

Health Needs Assessment of the Nepali Community in Rushmoor

October 2010

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Executive Summary

Introduction

This report was created because of the recent growth of the Nepali community in Rushmoor and as this trend is likely to continue. This is a consequence of the highly publicized campaign for the right of ex- Gurkhas to settle in the UK. This campaign has led to changes in the law which allow ex Gurkhas to settle in the UK and, as Rushmoor has a military base in Aldershot, this military connection has meant that significant migration has occurred to this area. The population of Rushmoor was estimated as being 89,600 in 2008 and recent research and anecdotal evidence suggests that at least 6000 of those residents are Nepali. Recent EMTAS data has shown that 800 children in Rushmoor have Nepali as their first language which is 7.4% of all children in Rushmoor. Despite the significant size of this community little was known about its specific health needs.

Methods

This health needs assessment is focussed on health as well as including information on the wider determinants of health.

Quantifying the health needs of this community through routine data sources such as GP information systems or hospital systems was not possible in most cases. This was due to the fact that Nepali are recorded within wider ethnicity categories which contains people from other countries. This is not a unique problem to health information systems as the Census also fails to categorize them separately. These data issues lead to the methods of this research to be redesigned. The only disease figures reported are those for notifiable diseases which were collected by the Health Protection Unit and data on infectious disease collected by Frimley Park Hospital. The rest of the information collected was from interviews and focus groups with local health professionals, the Nepali community and other community service providers. The following is a list of those interviewed.

<p>The Nepali Community</p> <p>Focus groups from:</p> <ul style="list-style-type: none"> • Madat Shamuha • British Gurkha Welfare Society • A female group who are taking English language lessons <p>A total of approximately 50 participants were involved.</p>
<p>Healthcare</p> <p>8/12 GP practices in the Practice Based Commissioning area of Rushmoor. Pharmacist Dentist Community Diabetic Nurse Community Team Midwife Health professionals from Frimley Park hospital:</p> <ul style="list-style-type: none"> • An ophthalmologist • An orthopaedic surgeon • A gastroenterologist • A Nepali dietician <p>Representatives from the Drug and Alcohol treatment services Hampshire NHS Quit4Life</p>
<p>Community Service Providers</p> <ul style="list-style-type: none"> • The Police • The Fire Service • Youth worker • The Pension Service • Job Centre Plus • A serving Nepali member of the military • Education: Teachers and a parent from Cove School, Cherrywood Primary School and Farnborough Grange Nursery/Infant Community School contributed to this.

Results and Recommendations

The results were as follows:

The wider determinants of health:

The main issues identified were:

- A public perception that the community carry knives
- Racism and bullying in the Rushmoor community
- Cultural and language barriers (particularly in elderly and women)
- Different educational system here compared with Nepal.
- Lack of understanding of the British justice system and fear of police
- Drug use in young Nepali males (heroin)
- Limited knowledge on how to access public services like the fire service
- Deprivation and overcrowding in housing
- Domestic violence being a taboo subject in the Nepali community

- Difficulty in gaining employment if in possession of poor English language skills
- Reluctance of Nepali to access benefits and administrative barriers when they do so.

Health and Health Care Issues

The main highlights from the infectious disease data are:

- 7% (35) of notified cases of TB in Hampshire from 2006-2009 were in Nepali individuals.
- The majority of those cases (82% or 29 cases) in Nepali individuals were in Rushmoor.
- The number of cases of TB in this community is generally rising, apart from a decrease in numbers in 2008. The highest number of cases was in 2009.
- There are very small numbers of cases of other infectious disease such as typhoid or paratyphoid.

The main priorities for action were chosen according to the priorities of the local community and healthcare professionals along with consideration of the implications and potential magnitude of the problem locally.

Main health problems identified by local professionals and the Nepali community

Disorder	Comments
Diabetes	<ul style="list-style-type: none"> Type 2 diabetes was felt to be more common in the Nepali community by both health professionals and the community itself.
Tuberculosis	<ul style="list-style-type: none"> Nepal is a TB endemic country with 173 cases/100,000 people. 7% (35) of notified cases of TB in Hampshire are in the Nepali community (based on figures reported by HPU from 2006-2009).
Cardiovascular disease and hypertension	<ul style="list-style-type: none"> These were both identified as significant problems by the community and by health professionals
Mental Illness	<ul style="list-style-type: none"> The health professionals reported very low levels of mental health problems in the community and difficulty in diagnosing it, perhaps due to cultural differences. The community spoke about depression being common in older ladies.
Reproductive and Sexual Health problems	<ul style="list-style-type: none"> Higher abortion rates in this community have been reported by health professionals. Ladies from the Nepali community spoke about the limited amount of available information on contraception. Despite hepatitis B having an intermediate prevalence in this community (according to the CDC) a very small number of cases has been detected in Rushmoor. Local health professionals wonder if this is due to low testing levels. Gynaecological cancers such as cervical and endometrial were suggested as common in this community especially in the newly arrived Nepali females. Opinion was divided in the health professionals on whether Nepali women have good attendance levels for cervical smears.
Dental health	<ul style="list-style-type: none"> 22% of the Nepali in the focus groups said they were registered with a dentist. Additionally a local teacher also thought that Nepali children had worse dentition than their British counterparts. The local dentist interviewed thought that those registered were well engaged with preventative dental health messages.
Travel related infections	<ul style="list-style-type: none"> Local healthcare professionals felt that the Nepali community rarely attended for travel advice prior to visiting Nepal. This was worrying to them especially as this might mean their children were not getting the appropriate vaccines prior to departure.
Substance Misuse (heroin)	<ul style="list-style-type: none"> The practice of smoking heroin has been widely reported by the community and local professionals. Young Nepali males are thought to be the most at risk group. Inpatient treatment in Nepal for this is preferred by the community. The providing organisation in Nepal, which was named by the community, is potentially affiliated to the Scientology movement (Narconon).

Main health service issues identified by local professionals and the Nepali community

Issues	Comments
Lack of accurate health data to quantify disease burden	<ul style="list-style-type: none"> This is because current health information systems do not have a specific “Nepali” code. This makes estimating the size of the population, their disease burden and evaluation of interventions aimed at this community difficult.
Difficulty registering with primary care	<ul style="list-style-type: none"> GPs in the area described how difficult they found it to interpret Department of Health guidelines in relation to rights to register. The local Nepali community also identified this issue as high priority for them.
Patient identity	<ul style="list-style-type: none"> Similar names, dates of birth and addresses have made confirmation of identity confusing in healthcare settings
Transportation to appointments	<ul style="list-style-type: none"> Some Nepali reported difficulty accessing appointments in secondary care because of being unable to afford transport.
Communication in healthcare	<ul style="list-style-type: none"> The interpretation service offered in primary care was spoken about by most groups. Local practices did not like using it and the majority of those in the Nepali focus groups spoken had not had it offered to them. Lack of translated health information. The community felt it would be useful although they did point out that older women were not literate in Nepali. Low levels of health messages to the community. Overall the focus groups spoken to were keen to hear more about health issues. They also reported that there were no health articles in their Nepali papers.
Health knowledge, beliefs and behaviours	<ul style="list-style-type: none"> Local healthcare practitioners reported different consulting behaviour in this community which centred on high expectations for immediate appointments/investigations and a low threshold for presentation to medical services especially in the case of children. The local Nepali community were frustrated by waiting times for appointments and investigations. They also reported that they did not understand how the health system works and which services to use. A number did not know what to do in the case of emergency. Health professionals held mixed views on adherence to treatment in this community. Some Nepali from Rushmoor return to Nepal for treatment or investigations.

Recommendations

These come under four main headings. More details about these can be seen later in the report.

<p>Patient education and enablement</p>
<ul style="list-style-type: none"> • Expert patient programme: This could encourage self management of conditions such as diabetes, mental illness, cardiovascular disease etc. This may also improve adherence to treatment. • Translated information: This could be useful for topics such as diabetes, TB, contraception, sexual health issues and local health service information. • A pharmacy project to develop specially developed medication use instruction sheets is being lead by local pharmacists. • Awareness activities in the community and for health professionals (where appropriate) which address issues such as mental illness, appropriate use of health services (including the importance of bringing back reports of investigations or treatment which occurred in Nepal), travel advice, infections such as TB and Hepatitis B, substance misuse, smoking and alcohol. This could involve the third sector as well as NHS organisations such as NHS Quit 4 Life. • Encouragement of Nepali lead physical activities such as health walks. This could be through community organisations and Rushmoor Healthy Living
<p>Safe access to services</p>
<ul style="list-style-type: none"> • Rights to healthcare: The rights of Nepali residents to healthcare have been clarified with local healthcare professionals. • Identity: Promotion of the use of the NHS number as a method of confirming identity. Local pharmacists are initiating a project for the more routine use of the number in pharmacies. Community organisations have been contacted and asked to promote knowledge of this. • Transport: Dissemination of Frimley Park Hospital's PALS list of voluntary organisations which offer free transport to appointments. • Communication: Review of interpretation services in primary care by NHS Hampshire alongside the Nepali community. The use of media preferred by Nepali to advertise healthcare posts alongside the usual sources to ensure recruitment is representative of the locality. Use of similar media to convey health messages. Additionally a social marketing project is to be conducted by NHS Hampshire.
<p>Research</p>
<ul style="list-style-type: none"> • Data on prevalence of diseases. This project has been initiated by attaching a “Nepalese” code to Nepali patients in GP information systems. This will allow for direct measurement of prevalence of disease. • Diabetes and diet: More research needs to be conducted on Nepali diet in the area as this will allow for the development of culturally appropriate dietary advice. Additional research on diabetes would prove useful especially around areas such as diabetic service utilisation and rate of diabetic complications etc.
<p>Specific service developments</p>
<ul style="list-style-type: none"> • Several services are being commissioned currently: A community TB nurse for the entire Rushmoor Community and a new dental service with a Gurkha outreach component. • A community development worker with a focus on substance misuse issues has been recruited by Rushmoor Borough Council for the entire Rushmoor community. • New born Nepali children are immunised in a local community paediatric clinic in Rushmoor with BCG. Other Nepali children under the age of 16 who may have missed this vaccination should be followed up and offered BCG vaccination.

Conclusion

These recommendations should be implemented through the Public Health team in NHS Hampshire in close partnership with primary and secondary care in Rushmoor as well as the other local healthcare organisations. Communication should be encouraged between those who are working with a similar community in East Berkshire PCT as it may provide opportunities for idea and cost sharing initiatives.

Chapter 1: Introduction and Methods

1.1 Introduction

A health needs assessment is “a systematic review of the health issues facing a population leading to agree priorities and resource allocation that will improve health and reduce inequalities”¹. A health needs assessment can also include the wider determinants of health. The Dahlgren and Whitehead model is widely used to depict these and draws attention to factors which have significant impacts on health, but at first glance, may not be seen to be under the remit of health or the health service.

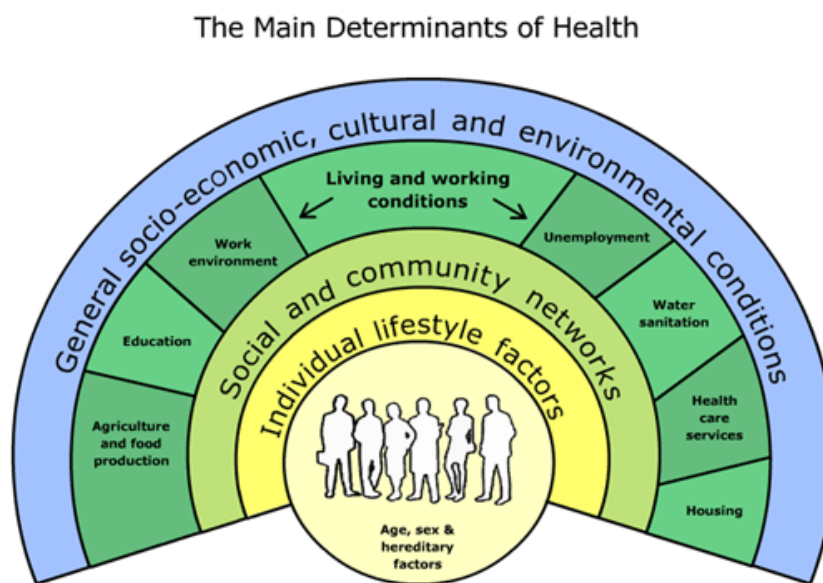


Figure 1 Dahlgren and Whitehead model

Taken from http://www.pharmacymeetspublichealth.org.uk/publichealthbackground_determinants.html

This report was created in response to three main drivers:

1. This community was recognised as a community about which little was known health wise. Traditional routine data sources fail to identify the Nepali as a separate group, hence it has been difficult to build a picture of their health needs to date.
2. Local GP practices in Rushmoor reported a rapid growth in the size of this population and their struggle in providing an appropriate service for them.
3. Following a recent ruling in the House of Commons it is expected that more Nepali, in particular ex- Gurkhas, will settle in the UK. They may settle in garrison towns due to old military links or because there are existing well established communities there. This may mean an unbalanced migration with large impacts on relatively small areas such as Rushmoor.

1.2 Methods

The health needs assessment involved the following steps:

1. **Project initiation.** This involved defining the population under study, objective setting, stakeholder identification, resource identification and risk assessment. This was achieved through setting up a local steering group with local health professionals and local authority representatives.
2. **Identifying health priorities.** This includes population profiling and gathering data on health conditions and perceptions of need. It was not possible to measure these through routine data sources due to data coding issues. This meant that the health needs assessment had a very significant qualitative element and most of the information was gathered by interviewing stakeholders. The quantitative data used included EMTAS data, data from the Department for Work and Pensions as well as data from the Local Health Protection Unit and Frimley Park Hospital.
3. **Choosing health conditions and determinant factors** with the most significant size and severity impact and determining effective and acceptable interventions and actions. The priorities for action were those identified by local health professionals and the community. Recommendations were adopted from suggestions made by these groups where possible.
4. **Planning for change.** This involves describing the interventions chosen and establishing methods for monitoring and evaluation and risk management. Interventions have been chosen and evaluative methods suggested where possible.
5. **Moving on and reviewing the project.** This involves examining the learning from the process, measuring the impact and choosing which priority to move onto next. This is a future step.

1.3 Steps in the Project initiation phase

1. Project Initiation

At the beginning of this project a steering group meeting was held to discuss the project and how it would be conducted. This meeting was used to define many of the points in the initial phase. This group included local health professionals, representatives from NHS Hampshire and the local authority.

2. Definition of the population:

The population covered by this health needs assessment was defined as Nepali who were registered with GPs in the Practice Based Commissioning area of Rushmoor.

3. Defining the Aim of the Health Needs Assessment:

The aim of the health needs assessment was to identify the health needs of the Nepali community in Rushmoor. This was to be done with consultation with local health professionals, other stakeholders in organisations with responsibility over the wider determinants of health, as well as the local Nepali community.

4. Deciding who to involve:

Important stakeholders were identified and approached during the process of the needs assessment. These included representatives from community groups, primary and secondary care as well as Public Health, youth services, Rushmoor Borough Council and other community services.

5. Resource identification

The project was contributed to by the above stakeholders and the report generated in the Public Health Department in NHS Hampshire. The project did not attract extra funding.

6. Risk Identification

The main risks identified in the initial stages were that

1. The Nepali are not identifiable from most routine data sources due to there not being a “Nepali” category for them. The ‘Asian other’ grouping was often used which meant they are often grouped with other ethnicities and nationalities.

2. It may be difficult to engage the community. It did prove difficult to map the community groups, although those who were involved contributed significantly.

Chapter 2: Background

2.1 The path of migration

Nepal: the source of the migration²

Location and Demographics

- Nepal is located in Southern Asia between China and India.
- The population was estimated at approximately at 28,563,377 in 2010.
- 1/3 of the population are under the age of 15 and only 4.2% over the age of 65.

Economy

- Nepal is the poorest country in Asia and the 14th poorest in the world.
- 24.1% of the population earn less than an American dollar per day and 24.7% of the population is living below poverty line.
- Prospects for foreign trade or investment in other sectors are poor. This is due to the small economy, lack of technology, its remote landlocked location, its civil strife and its susceptibility to natural disaster.

Education

- Literacy (defined as being aged 15 or over and can read or write) is low. It is 62.7% for men and 34.9% for women.

Culture and Religion

- There are over 103 caste/ethnic groups in Nepal. 80% of the population are Hindu followed by Buddhism and Islam in popularity.

Rushmoor: the destination^{3, 4}

Location and Demographics

- Rushmoor is a local government district and borough in Hampshire, England. It covers the towns of Aldershot and Farnborough.
- Population was estimated at 89,600 residents in 2008.
- It has the youngest age profile of any district in Hampshire, though the area is aging quickly.

