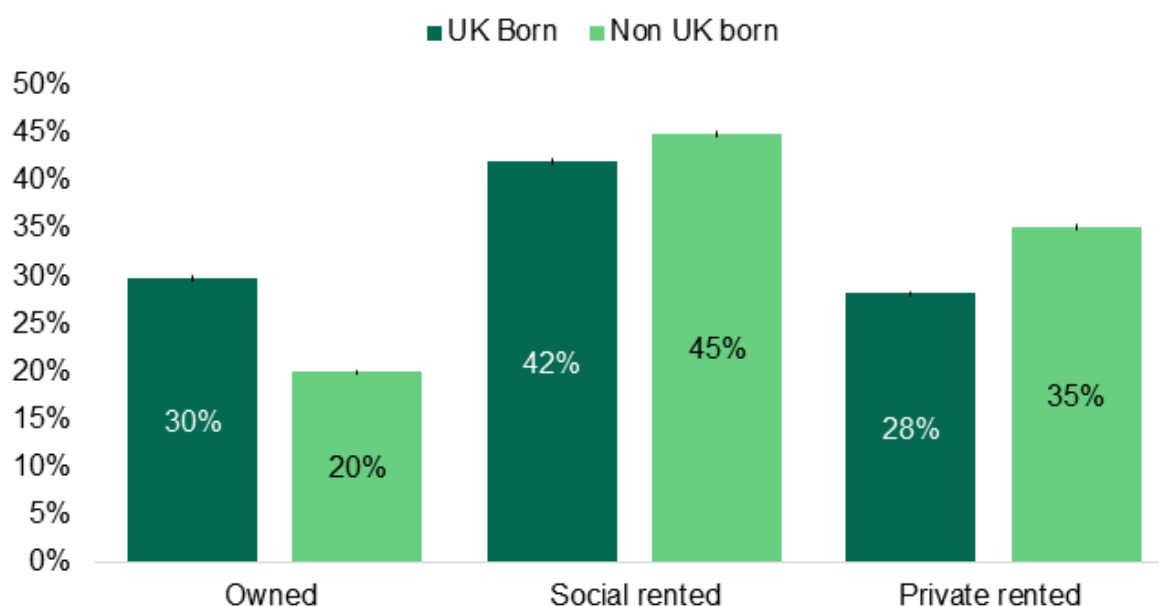
Source: Annual Population Survey (APS) 2014

Note: Confidence intervals are not available for this data. These are modelled estimates based on national survey data therefore results should be interpreted with caution.

## 9.3 Housing

Comparing the local housing data alongside the London and UK wide findings shows that a considerably higher proportion of Hackney's migrant residents occupy social housing than that of London as a whole (45% vs 26%). [14] (Figure 24). A substantially lower proportion of Hackney's migrant population owns their own property in comparison to the London wide average for migrants (20% vs 34%).

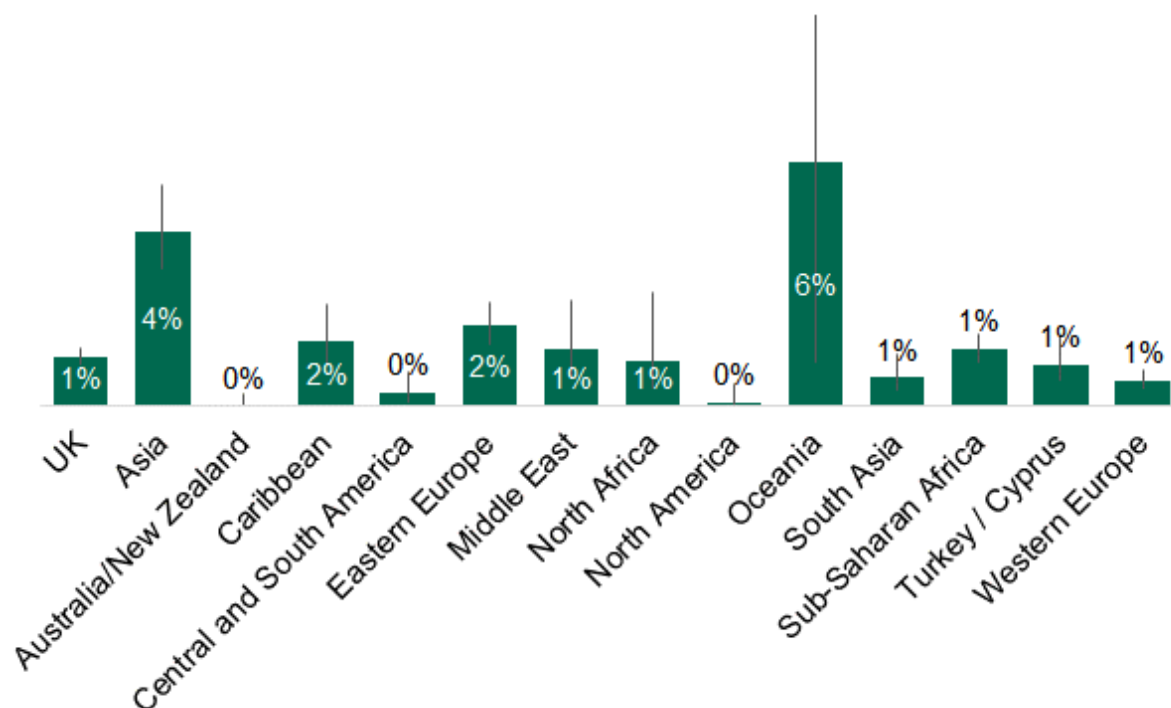
Figure 24: Tenure in Hackney, by migration status (2011)



Source: Census 2011

Homelessness includes both individuals who are rough sleeping and those of no fixed abode. GP recorded measures of homelessness showed an equal occurrence in both UK born and non-UK born individuals. However, when broken down by country of origin, Eastern European (2%) and Asian (4%) migrants had higher recorded prevalence of homelessness (Figure 25).

Figure 25: Prevalence of homelessness in City and Hackney patients by country of birth (aged 20+, 2017)



Source: GP patient data, Clinical Effectiveness Group

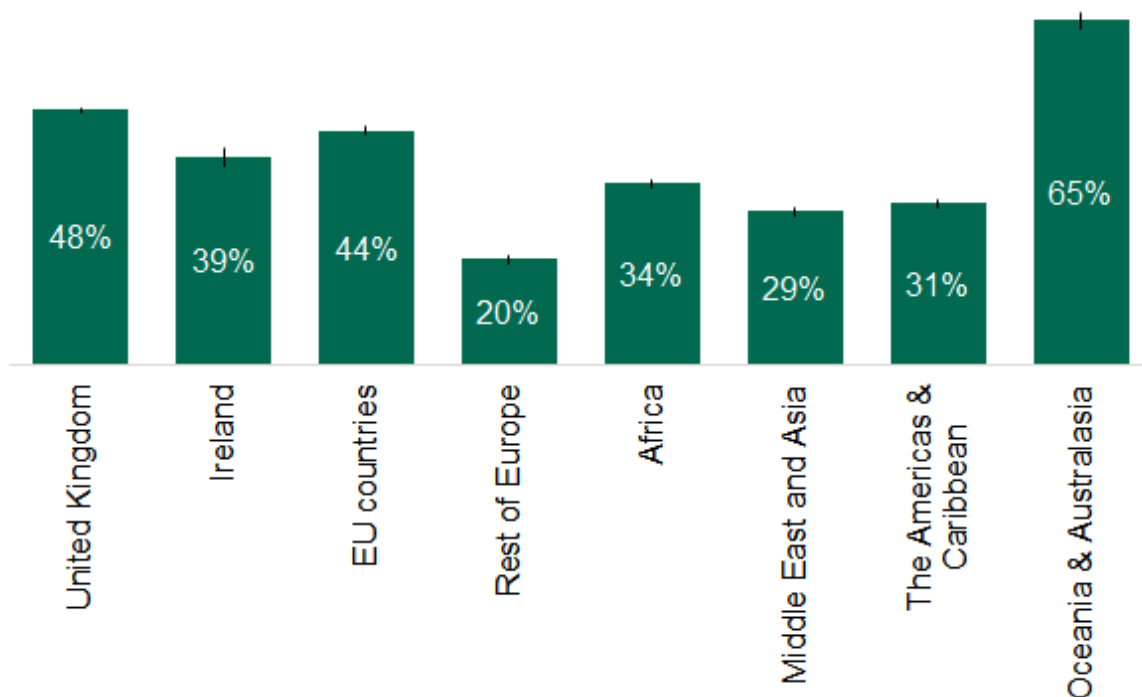
Note: Data on homelessness is not routinely recorded in primary care therefore estimates should be interpreted with caution.

## 9.4 Education

In Hackney, those from the EU and Australasia had higher levels of degree level education compared to those born in the UK. 16% of those born in the UK had no qualifications, compared to 34% of those born in Ireland, 33% of residents born in the Middle East and Asia, 27% of residents born in the Americas and the Caribbean and 43% of those born in European countries that are not EU member states.

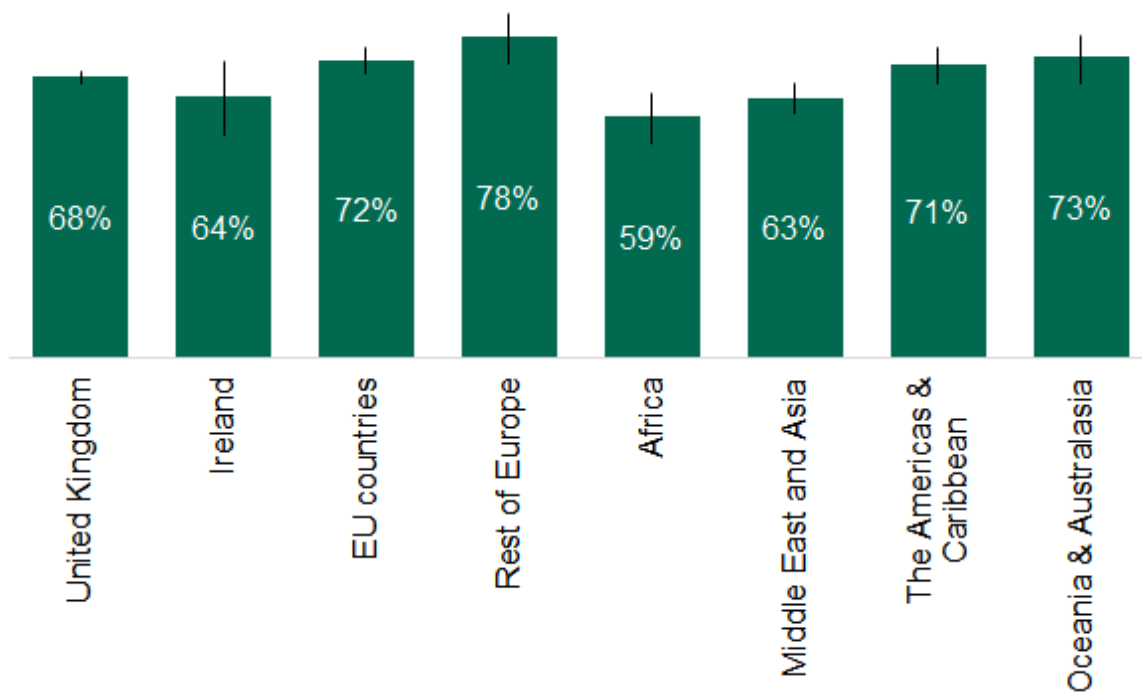
City of London residents have a higher proportion of degree level qualifications across all groups compared to Hackney (Figure 27).

Figure 26: Degree level education for Hackney residents by place of birth (aged 16-64 years, 2011)



Source: Census 2011

Figure 27: Degree level education for City of London residents by place of birth (aged 16-64 years, 2011)



Source: Census 2011

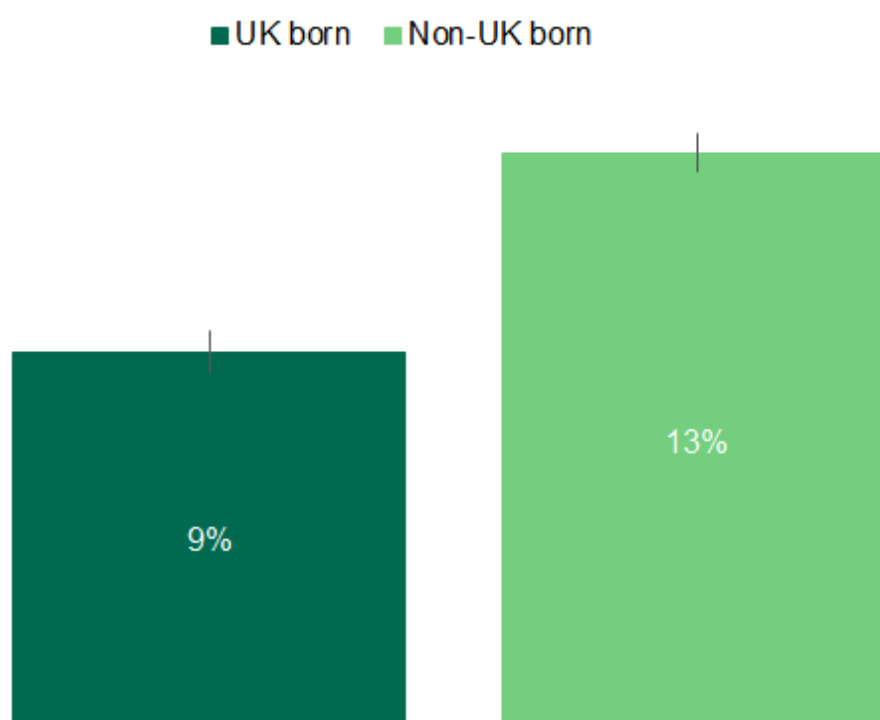
## 9.5 Health

### 9.5.1 Non-communicable disease

#### *Hypertension*

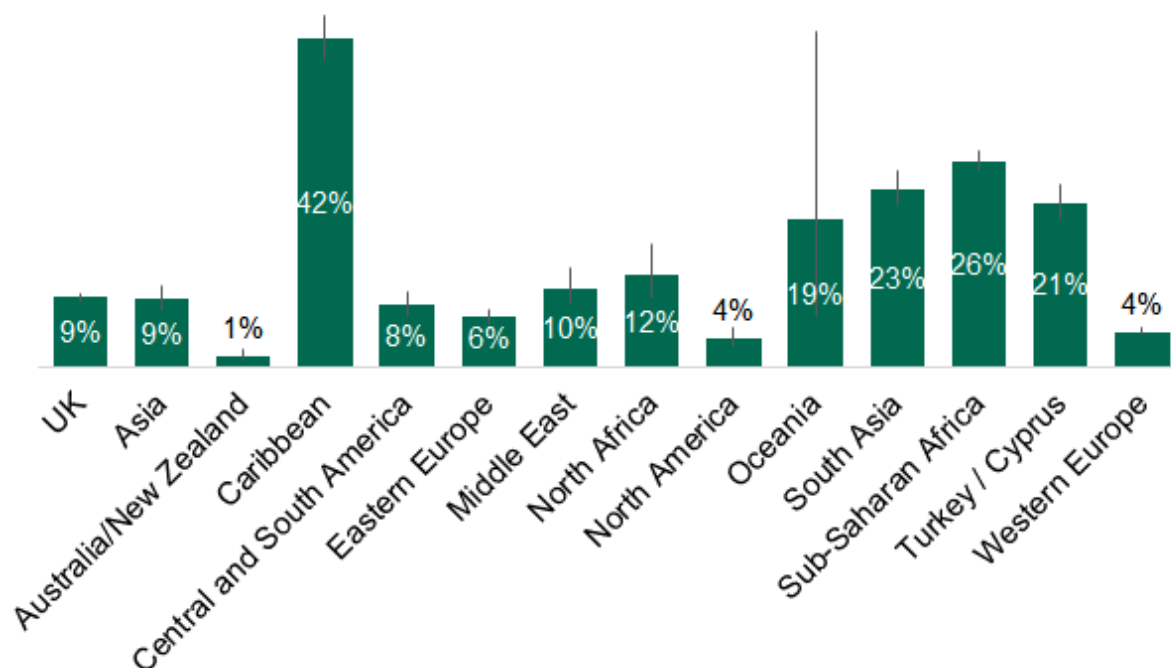
The recorded prevalence of hypertension in Hackney and the City was significantly higher among non-UK born individuals than UK born individuals with prevalence varying widely depending on region of origin (Figure 28). Those from the Caribbean, South Asia, Sub-Saharan Africa and Turkey/Cyprus had a significantly increased prevalence of hypertension (Figure 29).

*Figure 28: Prevalence of hypertension in City and Hackney patients by migration status (aged 20+, 2017)*



Source: Clinical Effectiveness Group

Figure 29: Prevalence of hypertension in City and Hackney patients by country of birth (aged 20+, 2017)

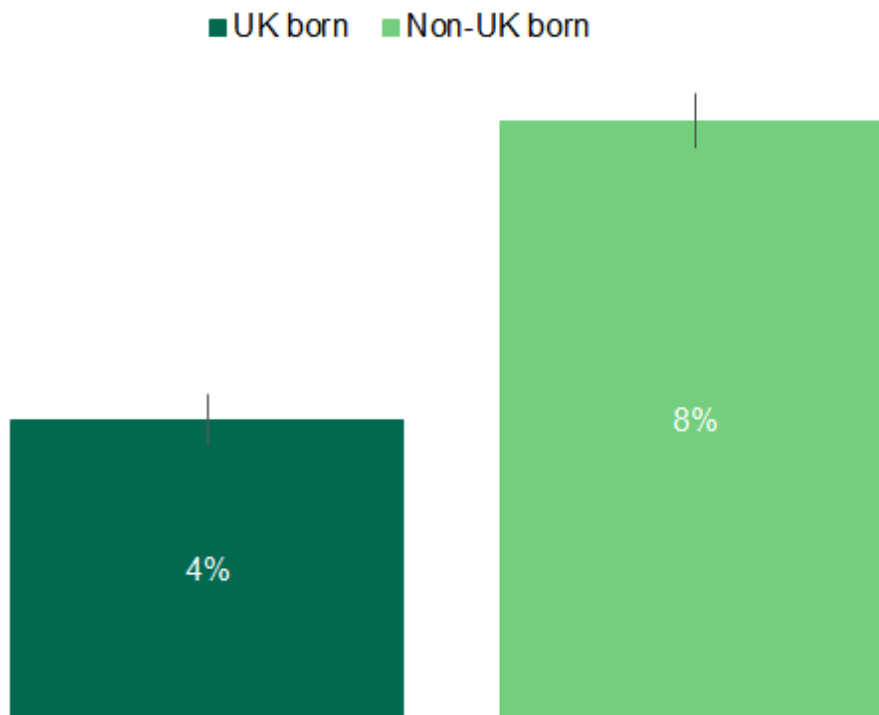


Source: Clinical Effectiveness Group

### *Type 2 diabetes*

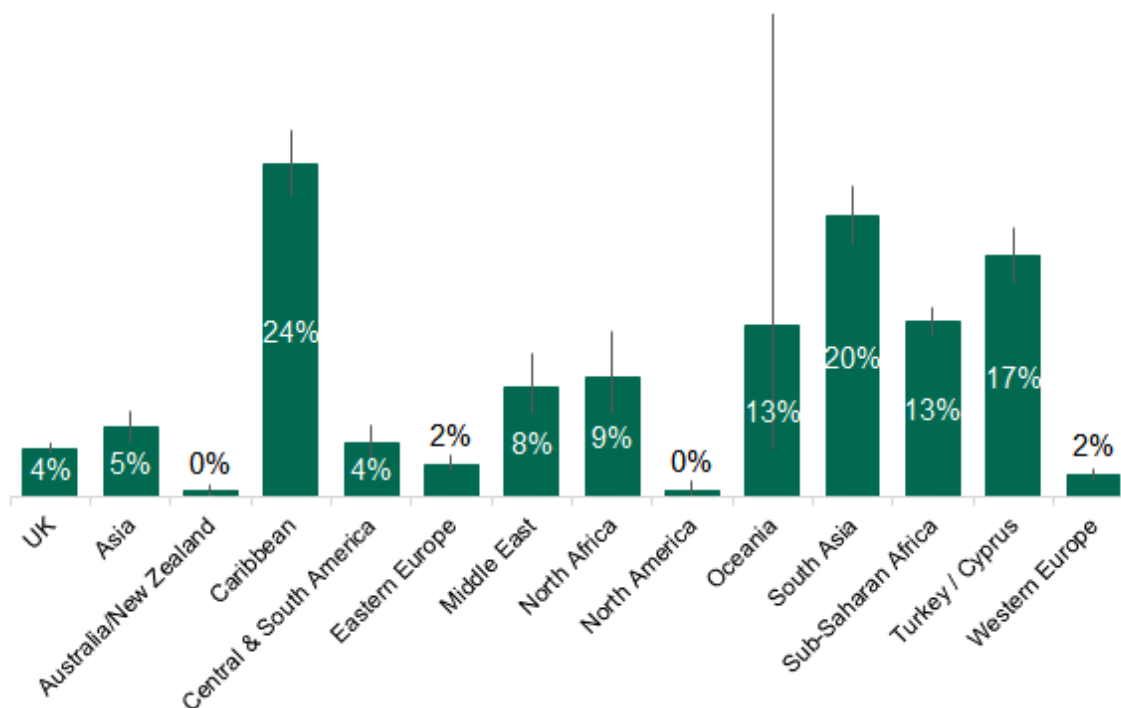
The recorded prevalence of type 2 diabetes in Hackney and the City was significantly higher among non-UK born individuals than UK born individuals (Figure 30). Those from the Caribbean, South Asia, Sub-Saharan Africa and Turkey/Cyprus had a significantly increased prevalence of type 2 diabetes (Figure 31).

Figure 30: Prevalence of Type 2 Diabetes in City and Hackney patients by migration status (aged 20+, 2017)



Source: Clinical Effectiveness Group

Figure 31: Prevalence of type 2 diabetes in City and Hackney patients by country of birth (aged 20+, 2017)

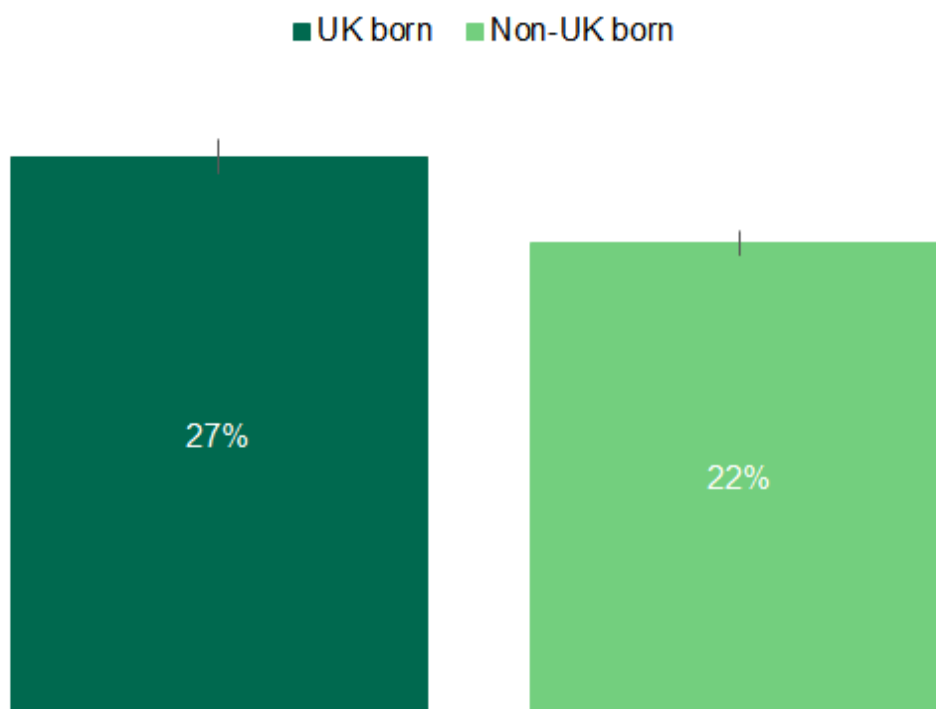


Source: Clinical Effectiveness Group

## Smoking

Smoking prevalence among non-UK born individuals was lower than UK born.

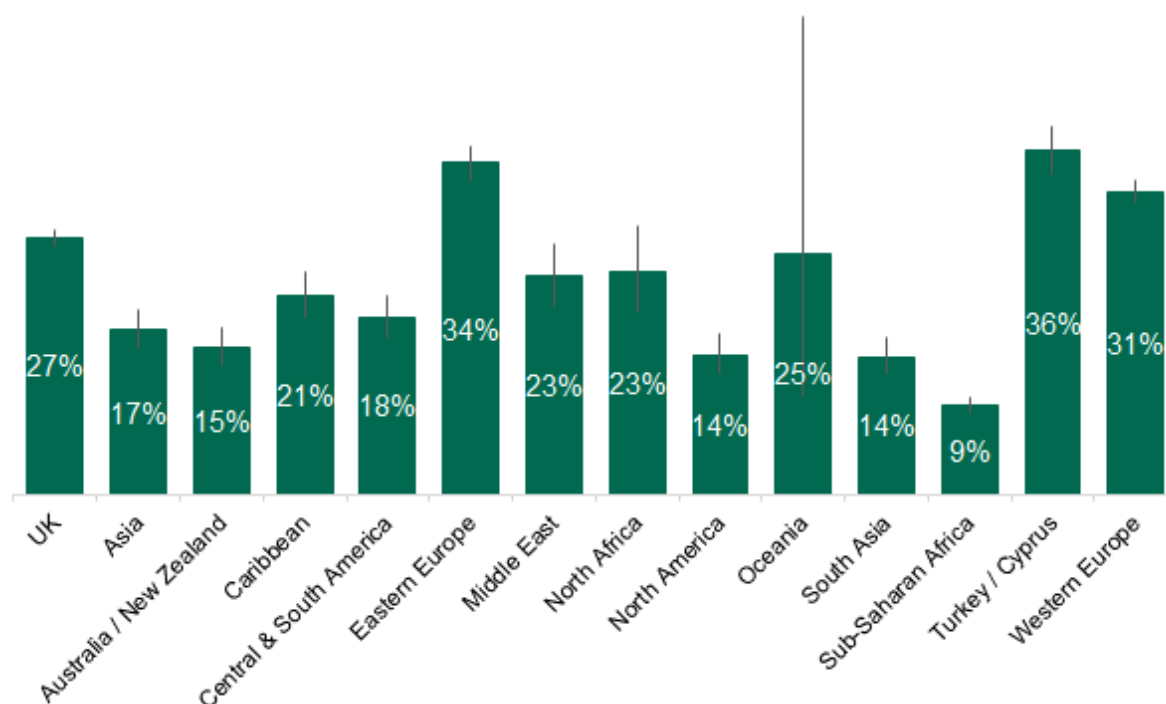
Figure 32: Prevalence of smoking in City and Hackney patients by migration status (aged 20+, 2017)



Source: Clinical Effectiveness Group



Figure 33: Prevalence of smoking in City and Hackney patients by country of birth (aged 20+, 2017)