Economy

- According to the Index of Multiple Deprivation 2004, Rushmoor is the third most deprived district in Hampshire. Areas of relative affluence in Rushmoor make local inequalities extreme.

Education

- GCSE attainment is also worse than the England averages.

2.2 Drivers of Nepali migration to the UK

The last Census (2001), which recorded 5,938 Nepali in the U.K., probably underestimated the true number as there was no specific “Nepali” category. This meant that a number of other categories were chosen by the community instead. The total number of Nepali currently in the U.K. is unknown although estimates of 50-80,000 have been quoted.⁵ The Centre for Nepal Studies UK conducted an online Census and estimated there were 72,173 Nepali in the UK on December 31st 2008.⁶

A Runnymede community study on the Nepalese in Britain attempted to describe the different categories of Nepali migrants.⁷ This report described how Nepali have been migrating to the UK as professionals, Gurkhas, overseas students, refugees and asylum seekers. The Gurkhas form the largest of these groups.

The Gurkhas are a significant part of the Nepali community in Rushmoor. (The Gurkhas are those who have served in the British Army and the Nepali are all those from Nepal. Gurkhas will also identify themselves as Nepali.) The Gurkhas have served the British Crown for almost two hundred years. Prior to 1997 the Brigade was focussed in the Far East but since then its base has been in the U.K. The major units of the Brigade are The Royal Gurkha Rifles (two infantry battalions, one in Brunei and one in Dover), The Queen's Gurkha Engineers (Maidstone), The Queen's Gurkha Signals (York, Staffordshire and Warwickshire), and The Queen's Own Gurkha Logistic Regiment (Aldershot). In addition there are two independent companies - Gurkha Company (Sittang) at the Royal Military Academy in Sandhurst and Gurkha Company (Mandalay) at the Infantry Battle School, Brecon.⁸ This strong military connection has meant that ex- Gurkhas and other Nepali have tended to settle in areas around garrisons such as Shorncliffe and Folkestone in Kent and Farnborough and Aldershot in Hampshire.

For the past few years there has been a well publicized campaign conducted by the Gurkhas to gain rights to residency in the UK and pensions which are on a par with British military personnel. Historically this pay differential was due to the assumption that all Gurkhas who served for the British Army would return home to Nepal for retirement, where the cost of living was much less.

In 2004, Gurkhas who retired after 1997 with more than four years service were permitted to settle permanently in the UK.^{9,10} 1997 was chosen as the cut-off date as this was when the headquarters for the Gurkha Brigade was moved from Hong Kong to the UK. Soldiers who retired before this date were only allowed settle in the UK in exceptional circumstances. In 2008, following a High Court ruling, new

rules regarding settlement were released. These were widely dismissed as being unfairly restrictive and in May 2009 Jacqui Smith, the Home Secretary, announced that that all Gurkha veterans who had served four years or more in the British Army before 1997 would be allowed to settle in Britain. In 2007 the MoD announced that serving soldiers who served after July 1997 were to receive the same pension as their British counterparts. There are still ongoing legal battles regarding the pensions of those who retired pre-1997.

2.3 Nepali migration to Rushmoor

The numbers of Nepali in Rushmoor are expected to increase because of these legal changes and it is predicted that up to 15,000 heads of household will seek residency in the U.K, although it is unknown when this will occur. This number doesn't include the dependents of those heads of household so the final number has the potential to be much higher. According to the Nepalese embassy there are about 27,000 army pension holders, 10,000 welfare recipients and 11,000 non-pension holders.¹¹ There are always approximately 3,500 Gurkhas serving in the British Army and, in November 2009 there were 352 Gurkha serving soldiers located in Aldershot. 197 of those had families here. This number varies from time to time as soldiers are posted in or out of the area.

This is only a small proportion of the total number of Nepali in Rushmoor. A paper in 2009 by Rushmoor Borough Council (Commitment to Equalities and Diversities) estimated the entire local Nepali population as being between 3,000 to 6,000 people, living in 1000 households.¹² Local community leaders now feel this number may be nearer to 9,000 people. Exact numbers for the whole community are not available but we do have some proxy measures which indicate possible population size.

These are National Insurance Numbers allocated to the Nepali and EMTAS (Ethnic Minority and Traveller Achievement Service) data which identifies children who have "Nepalese" as a first language.

- According to Department of Work and Pensions figures, 3,210 Nepali individuals with a Rushmoor address were issued National Insurance Numbers from 2002 until March 2010.¹³ Note that this does not mean that all those individuals stayed in Rushmoor, but rather this was the address they supplied while they were applying for their number.

- The EMTAS figures show that 800 children in Rushmoor have Nepali as a first language. This makes up 7.4% of children in the Rushmoor Area.¹⁴ This number does not include those who do not require language services hence the actual number will be higher. 156 of the 265 (58.9%) new referrals made to the EMTAS service from April 2008 until March 2009 were for children whose first language is Nepali.

Chapter 3: The Wider Determinants of Health

3.1 Introduction: The wider determinants of health

Geoffrey Rose, a famous epidemiologist, described these as the “causes of the causes” of ill health. The WHO describes the social determinants of health as “the conditions in which people are born, grow, live, work and age, including the health system.”¹⁵

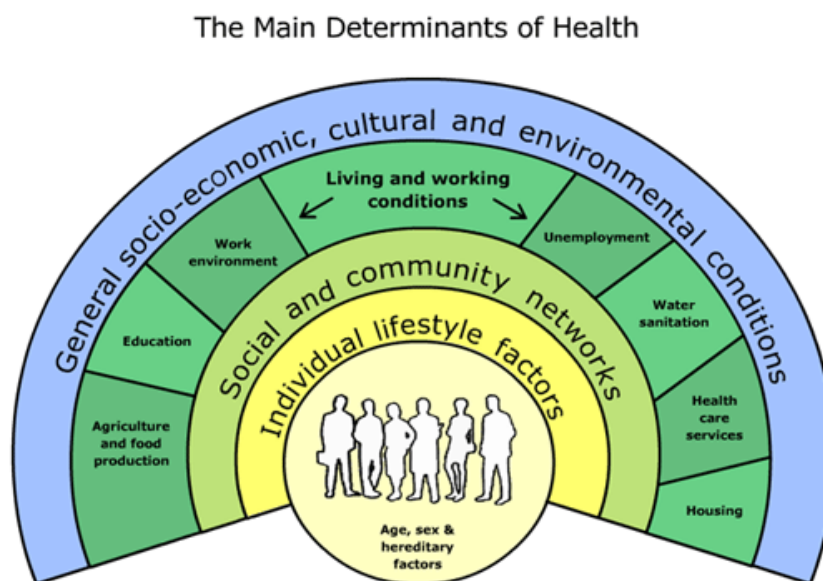


Figure 2 Dahlgren and Whitehead Model

Taken from http://www.pharmacymeetspublichealth.org.uk/publichealthbackground_determinants.html

The Dahlgren and Whitehead model above neatly categorises the wider or social determinants of health. This section is about the living and working conditions of the Nepali in Rushmoor and is based on interviews with local professionals who work outside the health system but whose area of work influences the health of Nepali community quite significantly. This serves to illustrate the additional environmental stresses that a migrant from Nepal may face after moving to Rushmoor.

For this representatives from the following organisations were interviewed;

- The Police
- The Fire Service
- Youth worker
- The Pension Service
- Job Centre Plus

- A serving member of the military
- Education: Teachers from Cove School, Cherrywood Primary School and Farnborough Grange Nursery/Infant Community School contributed as well as a parent.

The information gathered is presented by category and in the following order:

- **Summary of the wider determinants of health that affect the Nepali community**
- **Public and Community Services**
 - The Police
 - The Fire Service
 - The Youth Service
- **Employment**
 - The Job Centre Plus
 - The Pension Service
 - The Military
- **Education**
 - Local Primary and Secondary school teachers and a Nepali parent
- **The Community**
 - Community Groups

3.2 Summary: The Wider Determinants of Health; pressures the Nepali community face.



3.3 Public and Community Services: The Police

Issues identified by the Police

- Lack of understanding of the British justice system and fear of the police leading to underreporting of crime
- Racism and bullying in the Rushmoor community
- Public perceptions of the community as knife carrying
- Drug use in young Nepali males (specifically heroin use)
- Domestic violence could be a taboo in the Nepali community

Local adaptations

- Recruitment of a volunteer police officer who is Nepali
- Linkage of community crimes in their database to allow identification of trends

Recommendations from the interviewee

- More research to be conducted into this community
- Recruitment of police officers from this community
- More education in the community

The Police

Rushmoor

The rate of violent crime in Rushmoor is worse than the England average.

In 2008/2009 there were 1777 reported incidences of violent crime.

The local rate of violent crime is 19.9 reported incidences per 1000 population. To put this in context the England average is 16.4 per 1000 population and worst violent crime rate in England is 36.6 reported incidences per 1000 population.

Source: APHO and Department of Health. © Crown Copyright 2010.

A local police officer based in Farnborough Police Station contributed to this section. He works quite closely with the Nepali community. The main themes that arose out of our discussion were as follows;

Underreporting of Crime

The interviewee thought that the Nepali community tend to underreport crime. In his opinion this could be due to following factors:

- **Lack of trust in the police:** This may be a result of past experiences they have had with police in Nepal.
- **Lack of awareness of how to report crime:** He is aware of racist incidents during which rotten fruit or stones have been thrown at women by local young British males. He heard that these women were also giving money to their assailants to prevent attacks. These incidents went unreported officially as the women did not seem to know how to report crime and thought that they would get arrested.
- **Stigma and language barriers:** A police officer coming to your home is seen as shameful in the Nepali community and women often don't let them into their homes due to the language barrier.
- **Different justice systems here compared with Nepal:** According to the interviewee there is no official youth justice system in Nepal and illegal activities perpetrated by youths are often dealt with immediately. This is completely different to the UK system where the consequences, e.g. conviction, occur some time after the event and may affect life long opportunities. He has

also heard that the Nepali policing system is quite regional and there is no national database for recording crime. This could mean moving from an area means moving away from any convictions.

Racism and bullying

In the past there have been some attacks on British youths by Nepali youth. He thinks this likely to be in response to bullying which has gone unreported. He also feels that the poor knowledge of criminal consequences of such actions is also contributing to this problem. He acknowledged the local impact of these occurrences.

Public perceptions of this community

The local perception of the Nepali youth is one of gang culture and that they commonly carry knives. He acknowledges that Nepali teenagers do cluster in groups to socialise but added that this is normal behaviour for this age group in general. In his experience as a police officer, they have not been found to carry knives more than the local community.

Domestic violence

The interviewee is concerned about domestic violence in this community as he thinks it is likely to be underreported. Nepali women seem to be reluctant to report it because of fear of being ostracised from the community. The domestic violence coordinator is doing work with the women from this community about this issue.

Drug misuse

Community groups feel that drugs are an issue in their community and have voiced concerns about it. Young males seem to be affected in the most part and tend to smoke heroin. The interviewee said that they are not aware of Nepali drug dealers in the community but says that some Nepali youth may carry drugs for the dealers in return for heroin.

Local adaptations

- They have a volunteer police officer who is Nepali. He emphasized how useful it has been in past to have a member of the Nepali community working with them particularly when settling community tensions. They haven't had applications from this community for a police officer role or police community support officer post even though they can apply to be a police officer once they are resident for three years.

- They link all related crimes in their database so as to identify trends.

Recommendations for the future

- The police to do more exploratory work to understand the community properly.
- More education needs to occur and needs to be more sustainable.
- The interviewee thinks that they need to consider how to advertise properly and appropriately to the Nepali community about career opportunities.

3.4 Public and Community Services: The Fire Service

Issues identified by the Fire Service

- A changing Nepali community with a hard to access group (single males)
- Cultural barriers when communicating with this community
- Lack of knowledge in the community about the emergency services

Local adaptations

- Translated cards to communicate with Nepali during fires
- Current market research into this community
- Recruitment of a retained fire fighter who is Nepali
- Development of a local Community Engagement Project for the Nepalese

The Fire Service

The following themes emerged during an interview with a representative from the Fire Service in Rushmoor.

Changes in the Community

- **Growth in the community:** Four years ago the interviewee noticed that the Nepali community was growing as they were running home fire safety sessions in the Rushmoor to reduce accidents and fire deaths. At this time it was a small contained community which was concentrated in Mayfield. They then met with a local community group called the British Gurkha Welfare Society (BGWS) to build community links.
- **Heterogenous community:** The Nepali community is quite heterogeneous and made up of separate groups. Firstly the Gurkha families are more settled and well supported by community groups such as the British Gurkha Welfare Society. This structure helps those from the military to adjust to life outside the military. Secondly he thinks that the non- Gurkhas are a “silent population”. Eighteen months ago he became aware of an increase in the number of non- Gurkhas who were “hidden to us”. He thinks that these are single men in bedsits/private rented residences and that they don’t draw benefits. The fire service finds it difficult to access them for home visits as, when they approach private landlords, they obstruct the process.

Cultural differences

- They are not disproportionately at risk from fire and have only had a few which originated from improvised temples in garages.
- A number of people from this community don’t know to call 999 in the event of a fire.

Adaptations and outreach

- **Translation:** As communication is a big issue they decided to produce cards for use during fires e.g. ones which would ask about where the fire was in Nepali etc. They did not find these very effective as many can’t read their own language.
- **Research:** Their Nepali fire fighter has conducted a market survey to find out more about their lifestyle.
- **Recruitment** They have a part time retained fire fighter and a voluntary advisor from the Nepali community. Generally they have not found it easy to recruit from this community, and

the interviewee felt that this could be due to the fire service having a lower status in some Asian countries. In their experience having a Nepali speaker on the staff has proved very useful.

Future Plans

The station has a “2010/2011 Community Engagement Project for the Nepalese”. This involves

- Conducting the market survey of the Nepali community to establish areas of need and priority.
- Research other fire services with Nepali communities. This includes the Defence Fire Service who may have experience in dealing with Gurkha families.
- Develop initiatives to satisfy the needs of the Nepali community and engage this community. This could involve education about the service and leaflet translation.

Fire in Aldershot

The following is a description by the interviewee of a fire which was attended by the Nepali firefighter. It has been widely reported as an example of good practice.

The fire happened at 2-3 am in a building containing 16 flats over 2-3 floors. There was a large amount of smoke and it seemed to the firefighters that there were lots of Nepali. In reality only four flats were occupied by Nepali. There was a severe fire in the flat of origin which was British owned. They didn't know if everyone had been evacuated and this made the situation more difficult to manage. The Nepali firefighter was able to find out if everyone was out and calm people down.

Before he arrived they had had problems communicating with a Nepali family who lived across the way from the fire. Normal practice would be to block the family in and put out the fire in the other apartment. They had to take them down the ladder as they couldn't reassure them because of language barriers.

3.5 Public and Community Services: The Youth Service

Issues identified by Youth Service

- Difficulties in attracting this community to this service
- Deprivation and overcrowding
- Cultural and language barriers
- Local perceptions of a knife and gang culture in the Nepali community
- Heroin use in young Nepali males which can lead to them becoming “Not in Education Employment and Training” (NEET).

Local adaptations

- The youth service is the same for all those locally. Sporting events are held for the whole community.

Recommendations from the interviewee

- A more activity based service which will appeal more to the Nepali community
- A greater focus on tolerance in the short term as integration will happen over time and pressure to integrate groups may impede the process
- A wider education for children on all cultures as well as Nepali

The Youth Service

Existing Youth Research

- In 2008 research was undertaken by Childwise with youth from the Nepali community in Rushmoor as part of a wider project.
- The research involved a mix of methods both qualitative and quantitative. It involved questionnaires from 41 Nepali children, in depth interviews with community leaders, and a discussion group with secondary school children.

It covered three main areas

- The Children and Young Peoples Plan
- Children's aspirations for the future
- Healthy Living

Findings

These were deemed top priorities by young Nepali:

- Better health care for children and teens (71%)
- More steps to cut youth crime and anti social behaviour (64%)
- Reduce bullying (64%)
- More support for children affected by domestic violence (62%)
- Better public transport and reduced costs (62%)
- Less misuse of drugs and alcohol (62%)

52% of Nepali children were happy with the current projects, services and facilities on offer to children and young people in the area. (7% were dissatisfied).

One in four Nepali children (27%) know they want to stay in the Rushmoor area when they are an adult and just 13% want to move away.

The following themes emerged from a discussion with a local youth worker. About 5% of young people that she works with are Nepali.