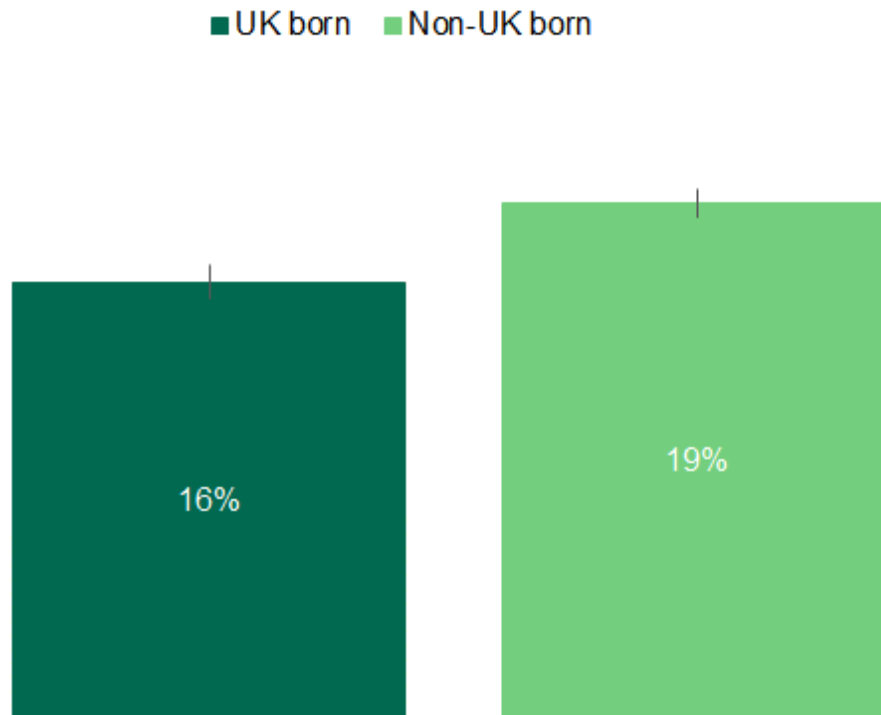


Source: Clinical Effectiveness Group

### Obesity

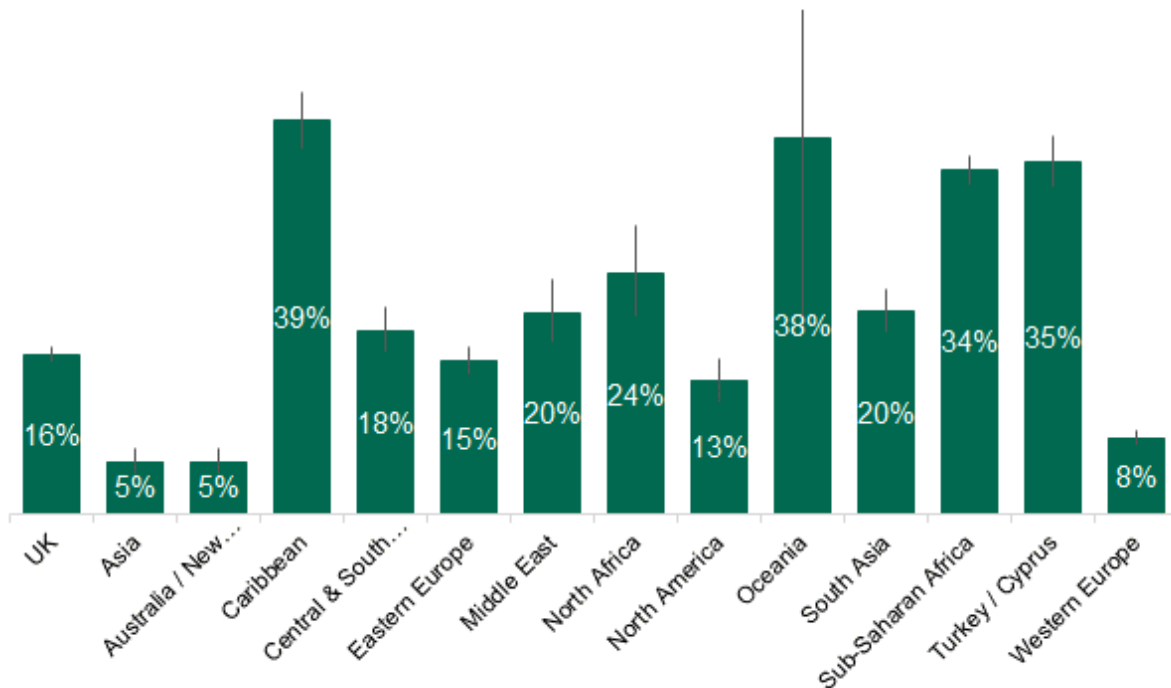
Recorded prevalence of obesity in Hackney and the City of London residents was higher among non-UK born individuals than UK born individuals with prevalence varying depending on region of origin (Figure 34). Those from the Caribbean, Sub-Saharan Africa and Turkey/Cyprus had a significantly increased prevalence of obesity (Figure 35).

Figure 34: Prevalence of BMI >30 in City and Hackney patients by migration status (aged 20+, 2017)



Source: Clinical Effectiveness Group

Figure 35: Prevalence of BMI >30 in City and Hackney patients by country of birth (aged 20+, 2017)



Source: Clinical Effectiveness Group

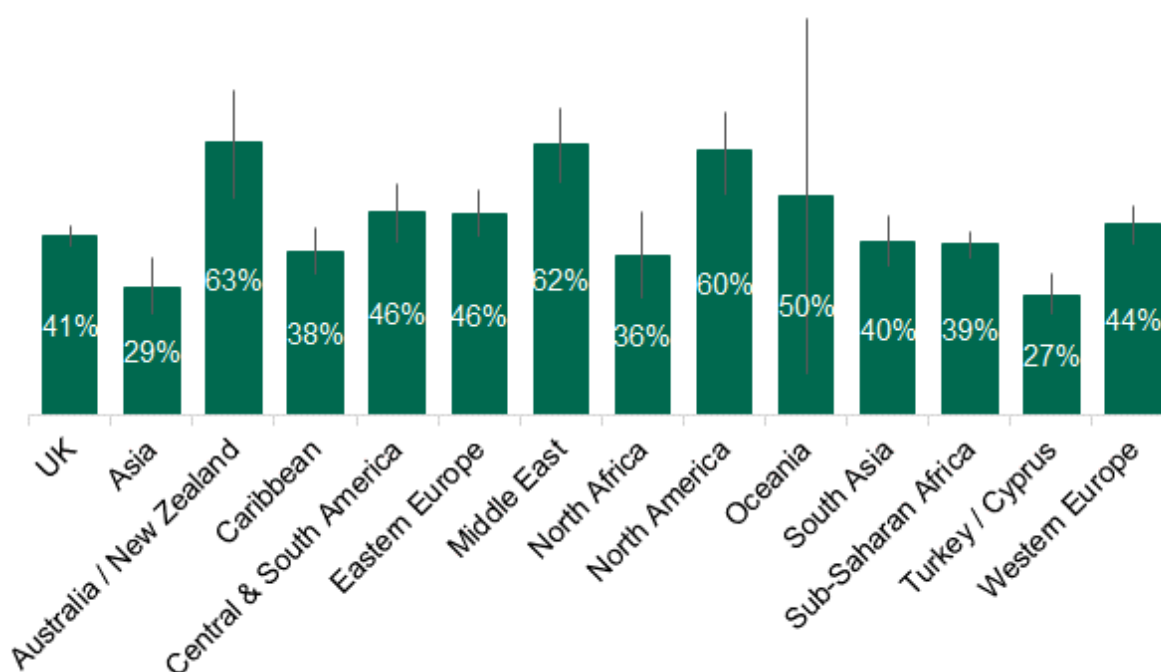
### NHS Health Check

The NHS Health Check is offered every five years to all patients registered to GP practices in Hackney and the City of London between the ages of 40 and 74 who are not previously known to have had a diagnosis of stroke, kidney disease, heart disease, type 2 diabetes, or dementia.

There are differences in the proportions of those offered a NHS Health Check by country of birth. However, this is to be expected given the substantially higher rates of diabetes and cardiovascular disease observed in individuals from regions such as the Caribbean and South Asia.

Rates of acceptance of the NHS Health Check are significantly lower among individuals from the regions of Turkey/Cyprus and Asia compared to the UK born population<sup>13</sup>. Individuals from Australia, New Zealand, North America and the Middle East were over twice as likely to accept the NHS Health Check compared to those from Turkey/Cyprus and Asia. This may be due to health care systems in Australasia, North America and the Middle East being more patient directed in comparison to the UK. Individuals from these countries may feel more familiar with instigating their own health checks and more inclined to take up the offer. Access to and uptake of the NHS Health Check may be a reasonable marker of more general behaviours in primary health service use among migrants in Hackney and the City of London.

Figure 36: Proportion of NHS Health Checks uptake in City and Hackney patients by country of birth (aged 40+, 2017)



Source: Clinical Effectiveness Group

<sup>13</sup> NHS Health Checks are offered to those aged 40-74 however data was only available for patients aged 40+. Nevertheless, these figures are indicative of relative differences between the populations.

Note: NHS Health Checks are offered to those aged 40-74 however data was only available for patients aged 40+.

## 9.5.2 Communicable disease

### *Tuberculosis (TB)*

Since it was piloted in 2006, the pre-entry screening programme has seen an increase in the detection of active TB in prospective migrants. Detection rates have increased from 44.9 per 100,000 in 2006 to 149.2 per 100,000 applicants in 2015. [75] Since 2014, pre-screening has been the principle method of detection of TB cases in those arriving to the UK. [75]

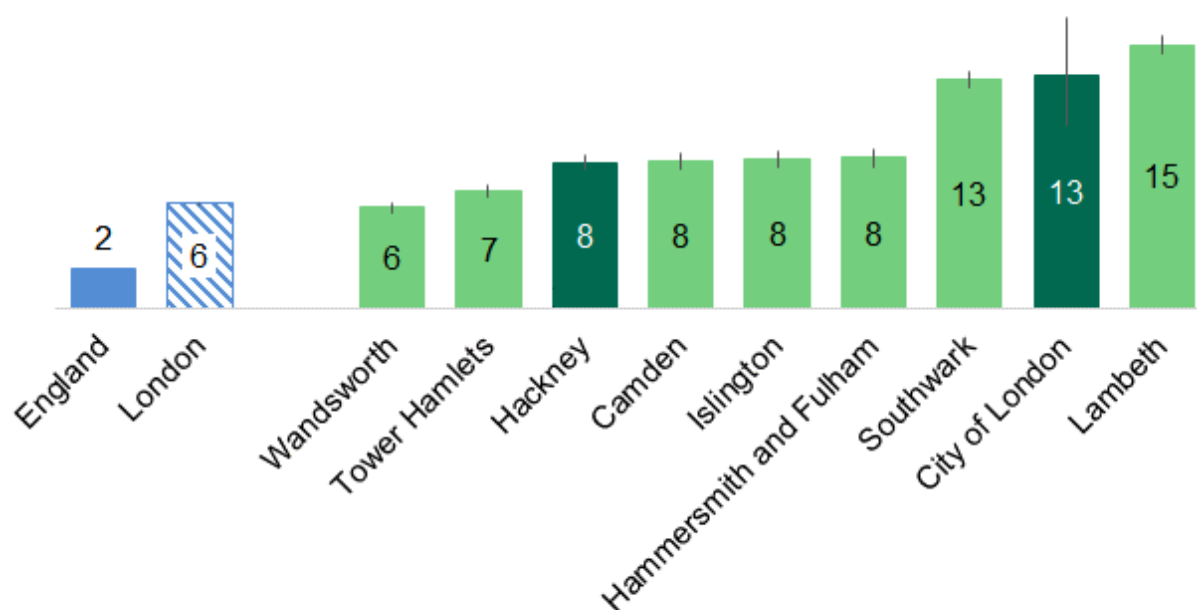
Public Health England data indicate that in 2010 in the UK (excluding Scotland), 5% of TB cases in those aged 15 and over were co-infected with HIV. Of these individuals, 86% were non UK born. [77] In the same period, the proportion of cases reported among migrants increased from 62% to 73%. Migrants also have a greater likelihood of presenting with extra pulmonary TB and higher proportion of multi-drug resistant pathogens than UK born cases [77].

Since 2010, TB notification rates in London have fallen year on year from 3241 in 2010 to 2,269 in 2015. Between 2013 and 2015 there were an average of 2,599 cases of TB per year in London; in Hackney there have been an average of 73 cases annually. In 2015, the TB prevalence rate in Hackney and the City fell below the average rate for London at 30.4 per 100,000. [166]

### *HIV*

In 2015, there were 97 new cases of HIV diagnosed in residents aged 15 and older in Hackney and the City of London. The HIV incidence rate was 43 per 100,000 population aged 15 and older. [167] In 2015, there were 1,647 people living with HIV in Hackney and 85 people living with HIV in the City of London. [168] Data indicate that Hackney and the City of London have slightly higher rates of HIV diagnoses than the average for London.

*Figure 37: Prevalence of HIV by local authorities, London and England (per 1,000 aged 15-59, 2015)*



Source: Sexual and Reproductive Health Profiles (Public Health England)

### 9.5.3 Women's health

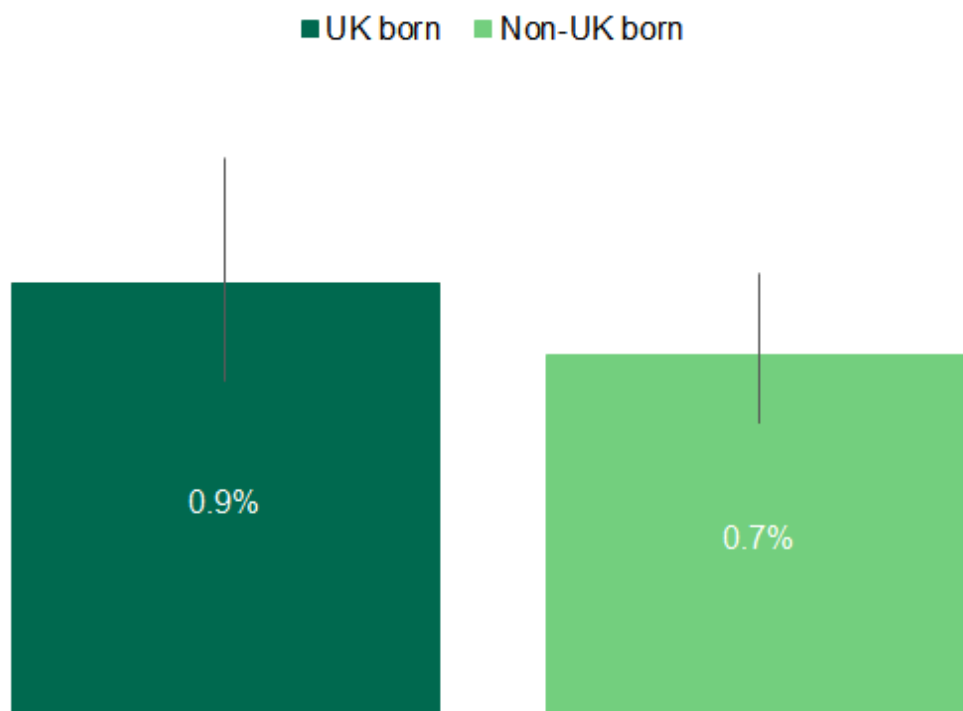
#### *Breast cancer screening*

Examination of local GP data finds no significant difference in screening uptake between UK born and non-UK born, however, complete figures are not available.

#### *Postnatal depression*

Rates of postnatal depression among migrant women were equal to UK born women but considerably lower than the rate of 10-15% accepted by the Royal Collage of Psychiatrists. [169] This may indicate that postnatal depression may be underdiagnosed in Hackney and the City of London.