Accessing this community

- This is difficult to achieve as they are a hard to reach group. They are not participating in significant numbers in her service and she feels that this may be because the service is too generic for them. They love sport and dance and activity based free time. She has observed

that even when they attend youth club they will play ping pong or air hockey and not relax in groups.

- She also feels the service is not supported by the Nepali parents locally. She has had no volunteers for her service from the Nepali community and she thinks that they are not able to see the benefits of her service and that perhaps a more activity based service is required. She also perceives that Nepali parents value academic achievement and education and that they may be trying to shield their children from British culture so as to preserve their own.

Barriers to Integration

- The language barrier can prevent integration and some older teenagers may only have arrived recently. She has observed that when the Nepali children speak Nepali with one another the local teenagers sometimes feel that they are talking about them. She also imagines that the Nepali children must experience severe culture shock when they arrive here.
- She feels that another significant barrier to integration is that they are in an area of deprivation. No clashes have occurred in her service but she does agree that the local British population perceive that the Nepali carry knives.
- She has also noted tension in competitive games. Last summer there were some fights involving weapons and the stigma has stayed.

Challenges in the community

- Aspirations: During her work she has found that the young Nepali males are less ambitious than their female counterparts. When the interviewee did some research she found that Nepali girls wanted careers in secure areas such as medicine, nursing and law. She found that young Nepali males had fewer aspirations for the future.
- Socioeconomic issues: Other challenges she feels the Nepali youth face include heroin use in young males which can lead to them becoming a NEET (Not in Education, Employment or Training). They also face deprivation and overcrowding which can occur in private rented accommodation. She is unaware of children who are living here without parents but this may be due to the fact she doesn't have enough contact with the community yet.

The future

She acknowledges the strengths of this community which includes their close social structure and the respect shown to elders and teachers.

- **Aim for tolerance:** As regards integration she thinks that forcing the issue could create more problems. The aim should be more for tolerance as in the long run this will lead to better integration.
- **Education:** She feels that in general that if the children in Rushmoor were educated more about the world and its cultures it might be more helpful. A total focus on Nepali culture alone may create additional pressure.
- **Tailor made activities:** A more activity based service would appeal to this community.

3.6 Employment: The Job Centre Plus

Issues identified by the Job Centre Plus

- Reluctance of the Nepali community to access benefits
- New arrivals appear to have less English
- Female Nepali have less English than their male counterparts
- Overcrowding in housing

Local Adaptations

- The service is the same as for the general population
- The service is phone based but they can access Nepali interpreters if the individual requests it

Job Centre Plus

There are two Job Centre Plus branches in Rushmoor; one on Victoria road in Farnborough and one on Station road in Aldershot. A representative from this service contributed to this section and the following themes emerged.

Differential needs in the community

- The community is quite heterogeneous and has different needs.
- The newer arrivals are coming over with virtually no English. They are different to those from the military who were stationed here previously, as they tended to have good English language skills. This has a huge impact on their ability to find a job. The interviewee thinks that they are unskilled workers although he admits this can be hard to establish due to their lack of English language skills.
- He has observed a gender differential in their potential needs. He describes how Nepali women have less English language skills than the men from that community. He does report that quite a few women use the Job Centre services although he suspects they have been sent to access information by their husbands.
- He was keen to point out that employers of those from the Nepali community say that they are “reliable, polite and highly regarded”.

Reluctance of this Community to access benefits

- In his experience this community tends to look after themselves and are reluctant to take benefits. He sees that they rely on their families to look after them. Not registering for benefits can mean that they are unable to access a variety of other services including English language lessons.
- Additionally he feels that some of this reluctance to take benefits could be due to misconceptions about the service. Some want to bring their families over later and are afraid that, if they take benefits, this will show on their records and the authorities won't allow their family to come to the UK. In reality this isn't the case.
- The Job Centre runs an out of hour's service for the Job Centre and the Pension Service. This is for those who are in dire financial stress over a weekend or a bank holiday which means they can be given an interim health payment to tide them over. The Nepali community have not accessed this to date.

3.7 Employment: The Pension Service

Issues identified by the Pension Service

- A growing number of elderly in the Nepali community
- The Nepali community are reluctant to access benefits
- New arrivals can have poor English language skills
- Some don't have the right documentation required by the Pension Service which delays applications
- It can be difficult for the community to open bank accounts
- Some arrive with little money and applications can take at least 8 weeks to process
- Lack of understanding in the Nepali community about the benefits system
- Complex Military Pension system
- Being sponsored means that the individual cannot access the benefit system for five years

Local adaptations

- Partnership working with a dedicated steering group for Nepali issues
- Benefit awareness events with local community groups
- Information sheet on the application process
- Allowing the NHS registration letter to be a valid form of identification for the Pension Service
- Contact has been made with the Financial Services Authority and the British Banking Association highlighting the difficulty in opening a bank account.

Pension Service

A representative from the Pension Service contributed to this section. The following themes emerged during the interview.

Background

The Pension Service is for those who are aged over 60 years. They operate differently to the Job Centre Service in that they conduct more face to face work rather than use a phone based service. They have a home visiting service which is for more vulnerable clients and they use interpreters if needed. They have 16 visiting officers who cover the whole of Hampshire.

The Service's involvement with the Nepali community is relatively new and they have only been seeing a significant number for two years now. They feel they have more exposure to the Nepali community than the Job Centre as they think older people are more common in this community. The interviewee has observed the following trends recently

- Increasing numbers accessing the Pension Service. Twenty five Nepali used their service in Hampshire in February 2010.
- Those aged over 60 those from a military background will have some English but it may have atrophied over time since their time of active service.
- Those pension holders may bring elderly family members. She saw a couple in their late 80's and 90's who emigrated for better healthcare. She thinks this kind of emigration may not be unusual.
- Many of those who do come have very little money and many have sold all of their possessions back in Nepal to migrate here.
- The community tends to move for the work and traditionally go for security and cleaning jobs.
- Those with limited English skills will seek employment in businesses where one of their community, who speaks English, is working.
- They have a very good reputation as employees.

The following is a list of the main issues that the Pension Service has identified.

Reluctance to assess benefits

- The interviewee spoke about how the community tend to prefer not to rely on benefits. She gave the example of a small group of Nepali, whom she heard about recently, who presented to a Job Centre Plus looking for work and who refused to take benefits in the meantime. This meant that they couldn't access other services such as English lessons.

Lack of understanding of the benefit system

- She has observed that many in the Nepali community don't understand the benefits system. She met one family where their elderly grandmother had been living with them for over a year and had not applied for pension credits. She was awarded pension credits but it could only be backdated by three months. She imagines that there is huge financial pressure on those sorts of families.
- She finds there is confusion around what they have to tell the pension service about (e.g. change in circumstance) and sometimes they forget to say they have moved on or have returned home for a significant period of time. This is important as they need to notify the Pension Service if they go home for over three months as, after this, the claim is closed and they have to reapply when they return.
- She has found that claiming housing benefit is also difficult for them as, if the house is owned by a family member, they can't receive it. Establishing the true nature of relationships of Nepali people in a residence has, in the past, been complicated as being from the same village can mean a type of brotherhood to the Nepali while not being an actual blood tie. She has also noticed a pattern of multiple occupancy in homes.

Administrative Issues

- Like other services their service has found confirming identity a challenge. Dates of birth are a huge problem as many Nepali don't know theirs. This can be for several reasons e.g. they operate on a different calendar and often the elderly ones have minimal official documentation or formal forms of identification. The Pension Service requires two documents with the date of birth on it and she has seen people present ones with two different days of birth. To help with this the Pension Service has decided that the NHS letter received after registering with a GP can now be used as a second form of identification. The MOD office in Kathmandu tries to help

migrating Nepali with the application process; however they have found that many come here without using that service.

- They need a bank account to receive benefits. Opening a bank account can also be difficult for them due to lack of documentation and because they move homes for work. The interviewee has contacted the British Banking Association and the FSA to address this.

The application process can be lengthy

- The application process is complex and when making an application the pension service needs to see all documents and establish if the individual is habitually resident. This test involves looking at the ties they have here and in Nepal, their bank accounts and whether they still have a home in Nepal. If they fail this test they cannot receive benefits. Note that pre- 1997 Gurkhas with at least 4 years service do not have to undergo the habitually resident test.
- The typical processing time for the Pension Service is about 8 weeks but it can be longer if the Pension service need to clarify the visa status of the individual as they will have to contact the Home Office. Some individuals are sponsored by their friends/relatives but this means they cannot access the benefit system for five years.

Complex military pension

- The military administer their own pension and for the purpose of the benefits system this income is taken into account. The interviewee is aware of some Nepali who were being paid in Nepal and who couldn't access this money readily. The local Gurkha Welfare Centre tries to help those in this situation.
- The army pension, which is paid to those who have served over 15 years, is paid in Indian rupees and converted to Nepali currency. For those who have served less than fifteen years they receive a 'Welfare pension' which is paid to them in Nepal and is forfeit if they leave Nepal.

Communication

- The Pension service has considered translating their documents but in their experience literacy is quite low in this community. To overcome this they often use partners or word of mouth to promote their service. Most of the Nepali know about pension credit through friends and community groups and often access the service by phone or through the CAB.

Actions taken to deal with these issues

- Partnership working: The Pension service works closely with the Gurkha Welfare Centre in Aldershot, CAB, Rushmoor Borough Council (for housing and social benefits), BME, Royal British Legion and Soldier, Sailors Air Force Association. The Pension service has a steering group on Nepali employment issues and this includes representatives from the GWC, Royal British Legion, BME, CAB, SSAFA.
- Awareness Events: The Pension Service holds benefit awareness events with community groups.
- Creation of an information sheet: The interviewee, after consulting with a group of Nepali, put together a basic information sheet describing the process and the documents they needed to see. That list has been issued to all the partners and it helps to expedite the process.

3.8 Employment: The Military

- The Queen's Own Gurkha's Logistic Regiment is based in Aldershot.
- Healthcare for military personnel is provided by the military. Their families are treated by local NHS services.
- Army recruits tend to have good English. In the past army wives could not speak English but this may be improving.
- Musculoskeletal problems are probably the most prevalent medical problems due to the nature of service and the age of those who serve.
- After approximately twenty years of service soldiers retire from service. As the local regiment is Logistics many of those retiring will end up working as drivers or in security. Those from the Gurkha signals also go to the telecommunications industry.
- Those who retire are likely to stay in the UK as their children are being educated here.

The Military

This is a major source of employment for this community. A representative of the army, who is also Nepali, described the typical experience of a Gurkha and how they are prepared for life outside the military.

Life in the Army

- The regiment which is located locally in Aldershot is the Queen's Own Gurkha's Logistic Regiment. (Army logistics involves "getting materials and supplies from A to B and making sure the Army has the equipment it needs". "It can involve taking supplies across country to ensure that all soldiers have food and water or backing up tank and helicopter crews with fuel and ammunition.¹⁶⁾
- They are a close community and hold social events such as mess functions, regimental parties, company parties and Christmas parties, which their families can attend.
- In the old days he thinks women probably did not speak English but he thinks the younger wives seem to be able to do so. Most of the recruits speak English very well.

Health in the Army

- The army provides healthcare to their soldiers, although the soldiers' families use local health services. Each regiment has a medical centre which is "like a GP". It is located locally in Aldershot Centre for Health which also contains a medical reception centre for non acute recovering personnel (22 bed spaces). If the medical problem is serious they attend a hospital. It should also be added that in some countries like Brunei where there are inadequate local health services the army will also care for military personnel's family.
- He did not have a major sense of what the main medical problems are in the Gurkha recruits but that he thought knee and back injuries secondary to work tasks must be prevalent.

Life after the Army

- Retirement age is set by army regulations and depends on rank. Generally soldiers tend to retire at 38-40 years of age after twenty years of service. Officers can retire at an older age (45-50 years old). What a retiree ends up doing during retirement often depends on their trade in the army and the type of resettlement training they have received. As the local regiment is Logistics, many of those retiring will end up working as drivers or in security. Those from the Gurkha signals can also go to into the telecommunications industry.

Resettlement training can begin two years before leaving the army. This training is optional and the individual can be trained to work as an electrician, in security, plumbing or health and safety, for example. The army will also help the individual to find a job.

- He estimates that 100% of Gurkha soldiers will stay here after retirement. This is generally due to their children being in education here and he suggests that in the longer term they may wish to return to Nepal.

3.9 Education: Local primary and secondary school teachers

Issues identified by local teachers and a Nepali parent

- A recent trend of rapid growth in this community
- Differences between educational systems in Nepal and the UK
- Local problems in integration
- Learning English as well as adapting to a new environment can be challenging
- Parents may have poor English

Local Adaptations

- Mixing of classes
- Recruitment of Nepali staff
- Use of diverse teaching methods
- Young translator programme
- Bilingual support from EMTAS
- Cultural events
- Local EAL cluster group
- A local school is trying to set up a translation service all local schools can use

Education

Staff from three schools in the Rushmoor area were interviewed. They were from Cove School, Cherrywood Primary School and Farnborough Grange Nursery/Infant Community School. Their reflections on teaching the Nepali community were largely consistent with one another and could be grouped into the following themes.

Rapid growth in the community

- All of the interviewees agreed that the community had increased rapidly in size and that this community formed a significant proportion of their school. One interviewee reported that 18% of her pupils are Nepali and another school had about 140, most of whom enrolled in the last 18 months. Another interviewee reported 20% of their student population are now Nepali and that five years ago there weren't any.

Differences between the Nepali educational system and the UK system

This formed a significant part of the discussion with all the interviewees agreeing there were some crucial differences between the two systems. These were around structure, teaching styles, and parental involvement.

- **Structure**

One of the interviewees had visited some schools in Nepal recently and found that private schools teach through English but state schools in teach largely through Nepali. There are also fees attached to any additional support given to a child who is not up to a certain educational standard.

She also noted that local political instability has had impacts on services such as transport and she thinks potentially upon Nepali children's education.

- **Teaching styles**

The learning environment is more formal in Nepal, with children sitting in rows and taught in a more didactic fashion. This means that they are good at sitting down and taking instruction. The focus is also more on rote learning rather than play. One interviewee (who had been to Nepal) also reported that physical punishments such as a "clip around the ear" can be used in schools there. She also felt that children must feel a sort of "shell shock" when they enter schools here, where movement is encouraged and learning is play based. One of them described a new child who felt unable to move from the writing station for four days.

- **Parental involvement**

They have all found that Nepali parents, on the whole, are involved in their child's education. Most of the interviewees reported good parent teacher meeting attendance from the Nepali community. One reported that the collaborative approach between the parents and teachers that is used in the English educational system needed to be explained to the parents. To communicate appropriately with Nepali parents two of the schools interviewed have Nepali staff members and they translate letters from the school into Nepali.

One teacher sees that the Nepali children have the same aspirations as the local children i.e. to go to the Sixth Form College. Another suggested that this was regardless of gender with Nepali parents being equally ambitious for their male and female children.

Integration and Socialisation

- These three schools reported that integration was not a major problem for their schools and that racist incidents were extremely uncommon. They did acknowledge that this was not the experience of all local schools.
- Two schools representatives spoke about how much the Nepali youth are involved in sporting activities and how they tend to favour active games. In Cove school the boy's school basketball team is made up mostly of Nepali. The girls are also quite involved in extracurricular activities and seem to favour drama and music.
- One teacher observed that the boys look after each other and "honour" is very important to them. He feels the girls have assimilated well and he sees that they adopt the same fashion sense as the other girls very quickly. He feels that if any barriers exist, it is due to the language and cultural differences.

Health Issues

- Overall all the interviewees felt that Nepali children are healthy. Three of the interviewees mentioned that they thought dental problems are common in Nepali children and one of the teachers wondered if they engage in preventative dental care. The interviewee who had been in Nepal noticed that the children were very warmly dressed there, too much in fact, and this reflected their parent's fear of childhood illness.

Learning English and educational performance

- One of the interviewees spoke at length about the importance of learning English. Nationally there is concern about children who don't speak English as a first language as they tend to do worse in maths as well. She has found, like the other interviewees, that the Nepali children tend to pick up English quickly. She did add that their technical reading can be good but it can take some time for their understanding to develop. One of the other teachers described them as "motivated" students.
- It can be difficult for the parents to support their children in learning English. Some of the teachers felt that the parents, in particular the children's mothers, can have limited English language skills. One of the teachers felt that fathers from military families tended to have better English. This means that a lot of the educational issues have to be communicated to the father or to the mother via any staff members or volunteers who speak Nepali.
- The interviewees from Cove School described Nepali children's academic achievement as being in the normal range. One teacher observed that it seems to take about six months for them to feel confident enough in class to speak freely in English.
- The Nepali community itself is divided on whether their children should learn Nepali. All of the schools hold Nepali events and some teachers/volunteers run extra Nepali cultural classes. Two teachers from two different schools spoke about how some parents only want their children to learn English and one mentioned a child who said that her father would be "angry" if he knew she was learning Nepali. On the other hand they spoke of some parents who worry that their children can't speak Nepali, especially if they wish to return to Nepal one day. One of the teachers described how she encourages parents to speak Nepali with their children at home as they learn English in school and if they need additional support (usually for grammar) they can get it in school.