Figure 38: Prevalence of postnatal depression in City and Hackney patients by migration status (aged 20+, 2017)



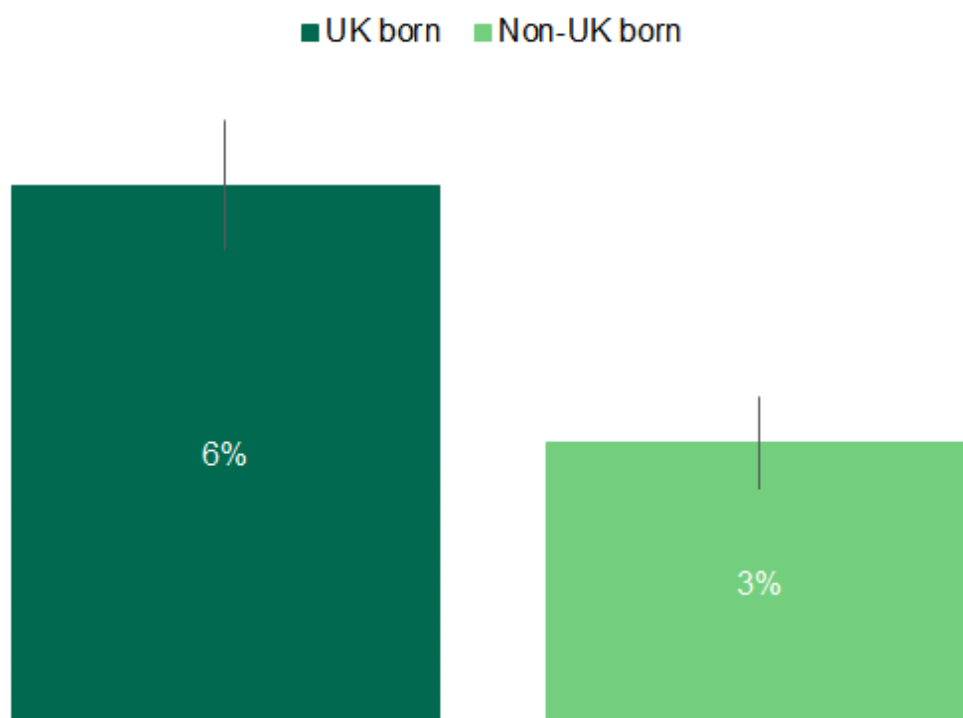
Source: Clinical Effectiveness Group

#### 9.5.4 Mental health

##### *Common mental health disorders*

Evidence suggest that mental health outcomes are worse among migrants, however local data did not capture this. This may be due to mental ill health being misdiagnosed in migrant residents or migrant residents not coming forward to be diagnosed in primary care. Alternatively, depression may be recorded only for those patients who present as having moderate or severe burden of the illness or who are receiving pharmacological treatment. Nationally, 8% of people experience mixed anxiety and depression. [170] In Hackney and the City, 3% of non-UK born individuals were recorded as having mixed depression and anxiety compared to 6% of UK born residents. This may indicate that common mental health disorders are potentially being underdiagnosed in Hackney and the City of London in both migrant and non-migrant populations.

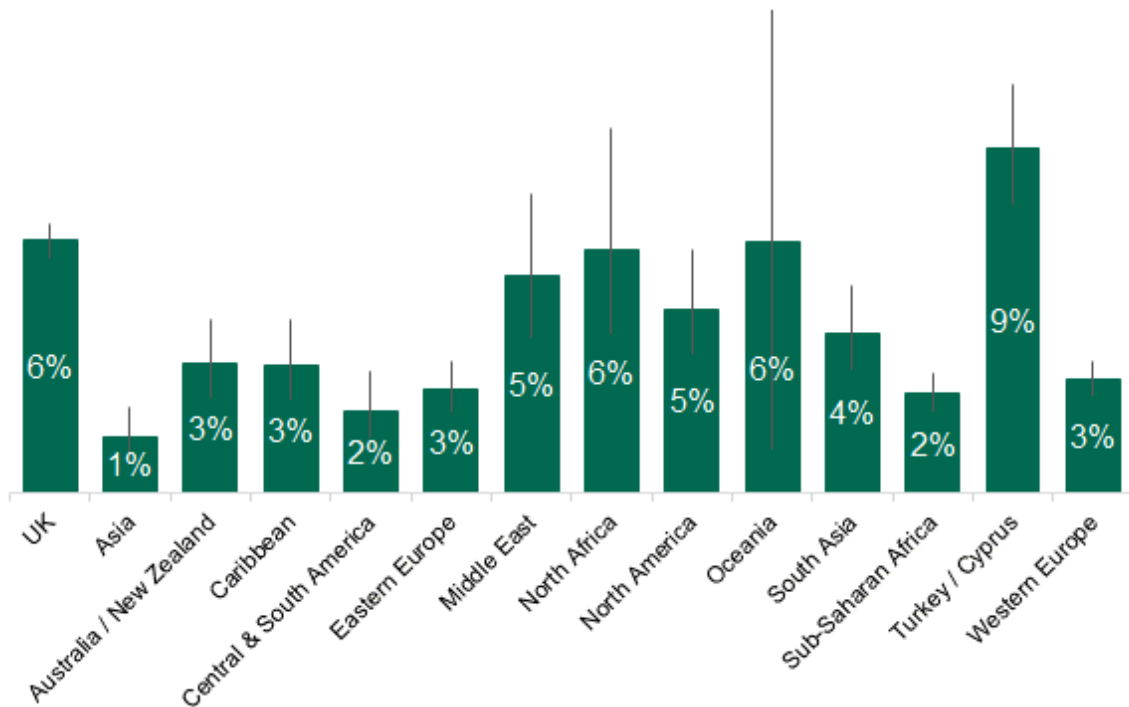
Figure 39: Prevalence of mixed anxiety and depression in City and Hackney patients by migration status (aged 20+, 2017)



Source: Clinical Effectiveness Group

Rates of depression and anxiety did vary considerably between migrants depending on their region of origin. Individuals born in Turkey or Cyprus had recorded rates of depression which were significantly higher than UK born individuals. Migrants from most other regions presented with a lower prevalence of depression than UK born individuals.

Figure 40: Prevalence of mixed anxiety and depression in City and Hackney patients by country of birth (aged 20+, 2017)

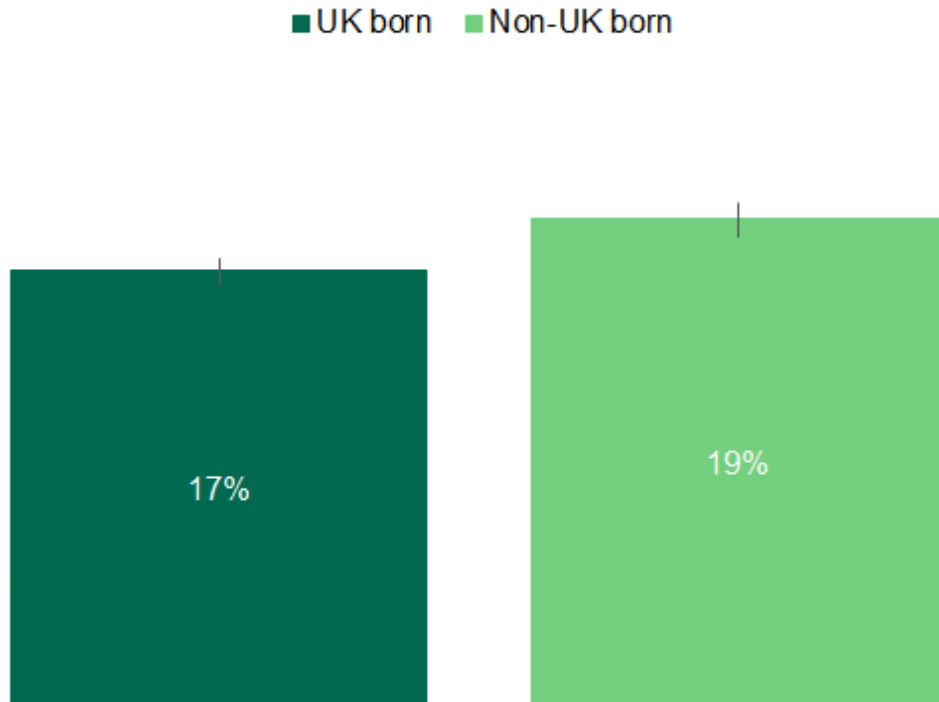


Source: Clinical Effectiveness Group

Recorded rates of back pain in individuals from Turkey/Cyprus, North Africa, the Caribbean, South Asia and Sub-Saharan Africa are higher than those in the UK born population. The presence of lower back pain has a well-established association with common mental health disorders. [171] [172] [173] [174] [175] While higher rates of back pain in these groups may be due to labour intensive jobs or other causes, the burden of psychosocial ill health may also impact the prevalence of back pain in migrant groups.

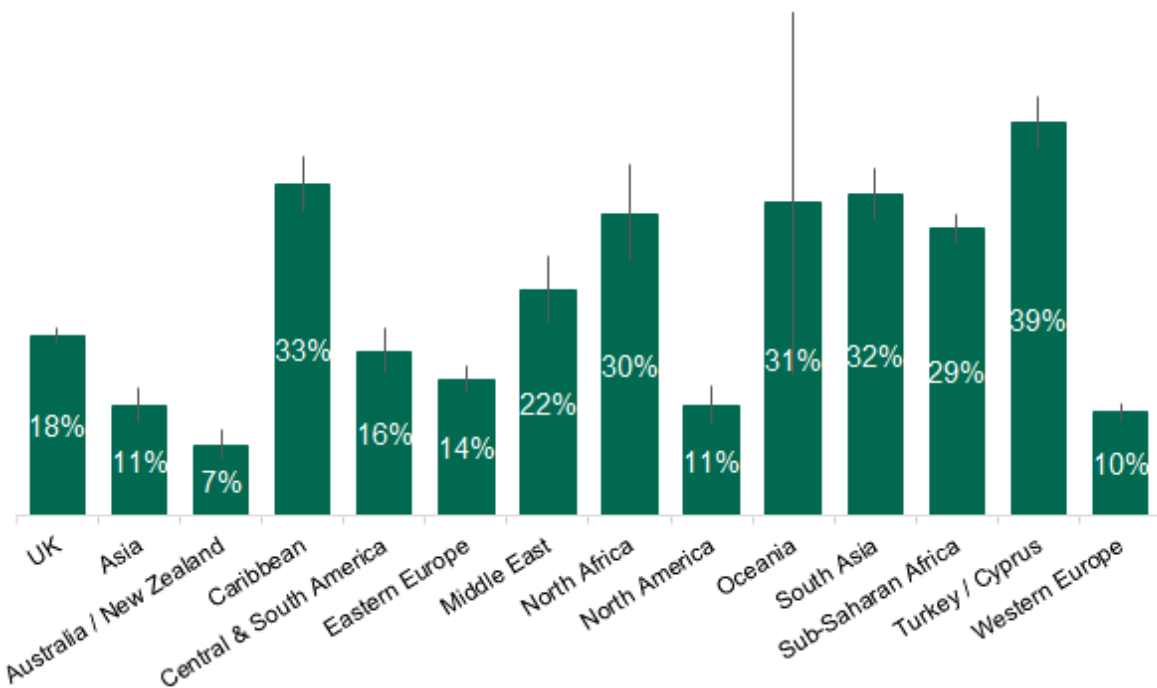


Figure 41: Prevalence of back pain in City and Hackney patients by migration status (aged 20+, 2017)



Source: Clinical Effectiveness Group

Figure 42: Prevalence of back pain in City and Hackney patients by country of birth (aged 20+, 2017)

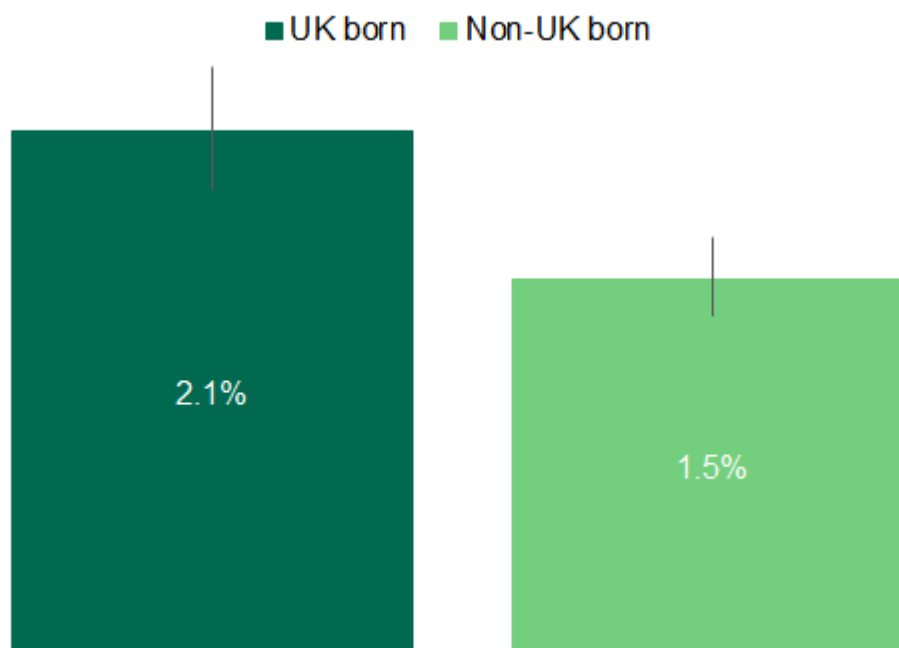


Source: Clinical Effectiveness Group

Serious mental illness

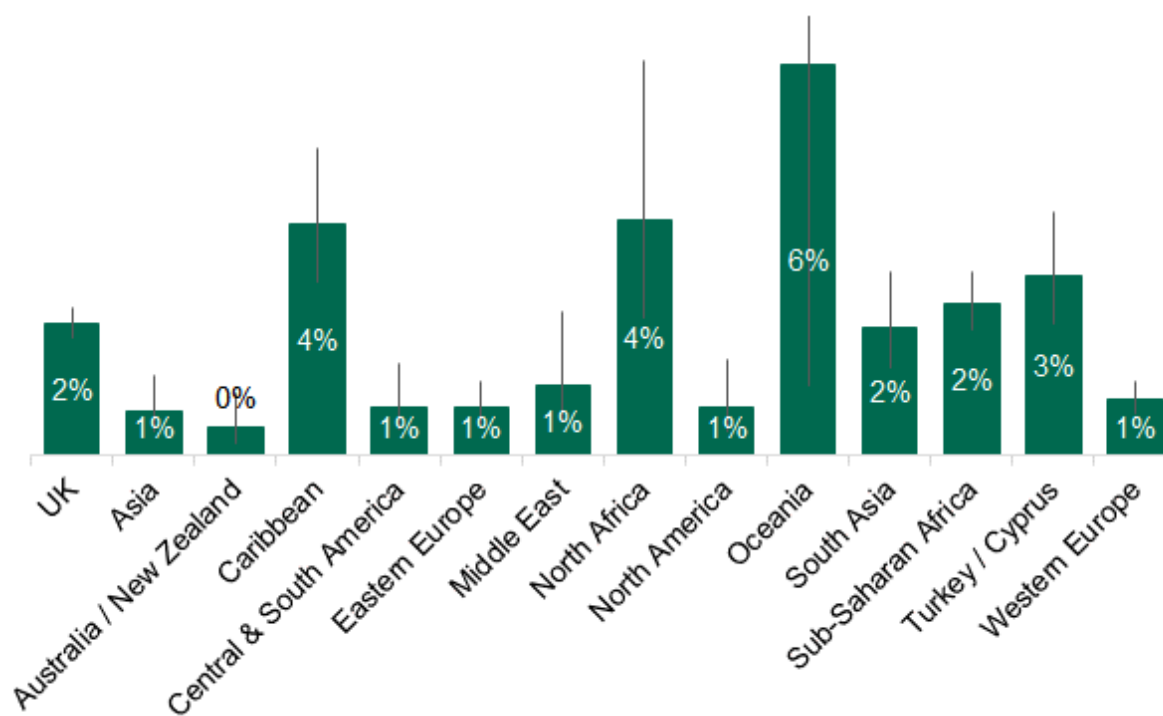
As with common mental disorders, the recorded proportion of non-UK born individuals with serious mental illness (such as psychosis, bipolar affective disorder and schizophrenia) was lower than that of UK born individuals. However, individuals from the Caribbean were significantly more likely to be reported as having a serious mental illness compared to the UK born population.