Adjustments made for this community

- **Recruitment of Nepali staff members**

Cove School recognised that their student population was changing and recruited a Nepali teacher. She is a qualified science and maths teacher and can offer one to one tuition to Nepali children who need help in these subjects. She also acts as a liaison between the school and the parents. Cherrywood School has two Nepali governors. They also employ a parent two mornings a week but to date have not managed to recruit any Nepali teaching assistants because of no applications from this community.

- **Mixing classes**

One of the teachers spoke about how he encourages the teachers to mix the children in their classes.

- **Cultural events**

Some of the schools have Nepali culture clubs. In Farnborough Grange Nursery/Infant Community School they run a 6 week programme of Nepali songs and rhymes for Nepali children entering the school to help them settle into play based learning.

- **Teaching methods**

Two of the interviewees spoke about this in detail and here are some of the examples they mentioned.

- **Cherrywood School**

This school's representative spoke in detail about this as she feels that "Quality First Teaching" should be used. She feels that if classroom teaching is right then the children shouldn't need extra support. This type of teaching uses a variety of methods such as visual and practical methods which are appropriate for all the children in the class, regardless of language abilities. Once a week she and the head and deputy head will examine the classroom planning of teachers and see if there is enough planning for the ethnic minority students. This is part of their planning which happens for all children whereby they track their progress through the school and teach according to their needs. Cherrywood School also trains their teachers in these issues.

They have had speakers from EMTAS on the differences between the English and Nepali languages and on what good teaching looks like.

This school also holds workshops for all parents on subjects such as phonics, handwriting, maths etc. Generally these are not that well attended but they had a good attendance from the Nepali community on the phonics evening and the feedback from the parents was positive.

- **Farnborough Grange Nursery/Infant Community School**

This school's representative described their use of the young interpreter programme. These are young children who are taught to communicate with the children who can't speak English using a mixture of methods- pictures, gestures, words and flashcards.

Planning for the future

- One of the interviewees spoke about how one of the schools in the area is trying to set up a translation service that all schools will use.
- The primary schools have an EAL cluster group which meets twice per half term. They share information about issues such as collecting information and ICT resources. They have quite a few bilingual books which they have gotten the children to translate and they are sharing these. Cherrywood primary school has a “pen” MP3 player which reads stories in both languages. They have also done displays around the school which can be “read” by the pen.

3.10 The Community

Community groups

According to Rushmoor Voluntary Services there are twelve Nepali community groups which operate in the Rushmoor Area. Here are the groups that are known in the area.

Name Of Group
Project Shiva Cultural and community Centre
British Gurkha Welfare Society
Gurkha Welfare Centre
Non Resident Nepali Association
Greater Rushmoor Nepalese community
British Gurkha Army Ex- Servicemen's Organisation
Tamudhee Association UK
The Magar Association Rushmoor branch
Lamjung Samaj UK
Madat Shamuha
Srijanshil Nepali Samaj UK
EMTAS Women's group

Table 1 Nepali community groups in Rushmoor

These groups provide support to the local community with some focussing on organising social and Nepali cultural events and others running community development like projects from their premises. Basingstoke has one community group for its Nepali community.

Chapter 4: Health

4.1 Introduction and Methods

Introduction

The health of the Nepali in Rushmoor is the main focus of this report and is presented in the following sections:

- Methods employed in the health needs assessment.
- Background: A review of existing research on Nepali health in Nepal, in the UK and in Rushmoor was conducted and summaries of this evidence are included.
- Findings from the health needs assessment: Data from Frimley Park Hospital and the Health Protection Unit on infectious diseases.
- Findings from the health needs assessment: Results of interviews and focus groups. These were held with health professionals and the Nepali community in Rushmoor. More details on the methods employed are reported later.

Methods employed in the health needs assessment

Initially the health needs assessment was designed to use the full range of appropriate health data sources alongside interviews and focus groups held with local health professionals and the community. These health data sources were explored alongside GP and secondary care information systems but it was not possible to properly identify Nepali individuals due to data coding practices which often focussed on the broader but less specific category of ethnicity. The lack of data on migrants is a national issue and in May 2006 the Office for National Statistics set up an interdepartmental Task Force on Migration Statistics.¹⁷ A report produced by SEPHO (South East Public Health Observatory) describes this as well as data sources that may be used to build up a picture of a migrant population. These are detailed in table 2.

Data Source	Appropriateness for the Nepali population in Rushmoor
Population turnover (ONS)	This indicates the net population changes in age bands. It is not possible to examine these changes in different ethnic groups or according to nationality.
Population estimates by country of birth and nationality (ONS)	This data is too high level. It gives national and regional estimates by country of origin. According to this data source there were an estimated 32,000 people from Nepal (95% confidence interval: 24,000, 40,000) resident in the UK from October 2008 until September 2009.

Data Source	Appropriateness for the Nepali population in Rushmoor
National Insurance Numbers	These figures are available at a local authority level and do give the country of origin. However they do only reflect how many were resident in Rushmoor at their time of application, not how many stayed afterwards. It also only covers those ages 16 or over and does not include asylum seekers.
Worker registration scheme	There is no separate data on Nepali in Rushmoor. The total numbers registered for Rushmoor are very small and probably reflective of low data coverage.
Supported asylum seekers UK Borders Agency	There is no asylum seeker data on Nepali people`.
International Student Register- Higher Education Statistics Agency	These figures depend on ethnicity coding and do not specify Nepali.
School Census (Or Pupil Level Annual School Census)	These figures only examine the wider ethnicity category and do not specify what the first language spoken is.
Patient Register Data System (PDRS)- Flag 4 GP registrations	A flag 4 is created in two situations: 1) An individual was born outside the UK and enters England and Wales for the first time and registers with a NHS GP 2) An individual's registration will also generate a Flag 4 if the previous address of an individual is reported as outside the United Kingdom. Data is available at the local authority level; however it does not give information on where the migrants have come from. This dataset only picks those up that have registered with a GP.
Birth registrations- live births by place of mother	This data gives live birth rates in Rushmoor; however it is not by country of origin but world region. This means that the data on Nepali mothers is in the "Asia" or "rest of world" categories which could include a large number of alternative countries.
Migration Indicators tool ONS	This dataset does not distinguish between Nepali and non Nepali migration.

Table 2 Data sources suggested by SEPHO for migrant health assessment

When these difficulties in finding accurate quantitative data became apparent the methods for the health needs assessment were reconsidered and the qualitative research component was increased and relied upon to identify health priorities.

4.2 Background health research

This is made up of the following sections:

- Nepali health in Nepal
- Previous research conducted on Nepali health in the UK which includes summaries of the following:
 - A cross sectional survey entitled “Health and lifestyle of Nepalese migrants in the U.K”.
 - Interim results from an online Nepali Census conducted by the Centre for Nepal Studies UK
 - A section on the Nepali community in a sexual health needs assessment (SHNA) which was commissioned by NHS Eastern and Coastal Kent.
- Rushmoor health research

4.2.1 Nepali health in Nepal

A comparison of health statistics in Nepal with those in the UK shows that life expectancy at birth in Nepal is 60 years for men and 61 years for women, which is significantly lower than that in the UK. Additionally if we compare the top ten causes of mortality in Nepal with the top ten causes in the UK we see a high burden of infectious disease in Nepal.^{18,19} The “big killers” such as ischaemic heart disease and COPD still figure in the top ten, in common with the UK. However there are no cancers at all in the Nepali top ten whereas five of the top ten causes of death in the UK are due to different types of cancer.

Top ten causes of death, all ages, Nepal. (2002)	Deaths (000)	Deaths %	Top ten causes of death, all ages, UK. (2002)	Deaths (000)	Deaths %
1 Perinatal conditions	24	10	1 Ischaemic Heart Disease	120	20
2 Lower respiratory infections	23	10	2 Lower respiratory infections	65	11
3 Ischaemic heart disease	23	10	3 Cerebrovascular disease	59	10
4 Diarrhoeal diseases	16	7	4 Trachea, bronchus, lung cancers	33	6
5 Cerebrovascular disease	11	5	5 Chronic obstructive pulmonary disease	28	5
6 Chronic obstructive pulmonary disease	6	3	6 Colon and rectum cancers	19	3
7 Hypertensive heart disease	6	3	7 Breast cancers	14	3
8 Tuberculosis	6	3	8 Alzheimers and other dementias	13	2
9 Measles	5	3	9 Prostate cancer	10	2
10 Road traffic accidents	3	2	10 Lymphomas, multiple myeloma	8	1

Table 3 A comparison of the top ten causes of mortality in the UK and in Nepal

Nepal shows a mortality profile consistent with a developing country, i.e. high infant and maternal mortality and infectious disease contributing significantly to mortality. It is important to note that the healthcare of those who may chose to settle in the U.K. could very well be different to that of the general population back in Nepal.

4.2.2 Research on Nepali Health in the UK

National research

There has been some previous research into the health of the Nepali in the UK, however some research gaps still remain.

1) Health and lifestyle of Nepalese migrants in the U.K

A cross sectional study conducted in 2007, which examined the health and lifestyle of the Nepali migrants in the U.K. by survey, highlighted the following issues⁵;

- 95% of the respondents were registered with a G.P but only 38% with a dentist.
- 14% of respondents smoked. This was made up of 17% of male respondents and 5% of female respondents. This is lower than the overall smoking prevalence in the UK.
- More than half (57%) did not do regular exercise.
- 23% rated their health as poor.
- Only a small proportion reported suffering from chronic disease such as diabetes (4.6%), high blood pressure (6.2%), high cholesterol (4.6%) and asthma (3.3%).
- 61% of the Nepali consumed alcohol (males were ten times more likely to do this than females- OR 9.7, 95% CI= 5.1 to 18.3). These are lower than the figures for the white British population.

We must exercise caution in extrapolating the results of this survey to the Nepali population in Rushmoor for the following reasons.

- The survey was small (327 participants) and it was conducted nationally.
- Most of the respondents were male (75%), tended to be highly educated and most were in the middle income bracket (annual income from £5,035 to £33,300).
- The research was done by survey and in general those who respond to surveys tend to be more interested in and educated about health matters.

2) Nepali Census

A census for the Nepali community was conducted in 2008 by an organisation called the Centre for Nepal Studies UK. Data was collected in a variety of methods and 7842 were surveyed in depth. The Census covered a wide variety of issues including demography. The research has not been fully reported to date but the interim results are as follows. Firstly here is a profile of the respondents.

Literacy and Educational Level of Respondents

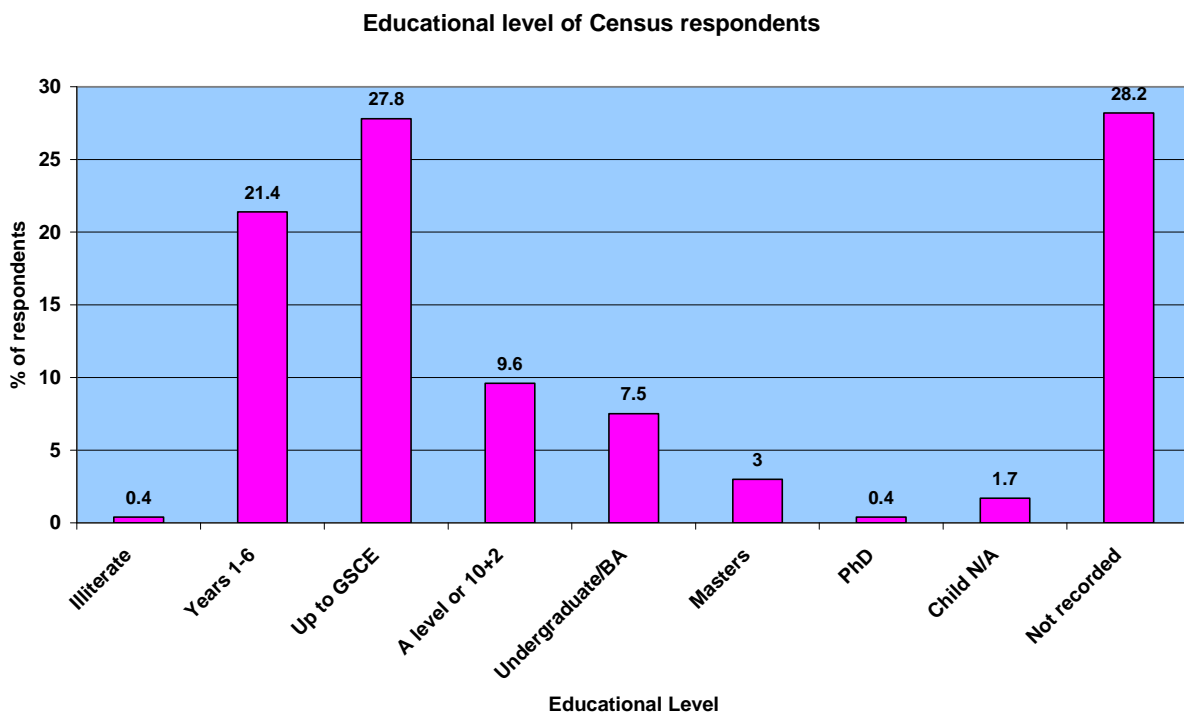


Figure 3 Educational level of Nepali Census respondents

Occupation of respondents

Occupation	%	Number	Occupation	%	Number
Medical Doctor	0.5	42	Sales Assistant/Advisor	2.1	165
Nurse	1.2	91	Student	31.0	2434
Engineer	0.6	48	Restaurant Business	1.1	88
Bank Cashier	0.1	5	Grocery Business	0.4	28
Accountant/Auditor	0.4	30	Unemployed	2.2	172
Security	11.2	882	Factory/Warehouse Operative	1.9	148
Social Scientist	0.1	9	Supermarket Worker	0.3	27
Teacher	0.5	37	Others	8.5	663
Lawyer	0.1	6	Housekeeper/Cleaner	1.8	141
Kitchen/Chef	2.2	175	Driving	0.6	46
Waiter	2.8	216	Domestic Assistant	0.3	24
Care assistant	2.7	213	Not recorded	27.0	2115
Pharmacist	0.5	36	Total	100%	7841

Figure 4 Occupation of Nepali Census respondents

Health Results of the Nepali Census

- 98% (6248) of respondents were registered with a GP
- 92% were satisfied with their GP health services
- 98.7% described themselves as having “good” health in the previous 12 months and 1.3% described themselves as having “bad” health in the previous 12 months.
- 5844 responded to a question on whether they had a family member who was disabled. According to those who conducted the study 2% of these said yes.
- 5827 responded to a question on whether a family member died in the previous 12 months and 1.2% said yes to this.

The overall conclusions of the researchers were that the Nepali community in the UK have “excellent” health. It should be noted that:

- The results presented here were gathered from presentations and full reporting has not yet occurred.
- Those who respond to questionnaires differ systematically to those that do not in that those who participate in this type of research are often more health conscious than those who do not.

- A large proportion of respondents did not put their educational level. Of those that did a significant proportion of them were well educated. A large proportion of respondents were students or professionals which may skew the results, as they are more likely to be young, healthy and informed about health issues.
- These issues may make it difficult to generalise the results to the wider Nepali population, especially the harder to reach groups with low levels of literacy or those who are unemployed.

3) A sexual health needs assessment entitled “Engagement with Hard to Reach and ‘At Risk’ Populations”

NHS Eastern and Coastal Kent commissioned a piece of work called “Engagement With Hard to Reach and ‘At Risk’ Populations” from Options UK, as part of a wider sexual health needs assessment (SHNA).²⁰ This involved engagement with key populations at higher risk of STIs, HIV and unintended pregnancy, including those who defined as hard to reach. The Nepali community in this area were included as a hard to reach group and the key findings are presented below.

Methods

Interviews included young people (9 males and 12 females) who were aged 16 and above, and 11 wives or partners of Gurkha soldiers. In addition, three people involved in sexual health service provision both off and on site at the barracks offered their professional insights into the health needs and current service provision for serving soldiers.