*Figure 43: Prevalence of serious mental illness in City and Hackney patients by migration status (aged 20+, 2017)*



Source: Clinical Effectiveness Group

Figure 44: Prevalence of serious mental illness in City and Hackney patients by country of birth (aged 20+, 2017)



Source: Clinical Effectiveness Group

## 10 Stakeholder interviews

Stakeholder interviews were conducted between April and June 2017. The Public Health team contacted health professionals, migrant organisations, and the community and voluntary sector. In total, nine anonymous 60 minute semi-structured interviews were conducted with participants working across a wide variety of professions. The interview questionnaire is available in the appendices. All participants had experience working with migrants and refugees; many identified as migrants or refugees themselves. Interviews were recorded and transcribed. Themes were analysed using a grounded theory approach. The major themes will be explored in turn.

### 10.1 Health issues

Mental health issues were raised repeatedly across interviews as an issue that affects all migrants, but particularly asylum seekers, refugees, and those who had experienced trauma. Often the immigration process itself – the journey from the country of origin to the UK, the immigration application in the UK, immigration tribunals, or being detained – was said to exacerbate already established mental health issues. A lack of support networks in the UK can also cause or worsen mental health problems for migrants. Severe mental illness and post-traumatic stress disorder (PTSD) was raised as particularly affecting those who had experienced conflict, torture, violence or sexual assault. In many migrants, interviewees argued that mental health issues may manifest in physical symptoms such as dizziness, back pain or fainting; this may make it more difficult for migrants to be treated for mental health conditions particularly if they do not understand or acknowledge mental ill health as a phenomenon.

Physical health issues caused by experiences of war or conflict were also raised such as amputations or shrapnel being embedded inside the body. Other issues that were raised include domestic violence, sexual health, female genital mutilation, alcoholism, malnutrition, and homelessness.

### 10.2 Heterogeneity of experience

A theme that emerged from interviews was the acknowledgement of the heterogeneity of the migrant experience and how this may impact their health. Depending on the countries migrants originate from, their migration routes, their current immigration status, and the experiences accumulated throughout their life, migrants and refugees living in the UK will have divergent and multiplicitous health experiences and health outcomes. Many health issues seemed to pertain to specific communities. However, it was suggested that “even the most empowered migrants who have little language barrier and a lot of social connections and cultural capital struggle.” Despite the heterogeneity of experience, interviewees suggested there was a commonality in the health experiences of migrants, regardless of other differences. As one GP put it: “Different communities differ. There is something about the experience of being a migrant that makes things hard.”

## 10.3 Knowledge

Knowledge and lack of knowledge emerged as a major theme from the interviews both on the part of migrants as well as health and social care staff and professionals. This included knowledge about health care systems in general and the NHS specifically, knowledge about migrant and refugee entitlements to access health and social care in the UK, and knowledge about primary care, secondary care, and acute care and the remits of each.

Interviewees said that migrant knowledge about the health care system can range from “high understanding” to “zero knowledge”. Some may know that the NHS is free at the point of access, some may not know this or struggle with the idea of a free health care system. One interviewee said that many patients were suspicious of notion of free health care and assumed this meant substandard health care. This can be influenced by the countries and health care systems that migrants came from, what they have been told about the UK system, and what barriers they face. One health care professional suggested that “recently arrived populations with limited levels of English with limited levels of integration in the community ... relatively closed communities, they really do struggle with knowing what they’re entitled to.” However, professionals were identified as also lacking knowledge about migrant entitlements, and in some cases wrongfully refusing care. One health care professional supporting migrant women access maternity care said:

“[The staff] were saying ‘no you’re not entitled to this’ we said ‘actually’, we had printed out the government guidance, ‘she is entitled to it, go and check with senior management.’ But you have to be fairly persistent or have that support around you to be able to have that fight.”

Interviewees spoke about migrants struggling with the notion of a general practitioner and the responsibilities of primary care services. Some migrants were suspicious of the notion of a ‘generalist’ as opposed to ‘specialised’ status. A GP said that some migrants “come from systems where the transaction is ‘I have a symptom and as a result I get an investigation and a prescription’ and we often don’t in primary care.” The limited time offered by GPs can make migrants feel like they haven’t been given care and – given the difficulties achieving an appointment in the first place – may cause migrants to lose faith in the UK health care system. The discrepancy between care provided by general practitioners in the UK and specialist doctors in countries of origin can lead to mistrust of health care and health professionals in the UK, which will be discussed in further detail later.

Interviewees discussed migrants feeling frustrated when not able to access more specialised treatment available in secondary care, and assumed that services that they conceptualised as simple and routine (such as x-rays) would be easily accessible.

When faced with barriers to accessing health care, many migrants used acute care services regardless of their health needs being able to be treated within primary

care. Interviewees said that translation services were thought of as better in A&E. Acute care also was said to offer a better chance of speaking to a doctor and receiving better treatment than in primary care.

## 10.4 Barriers to accessing health and social care services

Barriers to accessing health and social care services for migrants are multifaceted and intersecting. The main barriers identified through interviews were:

- Language barriers
- Misinformation and misunderstanding
- Fear of the state
- Fear of compromising immigration status
- Fear of real or perceived costs
- Stigma
- Structural barriers

### 10.4.1 Language barriers

Language was the primary barrier identified consistently across all interviews. Interviewees discussed residents who spoke little or no English and the difficulties they faced accessing health and social care as they were dependant on the availability of interpreters. GP practices may have limited availability of translators, particularly for certain languages, and as a result patients are faced with a longer wait for an appointment. The Vietnamese community in particular were identified as a group with poor English comprehension and few translators available within GP practices in the borough, in some cases barring the community from accessing services completely. Interviewees stated that within primary care interpreters can be booked for the appointment but not for a conversation with the receptionist; a telephone translation service can be used but is not conducive to busy practices due to the time needed to set up a connection. As a result, many use acute services due to the wider availability of translation services.

Interviewees report that patients are often asked to provide their own translators through friends or family, but this compromises patient confidentiality and acts as an additional barrier to coming forward for health conditions that are stigmatised. Furthermore, this may also lead to increased problems for children who are taken out of school to translate for their parents. There are also cases where friends or family interpreting do not have the patients' best interests in mind:

“I remember seeing a Bengali woman who wanted a termination who was using her husband as her advocate, to my shame. Thankfully they saw a better doctor than me a few days later who insisted on an independent advocate. She didn't want a termination. *He* wanted the termination! That taught me an important lesson about family and friends advocating.”

When translators are provided, interviewees report that their understanding and comprehension of their language can be subpar. One patient reported being provided a 'Turkish' translator who was from Azerbaijan who could not translate

appropriately. Interviewees also report a lack of trust in interpreters translating accurately and representing their best interests.

Limited appointment times in primary care was raised repeatedly as a barrier for migrants: migrants “are not [given] enough time to express themselves given their anxieties, background and language. I need time to get the right word.” Those who had experienced torture or conflict were mentioned as being at particular risk:

“Ten minutes isn’t long enough even with somebody with one straightforward problem who speaks English. It is certainly not long enough for somebody with complex psycho-social problems, multiple problems that may have not been sorted out for years who doesn’t speak English.”

Migrants who come from Anglophone countries may still experience cultural misunderstandings and differences in interpretation. Some patients speak to a level of English that may convince health professionals that patients have a good understanding of their health care, but this may hide their lack of comprehension around the more complicated aspects of their care. One interviewee discusses a case of a woman with a high risk pregnancy:

“She only had a good command of English in situations that she was familiar with so ... when we were asking questions about her maternity care, she had no idea and she was under consultant care. And we were saying ‘there must be a reason why you’re under consultant-led care’ but she had no idea, because her English wasn’t good enough for her to understand what the consultant was saying to her but it was good enough to appear that she did understand.”

Language is a major barrier to migrant and refugees accessing health and social care services. Depending on the level of English comprehension, the barriers to care may be larger for some. Nevertheless, even those with a relatively high level of English comprehension may still face difficulties accessing appropriate care.

#### **10.4.2 Misinformation and misunderstanding**

Misunderstanding on the part of patients and staff was identified as a barrier to accessing health and social care. The policy on what services migrants are entitled to access is incredibly complex and constantly shifting and as a result becomes difficult for both professionals and patients to grasp. Incorrect information can also spread among migrant networks in relation to accessing care: “I’ve just heard that you can’t do it – someone like me, you can’t do it.” Migrant and refugee knowledge of the health care system is explored further in the ‘Knowledge’ section.

#### **10.4.3 Fear of the state**

A clear barrier that emerged was migrants and refugees expressing a fear of the state, and this fear inhibiting migrants from coming forward for services, despite in many cases having every right to access health and social care. Interviewees

discussed how many migrants have been through traumatic situations where they developed a fear of authority. Many heard stories about “social services taking your children away.” This can also be tied up in the stigmatisation of certain health conditions. Migrants may fear coming forward for health problems (such as mental ill health for example) as they are worried that the state may see them as unfit to care for their children.

A professional running a homeless centre that sees many migrants and refugees clients described the political situations that many of his clients have come from:

“A lot of them are older so they would have been brought up under a military government, under communism, or Romania, or wherever they’re from. And I think they’re wary of being too carefully scrutinised a bit. They don’t particularly like showing their papers to people if they’re from that background.”

Other interviewees talked about migrants and refugees coming from countries that had experienced genocide and conflict, where they had witnessed the state and health professionals directly committing atrocities. One community representative said: “If you come in uniform, it is scary. If you come with badges, if you come as part of system, that is scary.”

#### **10.4.4 Fear of compromising immigration status**

Along with the fear of the state, the fear of comprising immigration status emerged as an additional barrier. This was not limited to undocumented migrants or those in the country illegally; rather, this also impacted migrants who have all documentation and are settled here legally. Many (but not all) interviewees said this was an issue for migrants and refugees in their communities. Migrants may fear that interfacing with anyone in an authority position might affect their immigration status or right to remain in the country. One community representative on why many in his community avoided using health services said: “It could be anxiety. It could be misinformation, like, ‘if you go to the GP you may be deported’.”

#### **10.4.5 Fear of real or perceived costs**

The fear of actual or perceived costs emerged as a major barrier to migrant and refugee groups accessing health and social care services. In some cases, migrants had every right to access the NHS and are entitled to free care; nevertheless, due to the lack of transparency around the guidelines, and gossip and misinformation being passed around the community, people who need care do not come forward because they do not think they can afford it.

However, there is also the fear of real costs which is another barrier. Interviewees said that some cannot afford prescription costs. Some may not be entitled to certain secondary care and face bills of thousands of pounds should they take up care. One interviewee said that migrants in some communities were having conversations about comparing cost estimates at different hospitals. This is also related to the fear



of compromising immigration status as the names of patients with large hospital bills are passed on to immigration authorities. One health professional said:

“My concern is that because of the nature of the charges and the likelihood, if you’re a migrant woman or refugee you’re more likely to have health complications during your pregnancy, so you’re more likely to get a higher bill at the end and if you have a bill of a certain amount for more than a certain amount of time then your name gets passed to the Home Office.”

#### 10.4.6 Stigma

Stigma around certain health conditions acts as an additional barrier to migrants and refugees coming forward for diagnosis. Sexual health and mental health were areas that were particularly stigmatised in certain migrant communities. Interviewees argued that any migrants, particularly men, did not want to accept that they had a mental health problem. A community representative on support for mental health issues among his cohort said:

“People won’t see psychiatrist. But if you go and tell them to see someone who will help, they are willing. But if you say psychiatrist, it scares them. In the community, mental health problems are called madness. Nobody wants to be mad.”

The fear of one’s health condition being known by others in the community was an issue that was repeatedly raised. Interviewees said that migrants feared running into friends and family in GP waiting rooms, interpreters being from the same community, or discussing health issues with community representatives: “they think if they talk to me, maybe I will tell someone else.” On mental illness, one GP said:

“In some cultures, and in some populations, that is a catastrophic diagnosis to make. Our Turkish population, for example, would rather suffer at home. The fears of other people in the waiting room recognising them and asking why they’re there ... they would never want that neighbourhood to know.”

#### 10.4.7 Structural barriers

There are numerous structural barriers that bar migrants from accessing services. Many migrants and refugees struggle with poverty and deprivation. On why migrants may not access health services a community representative suggested:

“Poverty has a link with it. Some are struggling to make ends meet. It is difficult to find time if they are working. Because if they leave, and take time off work, it will be very difficult. The earnings will go down. So they try and stay at work as long as possible.”

Interviewees also discussed the complications of collating documentation and paperwork needed to prove eligibility for accessing health and social care services.

Furthermore, if an individual is also facing other complex and pressing issues such as homelessness, immigration applications, or a lack of food, it may be difficult to manage the process of collecting documents to access care. As one interviewee said: “it’s not that the situation is too complicated, it’s that their lives are too complicated.” Some may not have original documents if their paperwork is being processed for immigration applications and thus will not be able to access practices that demand proof of residence in the form of original documents. Some also may have lost paperwork and passports during conflict, in the process of moving to the UK, or within the UK if their lives are particularly precarious.

The structure of the health care system itself can also be a barrier. Many interviewees spoke about the difficulty migrants having navigating the telephone system to book an appointment or not having the English language skills to speak to a receptionist. Receptionists also act as a triage and barrier system, and thus migrants and refugees who cannot express their needs accurately may not be seen, despite having more urgent issues. Hospital staff and health care professionals may also have a lack of understanding of the needs of migrants and refugees, as well as lack knowledge on the differences between immigration statuses and entitlements.

## 10.5 Self-treatment and self-management of health conditions

Due to migrants facing barriers to accessing health and social care, many rely on self-treatment and self-management of their health conditions as their primary health care strategy.

The common thread between most interviews was the practice of migrants obtaining and sharing medicines among their communities. Many spoke of their clients or patients coming “armed with suitcases full of medicines from their home country” some of which are appropriate and some of which are considered dangerous. Some “mix and match” these medicines with what they can purchase through pharmacies, or if they are accessing health care, what they are being prescribed.

Interviewees also spoke about the sharing and exchange of medications. Antidepressants, painkillers and antibiotics were raised frequently as the most common types of medications being exchanged among the community. However, everything from thyroid medicine to sleeping pills were also raised as being a part of this ‘secondary’ pharmaceutical market. One interviewee said: “They share medicine for headaches like co-codamol. For back pain they share painkillers. They love to share the medicine.” Interviewees were fearful of self-treatment as a strategy: “if there is no proper communication between GPs and migrant and refugee patients, they start getting advice from friends, relatives, they start exchanging tablets. ‘Oh its good for my headache’ they think. But what about side effects?” Medications from family and friends may be shared or mixed with other medicines and folk remedies obtained from alternative sources. One community representative, on self-treatment within migrant communities: “It can be poisonous. It can be dangerous. Some mix medication with alcohol to make it ‘powerful’. They heard that if you mix this and this it will be more effective.”

Interviewees report some migrants resort to faith groups in place of health care:

“[The faith groups] say they will pray and it will disappear. It can be dangerous. Some will stop the medication because of prayer. Someone will say ‘I will pray for you and the health issue will go away’.”

Community representatives spoke about clients who were engaging in health services but were encouraged to replace health care with prayer. As one interviewee stated: they are just “surviving on prayer”. Many spoke of other ‘alternative’ remedies being used, such as going to ‘Chinese shops’, using faith healers, or practicing ‘witch craft’. Interviewees also spoke of migrants with mental health issues self-medicating with alcohol.

One interviewee said that women have been ‘free birthing’, that is, giving birth without any medical support outside of the health care system, to avoid contact with maternity services due to fear of charging or compromising immigration status. For those who mistrust health care in England, many will enquire about remedies from ‘back home’, ask friends and family to bring medicines and treatment back, or when it is affordable, travel to their countries of origin to obtain treatment. One community representative said: “they go back to their countries for treatment or ask what works there and ask someone to send it here to deal with their problem. They trust [health care] there rather than here.”

## 10.6 Outcomes of self-treatment

Due to migrant and refugee communities using self-treatment as a health care strategy when faced with barriers to accessing care, interviewees argued that migrants can face worse health outcomes compared to non-migrant populations:

“Outcomes tend to be poorer. It’s like a circle of diminishing returns. Because their initial health isn’t great to begin with. Stats show the health of migrant populations is not as good as other populations. You add stressful life events which then often complicate pre-existing conditions and then you add in a potential reluctance to engage with NHS care ...”

Opportunities for prevention and health promotion are missed when migrants are not able to access health services and must resort to self-treatment.

Interviewees stated that many try to treat the symptoms without actually addressing the problem itself. Alternatively, while attempting to treat themselves, migrants may use the wrong medication or take medication incorrectly. One community representative said this was a common problem, as migrant communities were attempting to treat their own illnesses unsupervised: “Lots of people take the medicine in the wrong way. Most! Most! For example, I take a spray in my mouth, but doctors say I was supposed to take in the nose. But for a long time I take in my mouth.”

When medicine and tablets are shared, because treatment is unsupervised, illnesses can become worse. One community representative said: “they trust someone, and

are using their tablets or suggestions, [but the] side effects or horrible results from these types of things causing further problems.”

There are problems with associated with migrants travelling abroad to treat their conditions. They may be prescribed medication that is harmful or no longer recommended in the UK. There are problems with accessing medical records and understanding what medications patients have been prescribed. One GP said:

“I’ve seen real problems with not having access to a full medical record and Turkish doctors not communicating with us about what medicines people have been given ... But it’s a nightmare for us as GPs. A real safety issue. What anti-depressant did they give them and why? What other things are they taking? What other stuff is going on?”

The main outcome from self-treatment is late diagnosis, when the problem has worsened and become acute. As one interviewee said “when the problem comes, it comes big.” When it comes to communicable diseases, such as HIV or TB, this means that migrants unnecessarily suffer through the symptoms of the disease, potentially pass on the disease to others, and in some cases, risk their lives. Interviewees also brought up minor ailments that become aggravated and then need unnecessary medical care. Mental health was another major issue that often progressed to crisis point until treatment was sought.

Another impact of self-treatment is the additional pressures on the health care system. As migrant patients are coming in when the problem has worsened or become acute, it is more costly to treat, more stressful for staff, and can have worse outcomes if the migrant patient lacks a health record or health care professionals have to treat without prior knowledge of the condition. For example, an interviewee brought up known cases of women showing up at hospital in labour without having gone to a single antenatal appointment; they then were said to ‘disappear’ after childbirth barring any follow-up with mother or baby.

## 10.7 Trust

Trust and mistrust of health and social care professionals was a major theme that emerged from the interviews. Trust was related to a fear of compromising immigration status that acts as a barrier for migrants accessing health care. Many fear that the NHS may forward information on to immigration authorities, even when they had lawful right to live in the UK. Many interviewees brought up the memorandum between the Home Office and NHS Digital sharing data (see Information sharing subchapter), and feared this could cause more migrants to avoid accessing care.

Mistrust also came from a misunderstanding of the health care system and the deviation in responsibilities between primary and secondary care in the UK. For migrants who came from countries with ‘specialist’ doctors, they may lose faith in general practitioners who do not seem as knowledgeable or skilled as specialist doctors. If their expectation is to be treated in primary care, and their GP suggests a less intensive intervention (or no intervention at all), this may cause migrants to

mistrust primary care physicians. One GP said that she found migrant patients to be suspicious of 'generalism' and frequently questioned its validity. These feelings were aggravated by the brief appointment time in primary care; patients often felt they were not listened to or misunderstood. Interpreters and translators were also untrusted by some for fears they were not translating accurately or capturing everything the doctor or patient had to say.

Interviewees said that migrants and refugees often complained about the lack of knowledge health care professionals had about migrant issues. They often lacked knowledge about the immigration experience and different types of immigration status, and would suggest or prescribe interventions that were outside their capacity. Health professionals were also said to lack knowledge about the health issues that may affect the migrant and refugee population, such as torture, PTSD or tropical diseases.

Those who have the strongest feelings of mistrust of authority figures are migrants and refugees who had come from regions of conflict. One community representative spoke about how his clients had witnessed doctors commit atrocities, and they now found it difficult to trust any arm of the state, including health care professionals:

“Many people have seen doctors acting as killers. People from Rwanda. You are not going to tell them to see a doctor when doctors performed the duty of killing. It is very difficult to challenge the perception that that is not the purpose of the doctor.”

However, mistrust of professionals was not always the case. Those who offered specialist services (such as midwives working directly with migrant women or homeless GP practices) found that trust between professional and patient was good. This was attributed to higher specialist knowledge about the issues affecting migrant and refugee patients, and increased time and capacity to build more meaningful relationships.

## 10.8 Information dissemination

Interviewees spoke about how information is disseminated to and across migrant communities. Generally, word of mouth was seen by many migrant communities as the preferred and trusted form of learning about health issues, treatment, and services. This could also have negative ramifications when incorrect or harmful information was delivered through family and friends and trusted over the advice given by a health professions. Leaflets, posters, and information disseminated using paper or other materials was said not to be read, consumed, or trusted by many migrant communities.

## 10.9 How to improve services for migrants and refugees

Incorrect information that was disseminated from health and social care professionals and voluntary sector workers was seen by multiple interviewees as the source of many problems in relation to knowledge about entitlements, service

access, and anxieties about interacting with the state. Regular provision of training was seen as critical to combating misinformation, in particular in services where there were high levels of staff turnover. Services where migrants were identified as facing particular problems include GP practices, job centres, housing services, front desk and client facing services, and staff handling Section 17 assessments.

For health services in particular, better training and education for doctors and nurses on the health needs and social issues affecting the migrant and refugee community was needed as this is currently not included in the standard medical curriculum. In addition, receptionists and staff needed to be trained on the entitlements migrants have to access health care and how to ensure equity in health care access between migrant and non-migrant populations. More outreach was necessary, particularly for communities who underuse primary care. The offer of health services was suggested to benefit from more information on the particular needs of the different migrant communities. Interviewees suggested that continuity of care needed to be supported and promoted. Interviewees spoke about multiple pilots coming into communities for a short amount of time and how this often ruptured trust between the community and services providers.

There needed to be more service provision for the most vulnerable migrants. Signposting and advocacy services were seen as necessary for supporting the community to access general provision.

## 11 Services for migrants

In 2012, the UK government ended the Refugee Integration and Employment Service (RIES), a national service that provided monetary support and training for refugees who had come through the asylum process. [176] This services was not directly replaced; support services for refugees are now provided on a local level by voluntary organisations. However, unlike RIES, individuals are not automatically referred to local organisations by the Home Office and do not operate on a similar scale to the programme.

In comparison, refugees accepted via the Gateway Protection Programme receive extensive support. They are entered into a 12-month support programme intended to aid their integration into British society. [148] Provision under this programme includes:

- A caseworker for a period of up to 12 months.
- Assistance with engaging with health services, English language courses, public benefits and child education for children.
- Translation and interpreter support.
- Housing upon arrival and housing support for one year.

There are a number of local services for migrants that officer advice, signposting, ESOL classes, and health and social services. The following outlines a selection of services that were available at the time of writing.

### 11.1.1 Advice, signposting and ESOL services

Table 6: Advice, signposting and ESOL services

Name of Service	Description	Contact Details
<b>Hackney Migrant Centre</b>	Charity running a weekly drop-in for asylum seekers, refugees and migrants. Offers free advice on immigration, housing, and benefit problems. Help with access to NHS services and GP registration. Interpreters can be booked in advance.	07504332706  <a href="http://www.hackneymigrantcentre.org.uk">http://www.hackneymigrantcentre.org.uk</a>  Spensley Walk N16 9ES
<b>Praxis Community Projects</b>	Provides advice, ESOL classes, support, temporary accommodation and community development projects for vulnerable migrants.	020 7749 7608  Pott Street E2 0EF
<b>Hackney ESOL Advice Service</b>	ESOL classes and advice services	<a href="https://www.learningtrust.co.uk/esol">https://www.learningtrust.co.uk/esol</a>
<b>Roj Women</b>	Runs employability advice sessions and IT training primarily for women from Syria, Iran, Iraq and Turkey.	<a href="https://rojwomen.wordpress.com">https://rojwomen.wordpress.com</a>  31-33 Dalston Lane, E8 3DF
<b>Citizens Advice Hackney</b>	Advice on immigration debt, benefits, housing, legal, discrimination, employment, consumer and other problems	020 8525 6350  300 Mare Street, E8 1HE
<b>Toynbee Free Legal Advice Service for Women only</b>	Offers legal advice on immigration, employment, housing, domestic violence, and forced marriages.	020 7392 2978  Toynbee Hall, 28 Commercial Street, E1 6LS
<b>Rights of Women</b>	Telephone advice service. Offers legal advice to women on immigration and domestic violence.	020 7490 7689  <a href="http://rightsofwomen.org.uk">http://rightsofwomen.org.uk</a>  52-54 Featherstone Street, EC1Y 8RT
<b>Agudas Israel Community Services</b>	Offer assistance with claims for benefits, immigration, and employment as well as general advice to the Charedi community.	020 8800 6688



<b>Hackney Community Law Centre</b>	Provides free and independent legal advice and representation to Hackney residents.	020 8985 5236 <a href="https://www.hclc.org.uk/">https://www.hclc.org.uk/</a> 8 Lower Clapton Road
<b>Joint Council for the Welfare of Immigrants</b>	Free and confidential phone advice for migrants.	020 7553 7470 115 Old Street EC1V 9RT
<b>Central Africa's Rights and AIDS Society</b>	Provides free counselling, legal advice, advocacy and referrals on HIV/AIDS.	0844 478 0015 18-22 Ashwin Street
<b>Project 17</b>	Online resources for families with NRPF seeking local authority support.	07963 509 044 <a href="http://www.project17.org.uk/">http://www.project17.org.uk/</a>
<b>Body of Christ Church Charity</b>	Advice, signposting, translation and advocacy service for the African community.	020 7682 4948 <a href="mailto:bodyofchristcharity@yahoo.co.uk">bodyofchristcharity@yahoo.co.uk</a>
<b>Latin American Women's Aid</b>	LAWA provides advocacy, advice and temporary refuge space to Latin America women and their children.	020 7275 0321 <a href="mailto:info@lawadv.org.uk">info@lawadv.org.uk</a> The Print House 10-16 Ashwin Street E8 3DL
<b>Rise Community Action</b>	Rise Community Action (formerly Hackney Women's Project) was established in 2004 to provide information, care and support to HIV positive women living in the London Borough of Hackney.	02072496349 31-33 Dalston Lane E8 3DF
<b>African Support and Project Centre</b>	Supporting African French, Lingala and Swahili individuals and families in the UK.	020 8986 6966 Wally Foster Community Centre, Homerton Road E9 5QB
<b>Precious Lives</b>	Provides training opportunities, employment enhancement training, recreational activities and interventional services	0207 249 7634 <a href="mailto:contact@preciouslives.org.uk">contact@preciouslives.org.uk</a>

<b>Alevi</b>	Community centre for Turkish and Kurdish providing advice on benefits, employment, health, housing rights, immigration and discrimination.	020 7241 6285 89 Ridley Road E8 2NH
<b>Halkevi</b>	Provides advice and support services for the Kurdish/Turkish refugee communities in London.	02072496349 <a href="mailto:halkeviuk@gmail.com">halkeviuk@gmail.com</a> 31-33 Dalston Lane E8 3DF
<b>Vietnam Laos Cambodia (VLC) Centre</b>	Community centre and social enterprise offering a wide range of activities and amenities for the benefit of local and wider communities.	020 7739 3650 151 Whiston Road E2 8BN

### 11.1.2 Community services and forums

Table 7: Community services and forums

Name of Service	Description	Contact Details
<b>Hackney Refugee Forum</b>	Umbrella network for refugee organisations.	0207 923 1962 <a href="mailto:ali@hcv.org.uk">ali@hcv.org.uk</a> 24-30 Dalston Lane
<b>AFRIDAC</b>	Conducts research and provides advocacy, policy, engagement, and campaigns.	34 Vanner Point, Wick Road, E9 5AX
<b>Hackney African Forum</b>	Promotes culturally appropriate health strategies for African communities, capacity building for member organisations, and information to improve working relationships among African community groups.	
<b>Akwaaba</b>	Social centre for refugees and migrants. Offers a range of services and classes.	07516 675995 <a href="mailto:akwaabalondon@gmail.com">akwaabalondon@gmail.com</a> Princess May Primary School, N16 8AJ