Results

- Strong traditional norms valuing sexual abstinence before marriage means that access to sexual health services is difficult for young Nepali women, and to some extent, young men
- SRE was accessed in school, but mixed sex groups meant that young women had limited ability to ask questions, and were thus not well informed about local services available
- Young people said that access to sexual health services was likely to be an ‘emergency’ response, conducted alone for fear of social stigmatization
- Married women reported good access to primary health care, but had strong concerns and limited information about contraception
- Married women self reported a high level of unplanned pregnancy and abortions due to lack of access to contraception

Recommendations from the report

A common issue across all the Nepalese groups interviewed was a need for information that is accessible to them to help raise awareness levels and improve signposting to local sexual health services. Key to information of this kind was that it was:

- confidential
- given in separate male and female groups
- interactive, where questions could be asked to health care professionals

Other preferences for young people included:

- Young people targeted general information about contraception, sexual health and STI's
- Leaflet, in English, to signpost to sexual health websites which could give information about local sexual health services and sexual health in general
- Promotion of EHC as a method of contraception and sign posting to services providing EHC
- Increased condom distribution via toilets and public facilities to avoid registration required for C card schemes

For older men and women they were:

- Information to reduce a lack of awareness of sexual health services and to address the perceived high rate of abortions.
- Interactive talks with health professionals to reduce fears about the side effects of contraception, given in community based settings.
- Confidential one to one advice and information, in local GPs surgeries.
- Sexual health promotion aimed at soldiers to raise awareness of and precaution against STI's.

4.2.3 Health research in Rushmoor

1) Rushmoor locality profile

The life expectancy at birth in Rushmoor is 79.6 years for males and 82.6 years for females.⁴ This conceals the fact that life expectancy for men living in the most deprived areas is more than seven years less than for those in the least deprived areas. The gap is nearly six years for women. The early death rate from heart disease and stroke has decreased over the past 10 years and is below the England average.

The health of people in Rushmoor is similar to the average for England. However it is estimated that only 1 in 4 adults eat a healthy diet and almost 1 in 4 adults smoke. The percentage of children who spend at least 3 hours each week on physical activity in school is higher than the England average.

Deprivation levels and the percentage of children living in poverty are better than the England averages. The rate of violent crime is higher than the England average. GCSE achievement in state schools is below the England average.

2) Childwise Survey 2008

This local survey was conducted with 50 children and others from the Nepalese community as part of a larger piece of work. The main aims of the report were to

- (1) Determine priorities from those important areas identified by the Children and Young Peoples partnership.
- (2) Understand the future aspirations of the children and young people in Rushmoor in order to inform the community planning work of the council and its partners.

Health and Wellbeing

- Better healthcare was significantly more important to Nepali children than the general population.
- 6% of Nepali children smoke cigarettes (half the rate of the local population)
- 2% currently take drugs (half the rate of the local population)
- 20% drink alcohol on special occasions, none do so regularly.

- Awareness of healthy food and desirable levels of exercise is lower amongst children from the Nepali community (67% and 63% respectively compared with 90% and 87%). These children eat more chips and crisps than children overall but also eat more fruit and vegetables.
- More than half do no more than two periods of exercise a week although many would like to exercise more with aerobics and swimming being popular options.

Mental health

- 73% of Nepali children report that they are generally “happy” and optimistic about the future compared with 82% overall.
- 37% have experienced stress compared with 64% overall.
- 29% have experienced depression compared with 28% overall.
- 18% have encountered bullying compared with 37% overall.
- 8% have experienced an eating disorder compared with 9% overall.

4.3 Findings from the health needs assessment research: health data

The following includes the only health data that was available for this report. This includes

1. Notified cases of TB in Nepali individuals in Hampshire 2006-2009 (HPU data).
2. Number of cases of infectious diseases recorded in Frimley Park Hospital in Nepali individuals from August 2009 until April 2010.
3. Notified cases of other infectious diseases in Hampshire from 2006-2009 (HPU data)

1. Notified cases for TB in Nepali individuals in Hampshire 2006-2009 (HPU data).

This data was collected by Hampshire and Isle of Wight Health Protection Unit. It gives the total number of cases of TB which were reported to the HPU and whose place of birth was recorded as “Nepal”. This is an accurate way of gauging disease burden, however it does rely on reporting of the disease by health professionals and misses cases of Nepali who were born anywhere other than Nepal. This data shows the number of cases has been increasing over time and that most cases are arising from Rushmoor. Additionally other HPU data shows that seven percent (35) of notified cases of TB in Hampshire from 2006-2009 were in Nepali individuals.

Number of notified cases of TB in Nepali individuals in Hampshire 2006-2009

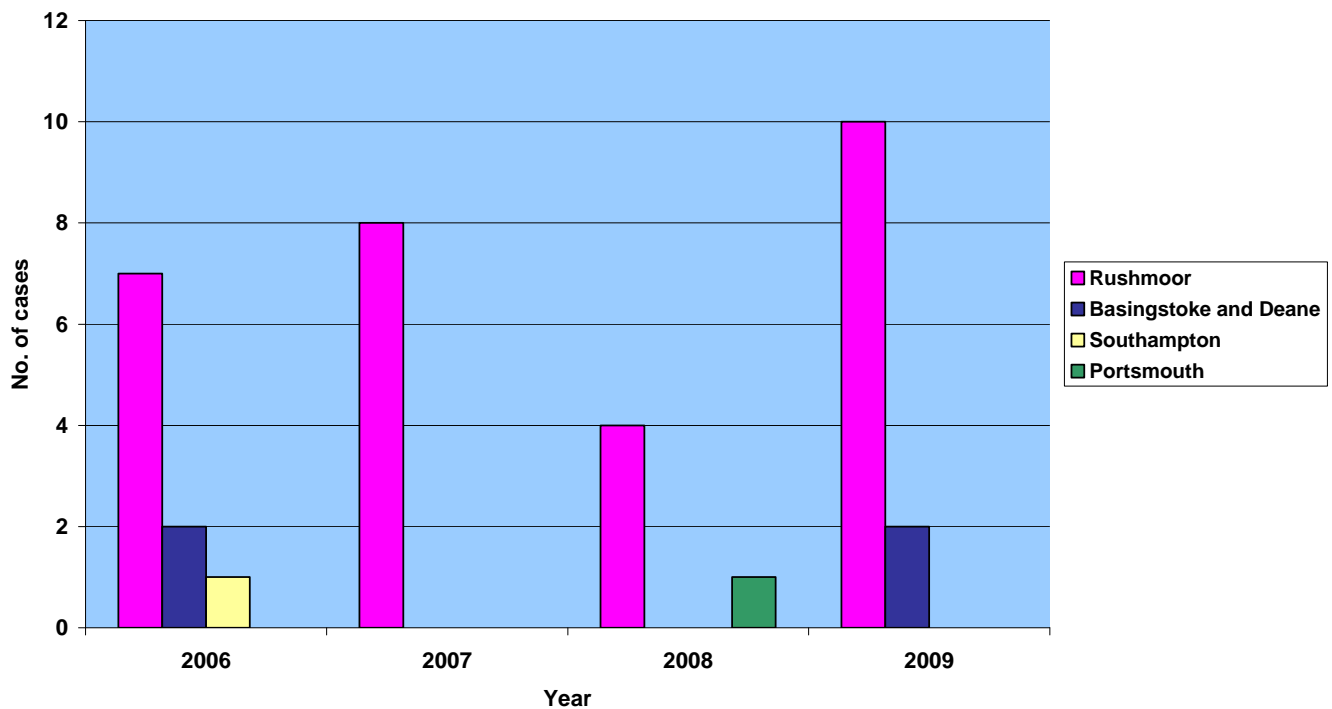
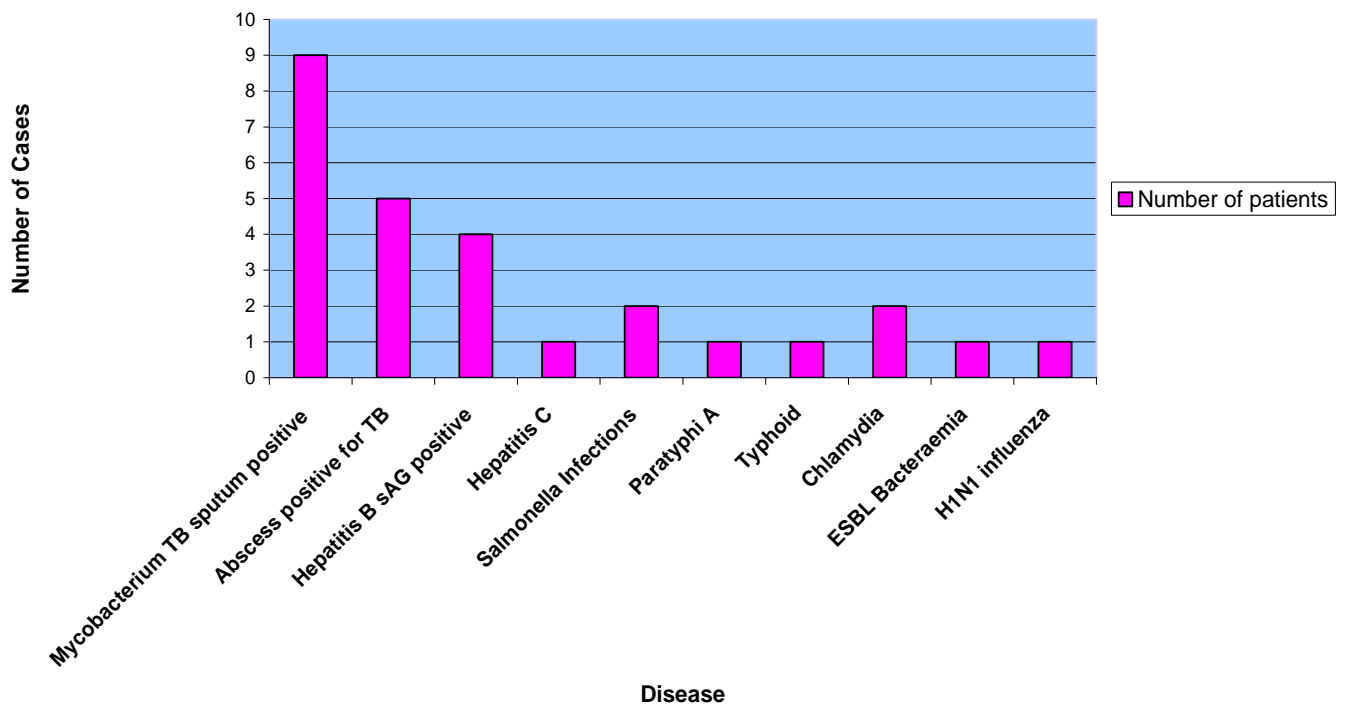


Figure 5 Number of notified cases of TB in Nepali individuals in Hampshire from 2006-2009 by location

2. Number of cases of infectious diseases recorded in Frimley Park Hospital in Nepali individuals from August 2009 until April 2010.

This data was generated from the microbiological database in Frimley Park hospital. Nepali individuals were identified by searching by common surnames in this community. This creates a very rough approximation of disease burden which may not be completely accurate. It should be noted that the overall numbers of cases are small but it is clear that there is a significant burden of TB in the community.

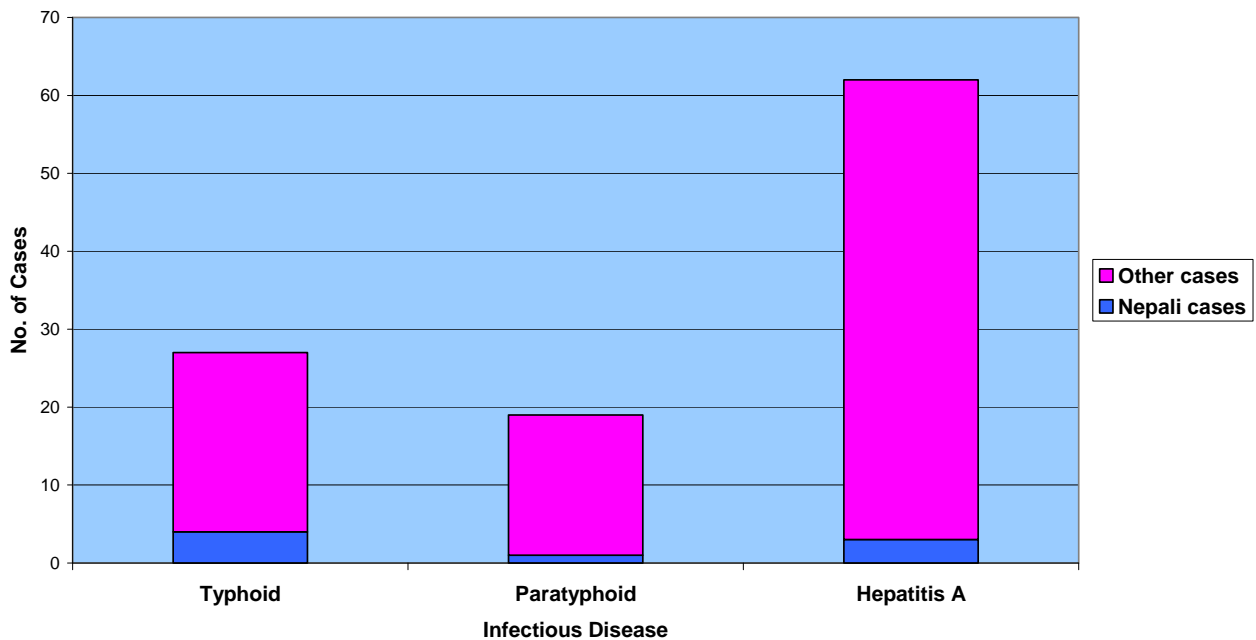
Number of cases of infectious disease recorded in Frimley Park Hospital in Nepali patients from August 2009 until April 2010 inclusive



3. Notified cases of other infectious diseases in Hampshire from 2006-2009 (HPU data)

This data is also from the HPU but it relies on searches based on surnames which are known Nepali surnames. This shows the proportion of total number of cases of typhoid, paratyphoid and Hepatitis A which were in Nepali in Hampshire. Again this method of searching may not be very accurate. Note that the total number of cases is small and the Nepali form a small proportion of the overall number of cases.

Proportion of Cases of notifiable Infectious Diseases in Hampshire residents which were in Nepali individuals, 2006-2009



4. 4 Findings from the health needs assessment research: results of interviews and focus groups

The following health professional groups and community members were interviewed about the significant health problems that they perceive in the community as well as the improvements that could be made in the service.

1. Focus groups in the Nepali community

Four focus groups from the Nepali community contributed to this section. All Nepali groups in the area were contacted through Rushmoor Voluntary Services and they were sent invitations to meet and discuss holding focus groups. This led to focus groups with the Madat Shamuha group, the female EMTAS group and members of the British Gurkha Welfare Society. These groups consisted of about 50 people in total; the numbers aren't precise as often the focus groups had some people joining halfway through. The age range was wide with men and women in their twenties to elderly men and women. Approximately half of the focus group participants were female. Few of those in the focus groups spoke English and their community organisers kindly translated for them.

2. Primary Care

Representatives from General Practices in Rushmoor were interviewed. These included practice staff as well as general practitioners and practice nurses. There are twelve practices in the Practice based Commissioning area of Rushmoor and these are listed in the table below.

Practice Name	Number of Nepali patients- practice estimates
Giffard Drive Surgery*	300
Victoria Practice*	850
Southlea Surgery*	900
Milestone Surgery	60 patients "born in Nepal"
Alexander House Surgery	132
Jenner House Surgery	No estimate submitted
The Border Practice	24
Alexandra Surgery*	106 patients "born in Nepal"
Mayfield Medical Centre*	2500
Southwood Practice*	No estimate submitted
The Wellington Practice*	600
North Camp Surgery*	300
Total	5772

Table 4 Rushmoor GP Practice and approximate estimations of Nepali on their lists

*These practices contributed to the qualitative research. The other practices felt their numbers of Nepali patients were too small to be able to make comment.

Note the methods used to estimate numbers in each practice were different due to differences in computer systems and difference in coding used. Most would say that the estimates above are a gross underestimation as often only a handful of “Nepali” surnames were used in a quick search or a code was used to search on (e.g. “born in Nepal”) which was not attached consistently to Nepali patients. Therefore this is a very crude population estimate.

3. Pharmacy

Pharmacy staff members and a branch manager in a local pharmacy in Rushmoor contributed to this section. This pharmacy deals with the wider Nepali community as well as families of Gurkhas. They estimate that they serve 1,000- 2,000 Nepali patients.

4. Dentist

A local dentist in Rushmoor who has experience in treating Nepali patients was interviewed for this section.

5. Community Diabetic Specialist Nurse

The local community diabetic nurse contributed to this section. She covers the area of Rushmoor and Harts, a total of 21 practices.

6. Community Team Midwife

This interviewee works in the Rushmoor area in the community setting.

7. Secondary Care

An invitation to be interviewed for this section was cascaded to consultants in Frimley Park Hospital.

The following replied and contributed to this section.

- An ophthalmologist,
- An orthopaedic surgeon,
- A gastroenterologist,
- A Nepali dietician.

8. Other health organisations who contributed included

- A manager from the Hampshire Drug and Alcohol Action Team and a key worker from Catch-22 youth drug treatment services in Basingstoke
- NHS Quit for Life

The information gathered is presented by the following list of themes which arose in the interviews or focus groups.

Section	Contents
4.4.1	Health problems in the Nepali community
4.4.2	Lifestyle factors <ul style="list-style-type: none"> • Alcohol, smoking and drug use • Diet • Preventative dental care
4.4.3	Child and maternal health
4.4.4	Women's health and sexual health
4.4.5	Older people's health
4.4.6	Mental health
4.4.7	Social issues
4.4.8	Health services <ul style="list-style-type: none"> • Background to the health service in Nepal • Community knowledge of the NHS • Access to healthcare <ul style="list-style-type: none"> ○ Registration with primary care ○ Identity issues ○ Communication ○ Transport
4.4.9	Health beliefs and behaviour <ul style="list-style-type: none"> • Expectations • Threshold for presentation • Adherence to treatment • Concurrent treatment in Nepal • Use of traditional medicines and healers • Family attending consultations with patients • Sources of health information within the community

Table 5 Themes of interviews and focus groups

4.4.1 Main health problems in the Nepali community

This section describes what the Nepali community, local health professionals and military health professionals think are the main health priorities in the Nepali community.

<p>General Practice High abortion rates Gynaecological cancers Typhoid Cholera Hepatitis C</p>	<p>Renal failure Somatisation of mental health issues</p>	<p>Military Malaria* Japanese encephalitis* Visceral leishmaniasis* Giardia* Hookworm* Ascaris* Endemic non venereal syphilis* Congenital abnormalities Auto immune disease (SLE and Rheumatoid) Post streptococcal glomerulonephritis</p>
<p>Asthma High cholesterol Cardiovascular disease Heroin Use</p>	<p>Diabetes Hypertension Tuberculosis</p>	<p>Peptic ulcer disease and dyspepsia Smoking and chewing tobacco</p>
<p>Hepatitis B Hypothyroidism Depression Alcohol use Cannabis Use <u>Nepali Community</u></p>		

Figure 6 Health issues perceived as common or important in the Nepali community

*These health issues are likely to be related to the foreign locations where serving military are.

4.4.1.1 Military medicine

Rushmoor is fortunate that many of the military medical personnel have had extensive experience in caring for Gurkha patients. The main contributor on military health issues in this report is a Nepali military medical officer. Some of the diseases described below are related to areas where the army serves, however it might be worth bearing them in mind for those patients who travel home to Nepal as one of the local GPs felt that they did not attend often for travel advice.

Additional detail on health of Nepali in the military

Japanese Encephalitis: Because of the high morbidity and risk of serious disabilities there was a policy for all Nepalese families in Brunei and Hong Kong to be immunised against Japanese Encephalitis.

Leishmaniasis: Visceral leishmaniasis is endemic in Nepal. They felt that the possibility of visceral Leishmaniasis should be considered in a patient presenting with fever, weight loss, enlarged spleen, and anaemia.

Intestinal Infection: Infection with Giardia, Hookworm, Ascaris and Entamoeba are common. In Hong Kong and Brunei it used to be the normal practice that all new patients and families returning from leave in Nepal were given a course of mebendazole.

Syphilis: Endemic syphilis is prevalent in Nepal. This is a non- venereal disease transmitted chiefly by direct contact amongst children living in crowded environment. The standard serological test that is normally used does not make a distinction between the endemic syphilis and sexually acquired syphilis. Management of both is the same and care must be taken in counselling the patients and their partners.

Dyspepsia and Peptic ulcer: Studies carried at British Military Hospital showed significantly higher prevalence of Helicobacter Pylori (HP) when compared to Caucasian population. After eradication treatment, it was further noted that the HP recurrence rate was also high.

Congenital abnormalities in babies: A survey of new born carried out at BMH Hong Kong showed higher incidence of congenital heart diseases. It was believed that a contributory factor was the common practice of inter-caste marriages or marriages between first cousins.

Auto immune disease: Rh Arthritis and SLE are not uncommon. Even without symptoms or signs of inflammation, they have found that generally the Erythrocyte Sedimentation Rates (a blood test that indicates inflammation) in Gurkha families are much higher than in the Caucasian population.

Higher risk of post-Strep glomerulo-nephritis and subsequent renal failure.

Table 6 Significant health issues identified in serving Gurkhas and their families- international viewpoint

4.4.1.2 Other healthcare providers health priorities

The other healthcare providers interviewed noted that the following were common or potentially serious health problems in the Nepali community. Many of these overlap with the problems already identified in this section.

<p>Pharmacy</p> <p>Hypertension</p> <p>Diabetes</p>
<p>Dietician</p> <p>Diabetes</p> <p>Gestational diabetes</p> <p>No nutritional deficiencies noted</p>
<p>Community Diabetic Specialist Nurse</p> <p>Although she covers 21 practices in Rushmoor and Harts she only has six Nepali patients. In these she has seen no difference in timing of presentation, ability to control diabetes or presence of complications compared with the local population but her numbers are small. No Nepali attend her diabetic support group.</p>
<p>Ophthalmologist</p> <p>Pterygium is commoner than expected. He has operated on 86 cases since 2004 and numbers are increasing. This condition is characterised by a triangular fleshy mass of thickened conjunctiva occurring usually at the inner side of the eyeball, covering part of the cornea, and causing a disturbance of vision.²¹ It is related to exposure to UV light and altitude which they are more exposed to in Nepal than here.</p> <p>Less than expected glaucoma. This could be due to low testing of ocular pressures</p> <p>Late presentation with cataracts</p>
<p>Orthopaedic Surgeon</p> <p>Arthritis of the knee</p>
<p>Gastroenterologist</p> <p>Alcohol use. Binge drinking leading to liver problems</p> <p>Viral hepatitis. Hepatitis B and C could be a large problem in this community as the prevalence of these conditions is high in Nepal and there is the possibility that the low numbers detected in the local Nepali community are due to low testing rates.</p> <p>Peptic ulcer and gastric irritation.</p> <p>Lower than expected lower gastrointestinal disease. This could be due to underreporting of these symptoms or a true lower prevalence.</p>

4.4.2 Lifestyle Factors

4.4.2.1 Alcohol

Most of the practice groups felt that the Nepali community does use alcohol although not to problem levels. One group felt that this may be due to underreporting of alcohol consumption. According to the GPs the types of drinks favoured by the community are beer and whisky and the dietician interviewed also described how they make alcohol from rice for their own consumption. This can have a very high alcohol content. This interviewee also felt drinking alcohol was more common than smoking. Most of those interviewed in primary care felt that alcohol consumption is higher in males than females.

4.4.2.2 Smoking

Of the staff in general practices who had an opinion about smoking in the Nepali community all agreed that smoking had a low prevalence in the community overall. Some suggested men smoke more than women and one practice suggested that women overall tended not to smoke. Two practice groups described tobacco chewing in older men. The dietician interviewed felt that the younger ones in the community may smoke more than the older ones and rates may be increasing.

In addition to this Quit4life in Hampshire also reported that they see very few Nepali people in their stop smoking services. The Department of Health does not classify as a discrete group for their service details so they fall in the 'other Asian' category. Only fifteen (10 males and five females) from the 'other Asian' category presented to this service from April to December of 2009 and five quit.

4.4.2.3 Drug Use

Drug use has also been noted by most of the practices. They feel this problem is confined to young Nepali males and have not seen it their female counterparts. Overall it is not very common, however the fact that heroin is the drug used has made it more noticeable.

To examine this trend further a representative from the Hampshire Drug and Alcohol Action Team and a specialist named worker from Catch-22 treatment services for young people in Basingstoke were interviewed.

The representative from the Hampshire Drug and Alcohol Action Team described how last year they were approached by a member of the Nepali community in Rushmoor who expressed his concern about the increase in drug use in his community. This view was also held by other members of this community and local healthcare providers and police. When this situation was reviewed the following became apparent.

Adult Drug Misuse

The ACORN Drug and Alcohol Service is an adult service which provides assessment, counselling and advice, community prescribing and testing and vaccination for Hepatitis. They have seen a rapid increase in the number of Nepali service users over the past two years. Opiate use tends to be the main problem and healthcare providers and police in area would add that smoking heroin, not injecting seems to be the norm. This does mean they require methadone, a form of substitute prescribing.

In November 2009 there were 20 Nepali clients accessing services at ACORN Frimley. All have heroin as their primary drug use. Nineteen of those twenty people were male. Local healthcare providers and police have also noticed this gender differential so it is unlikely to reflect differential presentation to services. To put the figures into a Hampshire context 8% of prescribed clients are now Nepali and 2 years ago there were none.

Youth Drug Misuse

They also noted that the Nepali heroin users tend to present earlier to treatment services than is usual. The average age of presentation is around sixteen years of age. The interviewee was unsure why but thinks it this may reflect either parental pressure to present, or a tendency to adopt treatment earlier than the British population.

Response

These are some of the strategic responses to this issue that her organisation and others have begun.

- Acorn has translated leaflets on treatment choices, harm reduction information, carers' information, overdose prevention information and new service user pack into Nepali. They have held awareness sessions for the community that were poorly attended.
- Cranstoun Young People's Drug Service delivered training to EMTAS to raise awareness of drug use in the community.
- Hampshire Constabulary Community Beat office ran a drugs awareness event for local a Nepali family which was well attended.
- Contact was made with community groups.
- A Community Support Officer has recently been appointed and his work plan is being developed and carried out currently.

The Catch-22 Service

To explore the issue around youth drug use in the Nepali community a specialist named worker in the Catch 22 Young People's Specialist Substance Misuse Treatment Service was interviewed. Catch 22 is a treatment service for those under than 18 and they received the tender for this service in July 2009. Since then they have had 13 Nepali (all male) in their service. This interviewee described how this "is a very different presentation than I have ever seen in my career". She described the following distinct characteristics of drug use in this community.

Unique aspects of drug misuse in this community

Choice of heroin as a substance to misuse

- They also smoke cannabis but the rates of use are lower than the local population. They rarely use cocaine or ecstasy.

Age at presentation

- They typically began using heroin age 13 or 14 and their mode of use is smoking not injecting. Their tolerance is very high when they present and their habit can cost £50 per day to sustain.

Intermittent drug use pattern

- They take it one day and not the next, usually those on heroin have a more continuous pattern of use.

Social pattern of use and low perception of harm related to use

- It's called "smoking brown" and is seen as a social group activity. She has had thirteen year olds phoning up and saying that they are "smoking brown" and they don't seem to understand it is heroin.

Low concurrent misuse of drugs or alcohol in heroin users

- None of those been currently treated are drinking alcohol. Only one client is using another type of drug.

Those who are using tend to present to their services in the following ways;

- Self referral
- Youth offending team (usually as a result of possession charges or because of running or selling heroin)
- Connexions
- Through any healthcare professional

Once they present they are assessed and treatment. The following paragraphs describe this process.

1. Assessment

This involves looking at their family life, sleep management, diet, checking drug behaviours, education on overdose prevention, coping mechanisms and sexual health promotion (although this community tends not to be forthcoming with sexual issues). Health wise those using tend to be underweight as their diet is poor.

2. Treatment

They have a prescribing clinic weekly, lead by a consultant psychiatrist. They prescribe Subutex (Buprenorphine) for younger people as it is a blocker and makes them ill if they use heroin. It is also less sedating than methadone. They don't prescribe methadone for young people unless Subutex doesn't suit them. If they are given methadone they are supervised in the chemist every day while receiving their dose. After the prescribing clinic they have a session with a specialist named worker. They also offer some alternative therapies including brief cognitive behavioural therapy, art work and acupuncture for relaxation.

3. Recovery

Once they are feeling well and not using they reduce their prescription. Catch-22 then put them in contact with employment and/or education organisations. She finds that they seem to be slow to move to this step.

Predisposing factors for drug use

Some of the boys say there is "nothing to do" in the Rushmoor area and this leads to them using. Staff from Catch-22 have also noticed overcrowding in the homes of teenagers they collect for treatment. The interviewee has seen that sometimes there is also little adult supervision and this can happen when the parents have long working hours. She reported how one set of parents were unaware their child was in prison for several days.

Effects of drug misuse

The interviewee observes that it tends to affect their education and willingness to work. There are also criminal implications. She is aware of one teenager who had mislaid their passport and who was not issued a replacement from the Home Office because of a drug conviction. There are also wider

effects as well and families can be severely affected. The interviewee is aware of one substance misuser who threatened his mother for money and how another stole their family's savings.

Stigma and shame

The service's biggest problem is communicating with the parents. They have noted that parents feel great shame when they find out their child is using and some are not happy if their child enters the treatment services as it means that they have "gone outside the community". The service always tries to involve the parents as they need this for consent to treatment. They often work with parents via a Nepali individual from the community.

Treatment in Nepal

The interviewee described how young people are sent home to Nepal for drug treatment. It is an inpatient model and lasts for several months. This is in contrast to the drug treatment model in the UK, as for an individual to be treated as an inpatient in the UK, they would need to be a high risk user who has failed community treatment. She has heard that it costs £2,500 to £3,000 for this inpatient treatment in Nepal. A representative from a private treatment service called Narconon comes over about five times a year to take groups of young Nepali substance misusers back with him so they can enter treatment. [Note there is the strong possibility that this organisation is affiliated to the Scientology movement and treatment could involve detoxification without medications, which can be dangerous²².] It has been reported to her that about thirty young people went back with him in December 2009. Her concern is that treatment abroad without familial support in an unfamiliar environment may not develop the coping skills in the individual which they will need when back in Rushmoor. They are aware of one boy who is homeless and using after returning back from treatment in Nepal.

Communication with the community

It has proved challenging to promote this service to this community to date. They have found word of mouth does not seem to have worked. They are aware of a group smoking heroin in Aldershot but they have not received referrals from there. To improve communication they have gotten some of their letters translated into Nepali and recently a new community support officer has been recruited from the community. This is a joint initiative between Hampshire County Council and Rushmoor Borough Council and his main area of work is on substance misuse.

The Nepali community on heroin use

All of the focus groups had heard about heroin use in their community. One group felt that young people have turned to drugs because they are studying/ working part time or they are waiting for ESOL classes to begin and are bored.

All of the groups were aware of young people sent home to Nepal for treatment for their addiction. Some groups mentioned the organisation in Nepal that treats their youth. They called it “Narconon” and described how a gentleman comes over several times a year to bring groups of young people back to Nepal for treatment. One group thought that about 50 from the Rushmoor area, Basingstoke and Camberley have done this. Another group estimated that 60% of young Nepali men with drug issues go home to Nepal for drug treatment.

The main reasons given for opting for treatment in Nepal were a preference for a stricter treatment style in Nepal, the cost of inpatient treatment here, stigma and perceived effectiveness of treatment in Nepal.

- All groups felt that the system here was too “relaxed”. Some reflected on how they brought up their children and felt their children were more likely to respond to “firmness”. One group also spoke about the difference in inpatient drug rehabilitation in England and in Nepal, namely that in this country those undergoing treatment are free to go outside whereas those in Nepal are chaperoned continuously. They preferred the inpatient model of rehabilitation and all felt that it was too expensive in England. One person said that the cost in Nepal is £3,000 and in England it is £7000-8000.
- There was less agreement in the groups around stigma. One group felt that stigma was not an issue while another group felt it was a big issue. They felt that they send them home to Nepal because they “don’t want people to know” and if people knew about the drug problem their child “may not be able to marry later.”
- Most also felt treatment in Nepal was more effective with “75%” getting better and being able to come home and get jobs or get married.

4.4.2.4 Diet

Change in dietary habits after migration

According to the dietician interviewed the Nepali diet in Nepal is much different to the one they are adopting here. In Nepal they tend to eat two main meals (including rice and daal) and one snack and generally they don't eat breakfast. Their diet in Nepal is also more vegetable and pulse based as meat is expensive there. Their meat preferences include goat, lamb, chicken, pork and buffalo. He observes that his Nepali patients seem to be adopting the UK diet. Here they might eat breakfast and have a British style lunch (sandwiches etc), but they then do an evening meal which is more traditional Nepali fare.