<b>Day-Mer Turkish &amp; Kurdish Community Centre</b>	Services mainly targeted at Turkish and Kurdish help with interpretation, accommodation and welfare advice.	020 7275 8440 <a href="http://www.daymer.org">http://www.daymer.org</a>
<b>Hackney Chinese Community Services</b>	Provides information and advice. Offers a range of services and classes.	020 8986 6171 <a href="http://www.chinesecentre.org.uk/">http://www.chinesecentre.org.uk/</a>  28-32 Ellingfort Road E8 3PA
<b>Hackney Cypriot Association</b>	Provides information and advice. Offers a range of services.	020 7249 4494 <a href="http://www.hackneycypriotassociation.org">http://www.hackneycypriotassociation.org</a>  5 Balls Pond Rd, N1 4AX
<b>North London Muslim Community Centre (NLMCC)</b>	Provides information and advice. Offers a range of services.	020 8806 1147 <a href="http://www.nlmcc.org.uk/">http://www.nlmcc.org.uk/</a>  66-68 Cazenove Road N16 6AA
<b>An Viet Foundation</b>	Advice on benefits, housing, immigration and nationality. Interpreting and translation service. Offers a range of services and classes.	020 7275 7780  12-14 Englefield Rd, N1 4LS
<b>Refugee Women's Association</b>	Provides information and advice. Offers a range of services.	020 7923 2412  The Print House, 18-22 Ashwin St, E8 3DL
<b>Refugee Workers Cultural Association</b>	Provides support to the Turkish and Kurdish community in Hackney. Offers a range of services and classes.	020 7249 9983  3-19 Victorian Grove, N16 8EN
<b>Congolese Youth Association</b>	Provides advice, assistance and support to Congolese parents and their children.	020 7923 0333  Unit C6, 3 Bradbury Street, N16 8JN
<b>Minik Kardes Children Centre</b>	Bilingual nursery providing full day care and education for children and families mainly from the Turkish, Kurdish and Turkish Cypriot communities	020 7923 7226  53-55 Balls Pond Rd, N1 4BW
<b>African Community School</b>	Offers revision class for GCSE's, homework support, ICT class, youth programmes.	<a href="http://acschool.org.uk/">http://acschool.org.uk/</a>

### 11.1.3 Health services

Table 8: Health services

Name of Service	Description	Contact Details
<b>Doctors of the World</b>	Offers primary care and health and social advice from volunteer doctors, nurses and support workers.	020 75157534  Praxis Pott Street E2 0EF
<b>Green Light</b>	Offer primary health screening in a mobile van. Work in conjunction with North London Action for the Homeless.	St Paul's Church Hall, Stoke Newington Road, N16 7UE
<b>Cara</b>	CARA provides HIV/AIDS prevention, care and support.	0844 478 0015  18-22 Ashwin Street, E8 3DL
<b>Bump Buddies</b>	Offers information, mentoring, training and support to pregnant women	020 7033 8500  Units 1–2 Waterhouse, 8 Orsman Road, N1 5QJ
<b>Maternity action</b>	Advocacy and advice on maternity related health and care services.	0808 800 0041  <a href="http://www.maternityaction.org.uk">www.maternityaction.org.uk</a>
<b>Hawa Trust</b>	Work with African and other ethnic minority communities to support communities tackling (FGM), changing attitudes, providing information for referrals	0203 441 4688  07852 360 272  info@hawatrust.org.uk
<b>DERMAN</b>	Free service for Kurdish, Turkish, Turkish Cypriot and Eastern European Turkish individuals. Offers counselling, mental health support and domestic violence support.	020 7613 5944  <a href="http://derman.org.uk/">http://derman.org.uk/</a>  66 New N Rd, N1 6TG
<b>Freedom From Torture</b>	Treatment and rehabilitation of survivors of torture; also write medico-legal reports	020 7697 7777  <a href="http://www.freedomfromtorture.org/">www.freedomfromtorture.org/</a>

<b>Room to Heal</b>	Therapeutic community for refugees and asylum seekers who have survived torture and other forms of organised violence.	0207 241 5941 <a href="http://roomtoheal.org">http://roomtoheal.org</a>
<b>Deaf Plus</b>	Offers advice and support to hearing impaired residents on a variety of issues including immigration.	Hackney Service Centre, 1 Hillman Street, E8 1DY HAS@deafplus.org 07459150081
<b>Star children</b>	Supports parents and relatives of children living with disabilities.	<a href="http://uk.starchildreninitiative.org">http://uk.starchildreninitiative.org</a>

### 11.1.4 Housing services

Table 9: Housing and homelessness services

Name of Service	Description	Contact Details
<b>Street Legal</b>	Links specialist immigration advisers with homeless outreach services across London.	<a href="mailto:Streetlegal@praxis.org.uk">Streetlegal@praxis.org.uk</a> Pott Street, London E2 0EF
<b>North London Action for the Homeless</b>	Provides advice drop in centre for the homeless and soup kitchen twice a week. Has associated TB screening service and mobile medical van.	St Paul's Church Hall, Stoke Newington Road, N16 7UE
<b>ASAP (Asylum Support Appeals Project)</b>	Offers free legal representation and advice to asylum seekers and refused asylum seekers appealing against Home Office decisions. Second-tier Advice Line enables other advisers to access expertise directly and receive legal advice for their clients.	020 3716 0283 <a href="http://www.asaproject.org">www.asaproject.org</a>

### 11.1.5 Domestic violence services

Table 10: Domestic violence services

Name of Service	Description	Contact Details
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<b>Domestic Abuse Intervention Service</b>	Telephone support and face to face service. Works with victims and perpetrators.	0800 056 0905 <a href="mailto:dais@hackney.gov.uk">dais@hackney.gov.uk</a>
<b>NIA</b>	Offers advice, support, refuge, and counselling.	0207 683 1270 <a href="http://www.niaendingviolence.org.uk/">http://www.niaendingviolence.org.uk/</a>
<b>Imece</b>	Works with particularly Turkish/Kurdish clients but also BME groups. Offers advice, drop in and counselling.	020 7354 1359 <a href="mailto:info@imece.org.uk">info@imece.org.uk</a> 2 Newington Green Rd
<b>Woman's Trust</b>	Offers person-centered one-to-one counselling self-development workshops and support groups for victims of domestic violence in east London.	0207 034 0303 <a href="http://www.womanstrust.org.uk/">http://www.womanstrust.org.uk/</a>

## 12 Discussion

This report has synthesised the health needs of migrants living in Hackney and the City of London. However, gaining a meaningful understanding of the health and wellbeing needs of such a large and varied group is complex. Migrants arriving to the UK have had a vastly different array of personal experiences and social backgrounds which makes drawing out general themes a challenge.

That said, drawing together findings from current literature, national policy, national and local data and interviews with stakeholders, clear themes emerge around the challenges that migrants living in Hackney and the City of London currently face. On first arriving to the UK, migrants have better standards of reported health than those of the same age and gender who were born here. However, over time this 'healthy migrant effect' declines and many health outcomes equate to or are worse than that of the UK born population. Forced migrants, who make up around 5% of all those immigrating to the UK, are different from general migrants in that they tend to have relatively worse health than the UK born population on arrival which then declines further over time.

*How can the disparity in health outcomes between the migrant and non-migrant population be eliminated?*

Answering this question will require a multifaceted approach. The decline in migrant health relative to UK born individuals is a result of a variety of interlinking hardships: poverty, social isolation, inadequate access to health services, discrimination, acquired unhealthy lifestyles and poorer work and living conditions. Improvements in all of these areas are possible but will involve coordination and planning over a wide number of areas in order to create significant and lasting change. Evidence has shown that migrants are consistently found to have more pronounced ill health in four main areas:

- Non-communicable diseases such as diabetes, obesity and cardiovascular disease
- Communicable diseases like HIV and TB
- Women's health, particularly outcomes related to pregnancy and childbirth
- Mental health

Our local data reflected similar findings in all these areas apart from mental health which may have been due to under reporting, under diagnosis, or miscoding. Notably, migrants from Turkey, the Caribbean, South Asia and Sub-Saharan Africa displayed worse outcomes in several domains, particularly around non-communicable disease and mental health issues. This finding may be helpful in targeting future interventions in these populations.

This report found low levels of uptake of the NHS Health Check among members of the Asian and Turkish/Cypriot communities. It may be that these groups are disproportionately affected by the barriers to accessing health care identified in this

report, particularly language barriers, knowledge about entitlements, and mistrust of health care professionals.

Due to barriers accessing health care services, migrants and refugees may more likely to self-treat and wait until health problems become acute. They may be more likely to use A&E. It is clear that in most respects the difficulty lies not just with migrants themselves but with the varying degrees of knowledge held by frontline health care workers and advice service providers in the context of the recent, rapid changes in UK immigration law and health care provision for migrants.

The recent introduction of charging for many NHS secondary care services is very likely to have a marked impact on the wellbeing of migrants and in particular, undocumented and forced migrants. From October 2017, NHS hospitals are legally obliged to check if patients are eligible for charges through identification checks. There is clear evidence of local migrants and refugees who are entitled to care delaying or underusing services because of a fear of incurring charges or risking future deportation. Identification checks may further exacerbate this disparity in health care access.

The impact of the introduction of charging on undocumented migrants should not be overlooked. There is now thought to be an estimated 400,000 to 800,000 undocumented migrants in London. Historically, health services and other support services directed toward migrants have not tended to actively distinguish between those with and without residency status to avoid discriminating against clients, putting them off engagement or indeed facilitating in their deportation. However, in the context of legislative changes aimed at creating a 'hostile environment' for those without residency status, it is highly likely that the health and wellbeing of undocumented migrants is likely to be impacted in the future. Restrictions in accessing health care, employment and housing in Hackney and the City of London may contribute to decreased health outcomes among undocumented migrants. Restrictions will continue to have a knock on effect on the lives of all migrants due to a lack of clarity around rights and entitlements.

Hackney and the City of London have a proud history of welcoming migrants and making positive steps to improve the lives of its diverse residents. With the advent of Brexit and rapid changes to health access and immigration laws, a thoughtful and co-ordinated approach is required to preserve and improve the health and wellbeing of migrant residents.



## 13 Recommendations

While healthier on arrival, migrants have worse health and wellbeing outcomes in comparison to those born in the UK the longer that they remain here. Recent legislative changes and the introduction of health charges are rapidly changing the health environment. We recommend:

- Key local stakeholders work together to address the health and wellbeing needs of migrant groups.
- Objectives for improving migrant health and wellbeing are embedded in Integrated Commissioning work streams with the aim of reducing health inequalities between migrant and non-migrant populations.
- Encouraging the development of champions in each stakeholder organisation whose focus is on improving the health and wellbeing of migrants living in Hackney and the City of London.

The following are specific recommendations for improving the health and wellbeing of migrants living in Hackney and the City of London. Recommendations address problems and issues identified through this needs assessment; we suggest a course of action and the responsible partner agencies.

*Table 11: Recommendations for maternity and mental health services*

<b>Problem</b>	<b>Recommended actions</b>	<b>Partner</b>
There is evidence that local migrant women are accessing maternity care late. This has resulted from fears regarding deportation, accruing costs, as well as being unable or unwilling to register with local primary care services.	<ul style="list-style-type: none"> <li>• Encourage the dissemination of accurate advice on potential charges and the means to resolve these debts.</li> <li>• Highlight the maternity issues to primary care staff and secondary care staff engaged in maternity services.</li> </ul>	<ul style="list-style-type: none"> <li>• City and Hackney Clinical Commissioning Group</li> <li>• GP Confederation</li> <li>• Maternity programme board</li> </ul>
Undocumented migrant women are being charged for care but are often unable to pay. Non-payment of accrued charges may lead to deportation.	<ul style="list-style-type: none"> <li>• Encourage local maternity services to produce clear guidance on their approach to charging undocumented migrants.</li> <li>• Encourage health care providers to share information on potential charges at the point of initial contact.</li> </ul>	<ul style="list-style-type: none"> <li>• Homerton University Hospital</li> <li>• Voluntary and community organisations</li> </ul>

	<ul style="list-style-type: none"> <li>• Flag women who may be subject to charging at early stages of pregnancy to support organisations.</li> </ul>	
<p>Migrants, particularly forced migrants, have poorer mental health outcomes which is exacerbated by barriers in accessing and using mental health services.</p>	<ul style="list-style-type: none"> <li>• Increase awareness of migrant mental health organisations among general migrant services, local advice services, mental health services, and health professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• City and Hackney Clinical Commissioning Group</li> <li>• GP Confederation</li> <li>• Homerton University Hospital</li> <li>• City and Hackney Mind</li> <li>• Voluntary and community organisations</li> </ul>

Table 12: Recommendations for improving knowledge of the UK health care system

Problem	Recommended actions	Partners
<p>Migrant entitlements to the NHS have changed rapidly and may continue to change.</p> <p>Migrants appear to lack understanding of their entitlements to the NHS and as a result they appear to underuse or misuse services.</p>	<ul style="list-style-type: none"> <li>• Disseminate guidance regarding migrant entitlements to access NHS services.</li> <li>• Ensure advice and information disseminated through frontline services are accurate and up-to-date.</li> <li>• Ensure iCare has a comprehensive list of services available for migrants that is accurate and up-to-date.</li> <li>• Encourage GP and A&amp;E professionals to ensure new migrants understand the NHS, particularly the</li> </ul>	<ul style="list-style-type: none"> <li>• Voluntary and community organisations</li> <li>• City and Hackney Clinical Commissioning Group</li> <li>• GP Confederation</li> </ul>

	remit of primary care and secondary care.	
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*Table 13: Recommendations for improving the health and wellbeing of undocumented and forced migrants*

<b>Problem</b>	<b>Recommended actions</b>	<b>Partners</b>
<p>There may be large numbers of undocumented migrants in Hackney and the City of London that may experience worse health outcomes compared to other migrants and the general population.</p> <p>Migrant services are reluctant to actively identify and gather information on undocumented migrants.</p>	<ul style="list-style-type: none"> <li>Consider how stakeholders can work together to ensure the health and wellbeing of undocumented migrants is being addressed.</li> <li>Develop understanding of the specific needs of undocumented migrants in the borough.</li> </ul>	<ul style="list-style-type: none"> <li>Hackney Council</li> <li>City of London Corporation</li> <li>City and Hackney Clinical Commissioning Group</li> <li>Homerton University Hospital</li> <li>Voluntary and community organisations</li> </ul>
<p>There is a lack of knowledge of the impact of modern day slavery and human trafficking.</p>	<ul style="list-style-type: none"> <li>Support available training for frontline staff on identifying the signs of modern slavery and human trafficking and how to report.</li> <li>Support the development of clear referral routes and data monitoring procedures on modern day slavery and human trafficking.</li> </ul>	<ul style="list-style-type: none"> <li>Met Police and City of London Police</li> <li>Adult Safeguarding Board</li> <li>Child Safeguarding Board</li> </ul>