They have good local access to traditional foods including black daal and have a local Nepali food shop. In areas where they don't have this kind of access they can find similar ingredients in Indian food shops.

They like fried foods and in Nepal they will use a lot of ghee. Here they have begun to substitute oil for this. Because of the change in their diets the interviewee feels that research into the diet histories locally would be very helpful as it can be difficult to give appropriate advice to them.

Dietary Advice

Dietary advice given to diabetics in Nepal differs to advice given here. In Nepal, if they are diabetic, they are told to stop eating rice. Here he advises diabetic Nepali to reduce carbohydrate consumption and overall portion size. He reports that it can be hard to get this reduction as they seem to always feel empty until they have rice and will add it to any meal. They also make flour breads and porridge from millet flour.

Cultural aspects of diet

The interviewee describes how there can be specific cultural attitudes to food and alcohol. Brahmins and Chhetris (Aryan's) are brought up not to consume alcohol, pork or beef. Mongolians make their own alcohol and eat pork but no beef. He feels that in more recent times those groups may not adhere to these traditions as strictly as they used to. Halal food is generally suitable for them.

He also spoke about how occupation can have an impact on diet, specifically in the case of Gurkhas. He has noticed that retired Gurkhas often go into security after retirement. This is a more sedentary job than they are used to and, as they are used to large diets in the army, they end up gaining weight.

Knowledge about diet

This varies from person to person but on the whole the elderly have less knowledge than the younger ones.

4.4.2.5 Preventative dental health care

According to a local dentist the Nepali are tending to pick up the preventative dental health messages and tend to keep appointments once registered. They are no more/less likely to fail to attend appointments than the local population and their overall DNA rate is about 10% of total appointments. He has not noted a habit of chewing tobacco in his Nepali patients. Some teachers interviewed spoke about how they thought Nepali children had worse dentition than their British counterparts.

4.4.3 Child and maternal health

Maternal and Infant health

The community team midwife spoke about her experience in providing antenatal care to this community. She observed that they present at the right time in their pregnancy for antenatal care and that their attendance rate is “excellent”. The breast feeding rates are extremely high in her experience and she estimates that 90-95% of Nepali mothers breast feed their babies. This high breast feeding rate has also been observed by military medics.

This service always screens them for diabetes at 27 weeks as they are an at risk group. Additionally a small number have tested positive for hepatitis B during the antenatal screening process. Overall the health of mothers in this community is quite good.

Most of those the midwife has seen have good English and the younger women seem to have no problem making themselves understood. They also often use their husbands as interpreters if there are problems in communication. The interviewee observed that the older generation tend to have less English language skills.

Child health

The military medics also spoke about different cultural practices in child rearing.

They observed the following

- Infant co-sleeping with parents is normal practice.
- Family members such as grandparents play an important role in child rearing.
- Parents may use physical punishment to discipline their children, not being aware of the laws prohibiting this.

Local GPs noted the following:

- Some GPs also spoke of how Nepali parents tend to have low threshold for presentation when their children had minor illnesses.
- One doctor also spoke about her concern that some of the Nepali children were overweight or obese and that parents tended not to perceive it as a problem, as it was seen as a sign of health in their community.
- Another doctor felt that parents put pressure on their children to achieve academically.

4.4.4 Women's health and sexual health

This section should be considered in conjunction with the sexual health needs assessment conducted by Options UK which is mentioned earlier in this report. There are many similar findings.

High abortion Rates

Three general practices were concerned that termination rates are high in this community. One doctor was concerned that this may not have been according to the women's wishes as they often attended with their husbands as translators, making counselling difficult. She also reported that one patient suggested to her that gender based termination was quite "normal". Another doctor was aware of a patient with three or four sequential terminations. However there was also the perception that this trend is changing with most feeling that the number of referrals for termination that they were making for this community is falling. One doctor wondered if this was because of higher rates of self referral to abortion services although other practices have reported a higher demand for long acting contraceptives in this group and attributed the change to this.

The issue of high abortion rates was raised in the female only focus group as they were more likely to speak about these sensitive issues in the company of other women. They all felt that abortion was very stigmatizing. They described how women from their community won't disclose it to anyone except for their husband, not even their family members. When asked why Nepali husbands attend with their wives for the abortion booking appointment the ladies had a very pragmatic explanation. One lady explained that in Nepal a doctor will advise a woman to have an abortion if her child is physically disabled. This can be carried out without the husbands consent. If the foetus is normal then the doctor requires consent from the husband for their wife to have an abortion. This lady felt that this may be the reason why husbands attend.

Contraception

GPs felt that there were distinct preferences for different contraceptive types in this community. One doctor felt that they didn't favour the combined oral contraceptive pill as it tended to cause weight gain. Another doctor in another practice also felt that the oral contraceptive pill was not the preferred method although they were unsure why. One observed that they tend to prefer contraceptive methods which don't disturb their menstrual cycle. One of the other practices also noted that the coil was particularly popular as well as the contraceptive implant.

When asked about contraceptives the Nepali women in the focus groups were able to name many different types of contraceptive including condoms, pills, the coil, depot and “something in the arm”. They did shake their heads when mentioning condoms and pills and the group agreed that the coil was preferred. When asked if the ladies would like their husbands to be involved in the discussion around contraception they answered that it would depend on if their husbands had time. They did not find individual contraceptive counselling in front of a group acceptable as they felt that it would be embarrassing to discuss their needs in front of a group. Their preference was for individual couple counselling.

Cervical Smears and HPV vaccination

The participating general practitioners had less agreement around attendance for smears with some doctors feeling Nepali women had good attendance and one practice feeling their attendance levels were low. Another reported that they seemed to be unsure of what was involved in the process of taking a cervical smear.

Two practices felt that they had seen more advanced gynaecological cancers in this community, both mentioned cervical cancer and one added endometrial cancer. One of these practices felt it was more in the “new arrivals” who may not have had access to screening services in Nepal.

One practice felt they had high HPV vaccination rates in this community. According to one healthcare professional there used to be a culture of Nepali women having to ask permission from their husband to avail of cervical screening or STI testing. They also felt that this trend was changing.

Sexual Health

According to one health professional, in the past, some military husbands were not keen to have their wives tested for sexually transmitted infections as it might uncover an infidelity, although this attitude seems to be changing. One doctor noted that they had found cases of Chlamydia in partners of serving military men and wondered if these patients are screened enough for other sexually transmitted infections such as hepatitis. Two doctors from two different practices spoke about condom use in men; one thought men were reluctant to use them whereas the other felt they were acceptable to them.

Cultural issues in relation to sexual health

The Nepali military medic who wrote about health issues felt that there is a huge cultural barrier to discussions around sexual health. He observed that Nepali find it very difficult to utter words that describe private anatomical parts and that these words are rarely used in Nepal. He also felt that

parents would be shocked if a health professional brought up contraception with their teenage children. Another doctor worried that younger Nepali may be deterred from using contraception because of their parent's attitudes to premarital sex. This was also echoed by another doctor who had observed that there is stigma attached to premarital sex in this community, perhaps leading to reluctance to attend for contraceptive advice. This reluctance to discuss sexual health issues was also echoed by the specialist named worker in Catch 22 Young People's Specialist Substance Misuse Treatment Service.

4.4.5 Older people's health

One general practice felt that the new arrivals were different to the existing Nepali community in that they tend to be older with less English. They can present with no medication but have a long list of medical issues due to poor access to healthcare previously. This practice was also concerned that new cases of cancer were being picked up in these new arrivals and that they might have advanced disease at presentation due to not having access to screening previously.

Their dental health was also a concern to the local dentist. The older people may have dentures and often only older dentists may be the only ones who remember how to make them. He thought that these patients are most likely to be registered with younger dentists because they are more likely to have list space.

4.4.6 Mental health

The major themes in this section were that of stigma, somatization and delay in diagnosis.

Stigma

Three of the practices felt that mental health problems may be very stigmatizing in the community. One doctor, despite having many Nepali patients, was unsure that they had ever picked up any mental health problems in a Nepali individual. One of the other doctors wondered if this is due to the Nepali culture having different concepts of mental health and mental illness.

Somatization

Two different practices described how they have found that some Nepali patients may somatize their mental health problems and this was more common than would be expected in this community. This means they may present with physical symptoms such as abdominal pain or dizziness but the underlying disorder is a mental illness. This phenomenon was also described by the military medics.

Two practices were concerned that older people (especially women) are socially isolated and present with depression. Another doctor worried that some ladies with poor English may feel unable to speak about mental health problems in front of their husband, who may be attending with them.

Delay in diagnosis

One practice was concerned that their diagnosis may not occur until very late in their illness as they tend to be very stoical. The same practice found that the Gurkhas tend to have a very positive mental attitude and the community itself is very self reliant. They described how one of their GPs offered to visit a recently bereaved family and they rejected the offer as they were receiving community support.

4.4.7 Social issues

The main themes identified were those around integration, English language skills and multiple occupancy in housing.

Integration

Three general practices mentioned lack of integration as a major social issue, two felt this was happening in schools and two felt women were affected more by this.

Two of the community groups were asked whether they felt part of the community in Rushmoor and whether they thought older people might be socially isolated there.

- The British Gurkha Welfare Society group felt that perhaps some Nepali were socially isolated in Aldershot, whereas this was not such a problem in Farnborough. This group also felt they were part of the community although money issues limited their activities. To combat this some of the older ones have a daily routine where they come in the morning to the BGWS community centre and watch Nepali television, go for a walk in the field together and have lunch together afterwards, followed by more Nepali television and dinner later.
- Another group spoke about how “everything is new”. The “weather is different” as is the society and when you have “no English, you have to learn from the beginning”. Some reported feeling lonely as they live in groups and large families in Nepal where they try to help one another. Here, they felt people, live a “very individual life”. They also thought that many people in England suffer more from mental health issues because of this lifestyle.
- On the other hand the Nepali are able to rely on their community as mentioned before. One practice felt the army wives, in particular, had a very close network.

English language skills

One of the barriers to integration that everyone spoke about was lack of English language skills. One practice reported that their practice population seemed to be trying to learn English. One health professional observed that the older ones felt unable to learn a new language and would prefer to return home to Nepal. The female focus group (EMTAS) were clearly engaged with learning English as the focus group was held in their weekly English class. Another community group was able to describe a number of classes that they could attend to learn English. One elderly Nepali gentleman described the difficulty in learning a new language at his age, saying that the elderly forget what they have learned once they leave the classroom.

Multiple occupancy in housing

The problem of multiple occupancy was mentioned in all but two practices. They were all able to give examples of this including one of a two bedroom house with four families in it and another with fourteen people in a three bedroom home. One practice group felt it could, in part, be due to close family ties. They were also aware of families who sleep in a shift system. One doctor mentioned that it could have a huge impact on list size as a small number of houses could generate a lot of patients. This practice had also been noticed by those working in the Catch 22 drug treatment service when they have collected children from their homes.

4.4.8 Health Services

Background to the health service in Nepal

It is useful initially to consider the structure of the health service in Nepal as it is significantly different to the NHS. The differences may also help explain the patterns of consultation in the community.

The Ministry for Health in Nepal oversees the Department of Health Services whose responsibility it is “to deliver preventive, promotive and curative health services throughout the country.”²³ (See appendix for a diagram of the structure Nepali health system).

Within this health system structure the Sub-Health Posts (SHPs) are the first contact point for basic health services. In reality there is a tier below that which is made up of the community based health providers. These include Traditional Birth Attendants and Female Community Health Volunteers. They can refer patients to staff in the Sub Health Posts. The Sub Health Posts are also used to deliver Expanded Programmes on Immunisations as well as run Primary Health Care Outreach Clinics. Those in Sub Health Posts can refer upwards to Health Posts, Primary Health Care Centres and to district, zonal and regional hospitals, and finally to the speciality tertiary care centres in Kathmandu. This complex tier system has been created to ensure that people can receive care where they want it and in an affordable way.

Alongside this government run system is a private health sector. A few hospitals are not for profit and are funded from mainly patient charges although one gets local community and governmental contributions in addition to this. The majority are, however, for profit organisations and are clustered in urban areas. The charges at these hospitals can be quite high despite attempts by the government to reduce them.

Because of the large differences between the Nepali health system and the National Health Service the community groups were asked to describe the service in Nepal which they were used to, their perceptions of the NHS and how they have learned about how to use the NHS.

4.4.8.1 Community knowledge of the NHS

All of the community focus groups spoke about how different the systems are and how many of them still struggle to understand how the system here works. They described the Nepali system as follows;

There is a private and state provided health care. There are no GPs but health centres which they can access. They are not registered with one doctor and they have to pay for an appointment whether they use private or state provided healthcare.

The Gurkhas are different in that they can access a welfare centre (for ex servicemen) which is free, however there is only a few in each area and there are huge queues there. They described two hour waits to be seen as typical. The cover provided by Welfare centres is not continuous and they are closed at weekends. The British Gurkha Welfare Society group described how fees for a private hospital are half reimbursed by the welfare centre if you notify the centre in advance of your appointment. If you are ill over a weekend and attend a private hospital then the money is not reimbursed by the welfare centre. These welfare centres also extend cover to the wife of an ex serviceman but not to their children.

The services differ in quality too, according to the groups. The government service is cheaper than the private sector but it is “slow and unreliable”. If they get acutely unwell they are brought to a government hospital even it is “life or death” and a private one is closer. There isn’t universal ambulance service cover and villages often don’t have access to this.

All of the groups agreed it is better here and that the service is “excellent” and “sophisticated”.

Learning to use the NHS

All of the groups were asked about how they learned about the NHS. None of the focus groups participants felt confident in their knowledge of how to access it. The women in the EMTAS focus group described how they relied on their husbands to organise things and that they probably learned about it from them. Others in other groups felt no-one had told them what to do. Their comments included that they found it “very confusing” and some said “we don’t know what to do in an emergency”. There was variable knowledge about the number to call for emergency services. Most of the ladies in the EMTAS group knew about dialling 999 in the case of emergency. Two new arrivals in the BGWS group didn’t know about it and nine out of sixteen people in the Madat Shamuha group did not know about it either.

The dental service

Throughout all the groups there was uniform confusion about the NHS dental services with many being unsure about the pricing of treatments and the difference between private and NHS care. Additionally only small numbers of those in the focus groups said they were registered with a dentist (nine out of forty one participants -22%). One man spoke about how when he phoned the dentist they could only offer an NHS appointment in one month but a private one the next day. This added to his confusion. Another man spoke about how he had a broken tooth and, as he had no money, he could not get it fixed.

The low levels of registration with a dentist could be for the following reasons. The ladies in the female EMTAS group also described how, in Nepal, the dentist and GP are not different roles and that a dental check-up can be part of an overall medical check-up. Others spoke about waiting for a problem to develop with their teeth before they go to the dentist. This means that if they haven't had a problem so far they haven't attended one.

Pharmacy

None of the focus groups participants had a negative experience with this service. Some said it was "fine" or "good". The Madat Shamuha group said they would ask pharmacists for health advice but the women's group and the BGWS group were not happy to do this. The BGWS group felt that they wouldn't be able to understand the advice due to the language barrier and were happier with prescriptions with written instructions. Interestingly none of the women in the EMTAS group knew they could approach a pharmacist to ask for advice and the majority of this group thought that they had to have a prescription to even access the pharmacy.

The GPs and the pharmacist spoke about how there can be the expectation that all medicines are free in this community and they ask their GPs to prescribe over the counter products such as calpol or calamine lotion. The pharmacist interviewed understood that medications are free for those who serve in the military in Nepal and this may in part explain the expectations that some from the community may have.

4.4.8.2 Access to healthcare

Registration with Primary Care

One of the Madat Shamuha groups spoke about their community finding it difficult to register with a GP. They have found that some practices are not aware they are entitled to register with them.

General practices felt very confused about the Nepali rights to register with them. This confusion led to a mixture of requirements for registration. Some practices required a passport and visa as a form of identification as well as a proof of address. Others did not require a passport specifically as a form of identification. One practice did not ask for proof of address. There was a general lack of clarity about entitlement to healthcare and some queried how the visas in their passports related to entitlement to elective secondary care. Overall there was no consensus view on how to register patients with most feeling need for more guidance on this issue. [Note guidance was issued to the practices when this was highlighted].