*Table 14: Recommendations for meeting the emerging needs of EU migrants*

<b>Problem</b>	<b>Recommended actions</b>	<b>Partner</b>
<p>EU migrants face a lack of clarity around their future rights and entitlements.</p>	<ul style="list-style-type: none"> <li>Develop and disseminate guidance on the rights of EU</li> </ul>	<ul style="list-style-type: none"> <li>Hackney Council</li> </ul>

EU migrants are likely to seek advice and support from pre-existing services for migrants which largely work with non-EU, forced and undocumented migrants. This may put an added strain on services.	migrants when information becomes available.	<ul style="list-style-type: none"> <li>• City of London Corporation</li> <li>• Voluntary and community organisations</li> </ul>
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Table 15: Recommendations for improving access to migrant services

Problem	Recommended actions	Partner
There are numerous services for migrants in Hackney. However, many seem to operate in isolation. There is overlap between some services, particularly advice services.	<ul style="list-style-type: none"> <li>• Encourage coordination and cooperation of migrant services.</li> <li>• Improve signposting between migrant services by ensuring iCare is comprehensive, accurate, and up-to-date.</li> </ul>	<ul style="list-style-type: none"> <li>• Policy team</li> <li>• Voluntary and community organisations</li> <li>• City and Hackney Clinical Commissioning Group</li> </ul>
There are many available advice services for migrants in the borough. The standards for advice, however, can vary.	<ul style="list-style-type: none"> <li>• Ensure guidance and advice is accurate and up-to-date.</li> </ul>	<ul style="list-style-type: none"> <li>• Policy team</li> </ul>
Primary care professionals may have limited knowledge of the services available to migrants in the borough.	<ul style="list-style-type: none"> <li>• Ensure iCare is comprehensive, accurate, and up-to-date.</li> <li>• Encourage primary care to be familiar with iCare and available services for migrants.</li> </ul>	<ul style="list-style-type: none"> <li>• City and Hackney Clinical Commissioning Group</li> <li>• GP Confederation</li> </ul>
Migrants with NRPF <sup>14</sup> are struggling to access section 17 support as well as other forms of social benefits.	<ul style="list-style-type: none"> <li>• Support available training on the rights of migrants with NRPF.</li> </ul>	<ul style="list-style-type: none"> <li>• NRPF team</li> </ul>
There are a limited number of ESOL <sup>15</sup>	<ul style="list-style-type: none"> <li>• Increase visibility of ESOL advice service.</li> </ul>	<ul style="list-style-type: none"> <li>• Policy team</li> </ul>

<sup>14</sup> No recourse to public funds.

<sup>15</sup> English for speakers of other languages.

services for migrants in Hackney and the City of London. Migrants may not be aware of what is available.	<ul style="list-style-type: none"> <li>• Diversify the times and locations of ESOL classes.</li> </ul>	<ul style="list-style-type: none"> <li>• Hackney Learning Trust</li> </ul>
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Table 16: Recommendations for guidance and professional development

Problem	Recommended actions	Partner
Many health professionals are unaware of the differences between different groups of migrants, changes to immigration law, and changes to NHS charging regulations.	<ul style="list-style-type: none"> <li>• Disseminate guidance for primary and secondary care professionals summarising recent changes to charging for migrants and entitlements to access health care.</li> </ul>	<ul style="list-style-type: none"> <li>• City and Hackney Clinical Commissioning Group</li> <li>• GP Confederation</li> <li>• Homerton University Hospital</li> <li>• East London NHS Foundation Trust</li> </ul>
There is a lack of knowledge regarding the data sharing agreements between NHS Digital and the Home Office.	<ul style="list-style-type: none"> <li>• Raise awareness of the memorandum of understanding between the Home Office and NHS Digital.</li> </ul>	<ul style="list-style-type: none"> <li>• City and Hackney Clinical Commissioning Group</li> <li>• Primary care programme board</li> <li>• GP Confederation</li> </ul>
There is evidence that GP practices have denied registering migrants as patients.	<ul style="list-style-type: none"> <li>• Disseminate guidance regarding accepting patients without documentation.</li> <li>• Encourage primary care providers to develop innovative approaches that would allow maintenance of a good standard of care.</li> </ul>	<ul style="list-style-type: none"> <li>• City and Hackney Clinical Commissioning Group</li> <li>• GP Confederation</li> </ul>

	For example, allowing patients to register the practice address as their home address.	
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## 14 Future research

While this report has sought to take as comprehensive an approach to migrant health as possible, several areas of this report remain underdeveloped due to the vast scope of the subject matter and time constraints of this project. Future updates of this report should seek to present a more in depth view of the health and wellbeing of those at the edges of the age spectrum. Childhood illness, geriatric and palliative care are central to migrant health but very little is recorded about this in established literature.

A greater understanding of the health needs and services in the City of London would also be beneficial, particularly in the areas of substance abuse, domestic violence, and mental health which are reported to be problematic for migrants in the borough.

A more in depth picture of more prominent migrant groups in Hackney and the City would also be useful. An example of such a report was produced in 2013 focusing on the Turkish population of east London [177].

Finally, it is almost inevitable that new additions to immigration laws and health charges will continue to be created in the coming years. The spectre of Brexit also hangs over the horizon adding uncertainty to the status of some migrants. Future editions should ensure to relay any changes to immigration law and health charges.

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## 16 Appendices

### 16.1 Glossary of terms

**A&E** Accident and Emergency

**AIDS** acquired immune deficiency syndrome

**CAB** Citizens Advice Bureau

**CCG** Clinical Commissioning Group

**DOTW** Doctors of the World

**EEA** European Economic Area

**ESOL** English for Speakers of Other Languages

**EU** European Union

**GP** General Practitioner

**HIV** Human Immune-Deficiency Virus

**JSNA** Joint Strategic Needs Assessment

**LA** Local Authority

**LGBT** Lesbian, Gay, Bisexual, Transgender

**NICE** National Institute of Health and Clinical Excellence

**NHS** National Health Service

**NRPF** No recourse to public funds

**ONS** Office for National Statistics

**TB** Tuberculosis

**UK** United Kingdom

**UKBA** United Kingdom Border Agency

**UNHCR** United Nations High Commissioner for Refugees

**VPRS** Vulnerable Persons Resettlement Scheme

**WHO** World Health Organisation

## 16.2 Interview questionnaire

### Semi-Structure Interview Questionnaire: Community Worker and Health care Professional Respondents

#### Introduction

- 1) Describe your role and organisation.
- 2) How long have you worked with migrant and refugee populations?
- 3) How often do you see undocumented migrants?

#### Barriers to Access

- 4) Describe the level of knowledge that your migrant and refugee clients have about the health care system.
- 5) Do your migrant and refugee clients face barriers accessing health care?
- 6) What types of issues or problems arise most frequently?
- 7) There has been evidence of a lack of trust in health care professionals, such as GPs, nurses, or other doctors, reported by migrants and refugees. In your work, have you found this to be the case?
- 8) What happens when your clients have difficulties negotiating the health care system?

#### Self-Treatment and Self-Management

- 9) Do your clients treat or manage their own health conditions?
- 10) Where do they access information or advice?
- 11) Do they receive health-related support from family and friends?
- 12) Where do they get medicine outside of the health care system?
- 13) What are the general outcomes of your clients treating or managing their own health conditions?

#### Better Outcomes

- 14) What is the impact of self-treatment and self-management on the health care system?
- 15) What needs to be changed to facilitate better access to health care for your clients?

## 16.3 Regional coding

Region	Country	Region	Country
Asia	Bhutan	Middle East	Afghanistan
Asia	Brunei	Middle East	Bahrain
Asia	Burma	Middle East	Iran
Asia	China	Middle East	Iraq
Asia	Hong Kong	Middle East	Israel
Asia	Indonesia	Middle East	Jordan
Asia	Japan	Middle East	Kuwait
Asia	Laos	Middle East	Lebanon
Asia	Malaysia	Middle East	Oman
Asia	Mongolia	Middle East	Palestine
Asia	Philippines	Middle East	Saudi Arabia
Asia	Republic of Korea	Middle East	Syria
Asia	Singapore	Middle East	United Arab Emirates
Asia	South Korea	Middle East	Yemen
Asia	Taiwan	North Africa	Algeria
Asia	Thailand	North Africa	Egypt
Asia	Vietnam	North Africa	Libya
Australia/New Zealand	Australia	North Africa	Morocco
Australia/New Zealand	New Zealand	North Africa	Tunisia
Caribbean	Antigua and Barbuda	North America	Canada
Caribbean	Bahamas	North America	USA
Caribbean	Barbados	Oceania	Fiji
Caribbean	Bermuda	Oceania	Papua New Guinea
Caribbean	Cuba	Oceania	Solomon Islands
Caribbean	Dominica	Oceania	Tonga
Caribbean	Dominican Republic	South Asia	Bangladesh
Caribbean	Grenada	South Asia	India
Caribbean	Jamaica	South Asia	Pakistan
Caribbean	Martinique	South Asia	Sri Lanka
Caribbean	Montserrat	Sub-Saharan Africa	Angola
Caribbean	St. Kitts and Nevis	Sub-Saharan Africa	Botswana
Caribbean	St. Lucia	Sub-Saharan Africa	Burundi
Caribbean	St. Vincent	Sub-Saharan Africa	Cameroon

<b>Caribbean</b>	Trinidad and Tobago	<b>Sub-Saharan Africa</b>	Cape Verde Islands
<b>Central and South America</b>	Argentina	<b>Sub-Saharan Africa</b>	Central African Republic
<b>Central and South America</b>	Bolivia	<b>Sub-Saharan Africa</b>	Congo
<b>Central and South America</b>	Brazil	<b>Sub-Saharan Africa</b>	Democratic Republic of Congo
<b>Central and South America</b>	British Guyana	<b>Sub-Saharan Africa</b>	Djibouti
<b>Central and South America</b>	Chile	<b>Sub-Saharan Africa</b>	Equatorial Guinea
<b>Central and South America</b>	Columbia	<b>Sub-Saharan Africa</b>	Eritrea
<b>Central and South America</b>	Costa Rica	<b>Sub-Saharan Africa</b>	Ethiopia
<b>Central and South America</b>	Ecuador	<b>Sub-Saharan Africa</b>	Gambia
<b>Central and South America</b>	Guyana	<b>Sub-Saharan Africa</b>	Ghana
<b>Central and South America</b>	Mexico	<b>Sub-Saharan Africa</b>	Guinea Bissau
<b>Central and South America</b>	Nicaragua	<b>Sub-Saharan Africa</b>	Guinea Republic
<b>Central and South America</b>	Panama	<b>Sub-Saharan Africa</b>	Ivory Coast
<b>Central and South America</b>	Paraguay	<b>Sub-Saharan Africa</b>	Kenya
<b>Central and South America</b>	Peru	<b>Sub-Saharan Africa</b>	Liberia
<b>Central and South America</b>	Uruguay	<b>Sub-Saharan Africa</b>	Malawi
<b>Central and South America</b>	Venezuela	<b>Sub-Saharan Africa</b>	Mauritius
<b>Eastern Europe</b>	Albania	<b>Sub-Saharan Africa</b>	Mozambique
<b>Eastern Europe</b>	Armenia	<b>Sub-Saharan Africa</b>	Namibia
<b>Eastern Europe</b>	Azerbaijan	<b>Sub-Saharan Africa</b>	Niger
<b>Eastern Europe</b>	Belorussia	<b>Sub-Saharan Africa</b>	Nigeria
<b>Eastern Europe</b>	Bosnia - Herzegovnia	<b>Sub-Saharan Africa</b>	Rwanda
<b>Eastern Europe</b>	Bulgaria	<b>Sub-Saharan Africa</b>	Sao Tome and Principe
<b>Eastern Europe</b>	Croatia	<b>Sub-Saharan Africa</b>	Senegal
<b>Eastern Europe</b>	Czech Republic	<b>Sub-Saharan Africa</b>	Seychelles

<b>Eastern Europe</b>	Estonia	<b>Sub-Saharan Africa</b>	Sierra Leone
<b>Eastern Europe</b>	former Yugoslav Republic of Macedonia	<b>Sub-Saharan Africa</b>	Somalia
<b>Eastern Europe</b>	Georgia	<b>Sub-Saharan Africa</b>	South Africa
<b>Eastern Europe</b>	Hungary	<b>Sub-Saharan Africa</b>	Sudan
<b>Eastern Europe</b>	Kazakhstan	<b>Sub-Saharan Africa</b>	Swaziland
<b>Eastern Europe</b>	Kosovo	<b>Sub-Saharan Africa</b>	Tanzania
<b>Eastern Europe</b>	Kyrgyzstan	<b>Sub-Saharan Africa</b>	The Gambia
<b>Eastern Europe</b>	Latvia	<b>Sub-Saharan Africa</b>	Togo
<b>Eastern Europe</b>	Lithuania	<b>Sub-Saharan Africa</b>	Uganda
<b>Eastern Europe</b>	Moldavia	<b>Sub-Saharan Africa</b>	Zaire
<b>Eastern Europe</b>	Poland	<b>Sub-Saharan Africa</b>	Zambia
<b>Eastern Europe</b>	Republic of Moldova	<b>Sub-Saharan Africa</b>	Zimbabwe
<b>Eastern Europe</b>	Romania	<b>Turkey/Cyprus</b>	Cyprus
<b>Eastern Europe</b>	Russia	<b>Turkey/Cyprus</b>	Turkey
<b>Eastern Europe</b>	Serbia	<b>UK</b>	England
<b>Eastern Europe</b>	Slovakia	<b>UK</b>	Northern Ireland
<b>Eastern Europe</b>	Slovenia	<b>UK</b>	Scotland
<b>Eastern Europe</b>	Tajikistan	<b>UK</b>	Wales
<b>Eastern Europe</b>	Turkmenistan	<b>Western Europe</b>	Austria
<b>Eastern Europe</b>	Ukraine	<b>Western Europe</b>	Belgium
<b>Eastern Europe</b>	Uzbekistan	<b>Western Europe</b>	Denmark
<b>Eastern Europe</b>	Yugoslavia	<b>Western Europe</b>	Finland
		<b>Western Europe</b>	France
		<b>Western Europe</b>	Germany
		<b>Western Europe</b>	Greece
		<b>Western Europe</b>	Iceland
		<b>Western Europe</b>	Ireland
		<b>Western Europe</b>	Isle of Man

		<b>Western Europe</b>	Italy
		<b>Western Europe</b>	Luxembourg
		<b>Western Europe</b>	Malta
		<b>Western Europe</b>	Norway
		<b>Western Europe</b>	Portugal
		<b>Western Europe</b>	Republic of Ireland
		<b>Western Europe</b>	Spain
		<b>Western Europe</b>	Sweden
		<b>Western Europe</b>	Switzerland
		<b>Western Europe</b>	The Netherlands