Identity Issues

Two GP focus groups spoke in detail about this and the pharmacist and dentist also identified similar issues around confirming identity. These were as follows:

- They all mentioned that the Nepali in the area often had similar names.
- The Nepali are often not aware of their actual date of birth. This means that on some official documents they are assigned a date of birth which is the first of the first in a selected year. This has meant that many of them have the same name and date of birth which can lead to confusion. The pharmacist interviewed spoke about how she has also seen an allocated year of birth. This confused one patient as they thought they were as old as another person who was receiving free prescriptions.
- They use a completely different calendar so dates of birth can often be confusing.
- Some move home quite often, often because of looking for work.
- Wives can have different surnames to husbands
- Their passports can have abbreviations in place of full names (Grg instead of Gurung) and some names can be reversed.
- Some share a mobile phone which is a problem if the practice uses a system which sends a reminder text of an appointment. It has resulted in a group turning up, unsure of who is meant to attend for the appointment.

This problem is not exclusive to the health service and one health professional had heard of one person's national insurance contributions being allocated to another person because of identity issues. One of community groups was asked whether they would be happy to use their NHS number as a way of confirming their identification and they felt that this was acceptable.

Communication: Health professionals' views

The major themes that arose from speaking with health professionals were that:

A large proportion of the Nepali community is unable to speak English.

- One doctor felt this could be up to 40% of their practice population.
- In general women tend to have less English language skills than their male counterparts. Like the local GPs in Rushmoor the military medics have found that "most wives find communication a problem."
- Young people have far better English than older members of their community. The pharmacist interviewed also observed that the elderly tend to have the poorest English language skills and sometimes bring relatives with them for the pharmacy visit. She has seen some people attend with two prescriptions which were written within a short space of time (a few days). She suggested that this is due to them having to wait for someone to come with them and meanwhile having to attend their GP for the same or a new problem. The pharmacist interviewed spoke about how difficult it can be to give instructions around medication use.
- One contributor felt that checking comprehension is very important in Gurkhas as they may nod and indicate understanding without comprehending what has been said. He felt it was to prevent "any loss of face" and, as Gurkhas are supposed to be Anglo-fluent nowadays, and admitting lack of comprehension might be seen as unacceptable.

Use of family interpreters

- Most of the health professionals reported that the patient's bring a relative or friend to translate for them.
- Health professionals were divided on whether this was ideal:
 - The negative sides reported by the local GPs were that the appointments took much longer while using a translator and often the husband, who was translating, would answer without consulting with their wife who was the patient.

- One practice felt this seemed to be what the patient wanted so they overcame their initial discomfort and allowed family translators. They also felt that this meant the consultation was less “rich” and mainly focussed on physical symptoms. Two consultants in secondary care felt that having a carer or relative present as a translator meant that they could enlist the carer or relative in the post operative care of the patient.

Views on interpretation services

Both primary and secondary care interviewees spoke about the interpretation services available.

- The overall view of the phone interpreter service available to primary care was not positive.
 - Most of the practices do not use it at all. The reasons given were:
 - It made the consultation last much longer
 - One practice believed it cost them money
 - It can be difficult to find a Nepali interpreter. Additionally one reported that, when they did book a telephone interpreter in advance, the patients often did not turn up.
 - The connection took too long
 - There were worries about patient confidentiality as patients in the waiting room might be able to hear the consultation.
- The interviewees from secondary care also described the phone interpreter service in the outpatients department as difficult to use and said they thought that not many doctors use it.
- One GP corroborated this by saying that interpreters were often not arranged in secondary care and they also felt that “Choose and Book” would be inappropriate for these patients.
- The dietician interviewed spoke about how there are lots of Nepali nurses in Frimley Park who act as interpreter for the inpatients.

Lack of translated material

There is also a lack of translated health information.

- Mayfield practice developed some leaflets on coughs and colds which some of the other practices use.
- North Camp surgery has translated information on smears which they found online and they have some translated information on diabetes and meningitis too.
- All practices agreed they need more translated information.

- All those interviewed in secondary care also said that they had no translated material for this community.

Local adjustments to practice

- Some organisations have recruited Nepali to their staff
 - The dentist interviewed had recruited two Nepali trainee dental assistants.
 - One GP practice has employed a Nepali office worker who acts as an interpreter. The feedback from the patients and doctors in this practice has been very positive with one patient expressing how they felt it was the first time that they really understood about their health problems. Another GP practice has a volunteer interpreter.

Communication: Nepali community views

A large proportion of the Nepali community is unable to speak English.

This was brought up repeatedly by all the groups as very few of the focus group participants could speak English.

- One gentleman spoke about how this problem primarily affected the older age groups and that he thought 99% of men in the over sixty age group would need an interpreter and 100% of women over the age of fifty would need one.
- One gentleman suggested that this would become a greater problem in the future as many more elderly people are going to come to Rushmoor.
- As the pharmacist suggested, they find it very difficult to understand diagnosis and instructions around medications.

Use of family interpreters

- The women's focus group said that they were not happy to have their husbands act as an interpreter for the following reasons;
 - It can mean that their husbands have to take time off work. Additionally if their husband is at work they are unable to attend without him.
 - The husbands English may not be good enough either and that he may not be able to give or get an exact explanation. One woman spoke of an occasion when she was given medicine that didn't work. She had to represent to the GP and thinks it was possible that the original "medicine wasn't for what I was suffering from".

- Some older people spoke about having to rely on their children to interpret and that they may not be available because of work commitments. This was a source of great anxiety.

Views on the interpretation service

- None of those in the focus groups had ever experienced a translation service in their GP practice. Only one had experienced it in secondary care.
- One patient was told to bring his own interpreter and, as he is a new arrival, he did not know who to bring.

Consequences of communication barrier

- This leads to fear and anxiety in the community with one participant saying “We don’t get the right treatment, we can’t communicate symptoms”. The women’s group, in particular, recounted stories of patients who had presented numerous times with a problem, did not receive appropriate investigations or treatment and were seriously ill or died as a result. These occurrences made them feel even more anxious about symptoms and how they were communicating with their doctors.
- It also limits the patient’s ability to communicate their anxiety about medical issues and to receive reassurance.
- It can lead to increased numbers of consultations.
- Sometimes patients feel unable to say they don’t understand. One lady spoke about how the consultation is much shorter if the doctor thinks she can’t understand. This means she sometimes says “yes, yes, yes” to convey that she understands even if she doesn’t.
- It doesn’t allow the health professional to discuss the treatment options in depth. This is important as there can be differences in approach to treatment in the UK compared with Nepal. Most of the groups gave examples of where they, or someone they know, were told they needed a particular investigation or treatment in Nepal and when they came back to Rushmoor they were told that they did not need this. The ladies particularly emphasized this especially in relation to gynaecological issues. One woman mentioned that her doctor told her husband that “it sounds like Nepal doctors do operations on ladies very quickly.”

Patient story

One lady spoke of repeatedly presenting to her GP with throat pain, having previously being told in Nepal that she needed a tonsillectomy. She was referred to ENT in Frimley Park Hospital but the doctor she attended discharged her from the service. She had been seen without an interpreter.

She was eventually re-referred to the same department and another doctor who saw her confirmed that she needed a tonsillectomy. This time was the first time she had ever been offered an interpreter to help convey her symptoms. This whole process took months and during this time she was worried that she had throat cancer as someone in her community told her tonsillar problems could turn into cancer. She was unable to convey her anxiety about this to any of the health professionals that she had encountered.

Transport

Two gentlemen expressed how they are unable to get transport to the appointments that they have to attend. This was due to not having enough money to get there.

4.4.9 Health beliefs and behaviours

Health professionals and the community were asked about health behaviours and beliefs in the Nepali community. Some of their comments overlap and are presented together.

- **Expectations**

Health professionals

Faith in health professionals: According to our military contributor they have tremendous faith in doctors and nurses and many believe that modern medicine can cure all illnesses. They felt that they therefore come to see doctors asking for treatment for minor conditions such as “flu or cold”. They also felt that they attend with expectation of receiving medicine that will cure them or that they will be sent for investigation or referred to a specialist.

Appointments and Investigations: Some GP practices reported that the community expected immediate access to a doctor’s appointment. One mentioned that it was the same for investigations.

The community

Appointments: All groups spoke about the length of time it took for them to get a GP appointment and that it could take weeks. Some were concerned that this waiting was especially bad for the

elderly. One spoke of how many “die of waiting” and another described how they only attend their GP when it is “unbearable”.

People in the groups often spoke about the lengths of their consultations. All felt they were too short, taking into account the language barrier and the number of medical issues that the elderly can have. One group expressed how they did not know what to do if they had a few medical issues to communicate to their GP. Another group spoke about their frustration in being told to book more appointments.

- **Low threshold for presentation**

Health professionals

All of the practices except one felt that the Nepali community a low threshold for presentation, especially in the case of children. One health professional felt that this could be because of past experiences of child mortality in Nepal.

One doctor who had worked in Nepal in reflected on how this was different behaviour than was exhibited in Nepal where they would wait until they were really unwell to attend.

Examples of low threshold for presentation included

Attendances to Accident and Emergency for minor health problems as well as for running out of medication.

A parent insisting on a same day appointment with their GP to get a plaster for a graze on a child’s knee.

One doctor felt that phone consultations failed to reassure the patients and another practice felt that sometimes phone consultations were ineffective due to poor language skills.

- **Adherence to treatment**

Health professionals

The view from the health professionals on this was mixed. Three practices felt that this was poor although two practices felt that their Nepali patients were adherent to treatment. One doctor described his Nepali patients as “precise” in their history and “excellent” in adhering to treatment. Interestingly this GP practice has doctors who can speak Hindi which many Nepali can understand.

A consultant in secondary care and the community diabetic nurse also felt that they are health conscious patients and are adherent to treatment as long as there is no communication barrier.

Examples

One doctor reported that some believe their medication for hypertension is short term and stop taking them.

The patient group that most concerned the GPs were diabetics, as these patients need to be able to receive and understand a lot of complex information to control it well. One practice reported that they have a patient who is insulin dependent and is unable to speak English or read Nepali. This patient rarely attends with an interpreter and this causes his doctors to worry about his management.

- **Concurrent Treatment in Nepal**

Health professionals

This phenomenon was reported by over half of the practices interviewed as well as some of the consultants in secondary care.

The health professionals felt that this had the following adverse effects:

- **Difficulty in providing follow up to patients:** After returning home from investigations or treatment in Nepal local doctors reporting being unsure of what was actually done. Some doctors spoke about having to repeat investigations conducted in Nepal as they did not receive the investigation reports. Often they were unsure why the investigation was done in the first place.
- **Differences in approach to treatment of illnesses:** One doctor described different treatment regimens used there e.g. antipsychotics used when the patient was not psychotic and higher doses of drugs. Some doctors felt it disrupted their continuity of care as drug regimes could be changed completely. Some felt that patients are more likely to be investigated there with one doctor giving the example of a patient who spent thousands on the investigation of a mild health problem.

In common with the local Rushmoor practices the military medics have observed a trend of consulting multiple doctors. They have seen that when patients with existing illness or chronic conditions are on leave to Nepal they are highly likely to see a “specialist” in Kathmandu. There they undergo multiple investigations or simply buy all sorts of medication from the pharmacy without prescription.

The community

All of the focus group participants were aware of this practice and either they or they knew of someone in the community who has done this. One group acknowledged that some go home for treatment, usually for “orthopaedics, dentists, ladies cancer, gallstones”. Some were also keen to point out that not everyone could afford to do this.

Reasons given for seeking treatment in Nepal:

- Long waiting times in the NHS for surgery
- Demand for “full health checks”. These were described as full sets of investigations which are often carried out in healthy people to ensure this is the case. Most groups told stories of how people from their community were investigated here and reassured nothing was wrong only to undergo further investigation in Nepal where serious conditions were detected including stomach ulcers, a deep vein thrombosis, a paediatric cardiac defect, cancers and other illnesses.

- **Use of traditional medicines and healers**

Health professionals

Traditional healers: One of the military medics described how because Hindus can believe that illness and misfortune are a result of Karma a “priest” may be asked to read the astrological chart and perform “puja”, which are prayers with rituals and offerings. According to him, consulting Shaman called “Dhami-Jhakri” is common in Nepal and occasionally there may be a “Dhami-Jhakri” amongst the troops. These shamans are believed to have healing power and will carry out a healing ritual for someone who is ill.

The community

Traditional healers: One group described how they have three female “witch doctors” in the area. They act as traditional healers and offer psychological treatments mostly. The group described how they pray with you, look at your hands and pulse and tell your fortune.

Traditional treatments: None of the groups admitted that they took any herbal remedies for illness with one saying that they “left all that behind in Nepal.” The local pharmacist has also noticed this. The following were described as treatments that they do use.

Lemon ginger and honey for a cold, salt water gargle for a sore throat, turmeric in hot water- to “ease heavy chest”, Oil massage for “if your body hurts”, herbal teas and black salt “to ease indigestion”.

- **Family attending consultations with patients**

Health professionals:

The use of family members as interpreters has been previously discussed, however there is also a cultural component to having a family member act as a chaperone during a medical consultation. The military medics also recognised this and felt it was due to a kind of collaborative decision making process in couples. Once they were happy about confidentiality and that it was according to the wives wishes they found it beneficial as it would give a better picture of the family dynamic as well as allowing the medics to enlist the husbands support in management. The military contributor who was also Nepali also described how, because of religious and cultural traditions, women can feel that their bodies are “sacred and can be touched by no other men but only by her husband”. In his experience as a medical professional acting contrary to this could cause “guilt, discomfort or even pain”.

The community:

The female focus group felt that older women take their husbands for “security”, because their “husband is clever” and because “it’s important for the women to talk to their husbands about problems”. Older husbands in other focus groups felt that they should attend out of “love” and “worriedness”.

The women from the women’s group confirmed that their husbands may feel insecure about sending their wives on their own as they may not be able to explain their medical problems properly. One lady told us of how their husbands may phone in middle of an appointment to check on them.

- **Sources of health information within the community**

Community groups

One of the groups was asked where they usually got health information and where they would like to receive it in future. They wanted to read more descriptions of illnesses and symptoms to look out for.

The top sources of health information for this community were:

- Asking friends and relatives for advice: Most would ask friends and relatives about minor symptoms before looking elsewhere for information.
- GP: This was deemed their most trusted source of information.

The sources of health information rarely used by this community were

- Internet: When asked only one person out of almost fifty people in the focus groups felt comfortable using this. All other participants admitted to not being able to use this and the women's group said their husbands may be able to use it but they could not.
- Leaflets: This is because not many are translated into Nepali. Two ladies had read some translated leaflets on diabetes and found them very useful. They suggested that usually whoever acts as their interpreter in the consultation will translate an English one into Nepali for them afterwards.

Preferred Sources of Information

- They would like to see health articles in their newspapers which include :
Everest times (most popular locally), Nepali Sandesh, Naya Sandesh and Nepali Patrika.
- Leaflets in Nepali: The main issue with written information which all groups stressed was that many in their community, especially females and those in the older age groups, are unable to read in their own language. One group suggested that if it was part of a wider programme of health promotion it would be useful. The female focus group suggested the use of pictures for older ladies.
- Presentations on health issues to community groups

4.5 Recommendations

Summary of recommendations made by Stakeholders

Stakeholder Group	Recommendations
General Practices	<ul style="list-style-type: none"> • Face to face interpretation service • More translated health information
Pharmacy	<ul style="list-style-type: none"> • Improved recording or assigning of dates of birth • Patient awareness about keeping an up to date address on their records
Secondary Care	<ul style="list-style-type: none"> • Improved interpretation service, although most interviewed were satisfied with family interpreters. • Translated health information • More research into certain diseases in this community
Community Diabetic Specialist Nurse	<ul style="list-style-type: none"> • More translated literature on diabetes • Formation of a diabetes support group if the community found this acceptable.
The Nepali Community	<ul style="list-style-type: none"> • Interpretation services were a priority for all groups. When I asked one of the groups how they felt about an interpreter coming from their own community they said they were happy with this as long as they were trained in confidentiality. Others suggested times at practices when interpreters might be available to them if full time provision was not possible. • Easier access to appointments • Making sure all practices were clear on their rights to register with them • Less waiting for appointments and investigations • Receiving results of investigations which are conducted. Some reported having tests done and were unsure of what to do to obtain the results.

Table 7 Summary of recommendations made by stakeholders

Priorities for action by disease group

Diabetes

According to the community and the local general practitioners this is common in the Nepali community. Interestingly the local community diabetic nurse has seen minimal numbers in her service, far less than would be expected. (This may mean that they are accessing hospital services directly). No Nepali attend her patient groups for diabetes.

Recommendations

- An expert patient group programme. This could develop this patient group's confidence in self managing their condition. This intervention is well evidenced and could particularly work in this community as it is very active at the community level. All of the focus groups participants also spoke about how they would welcome talks on various health issues. This programme is based on verbal presentations and discussions which may overcome the communication barriers of low literacy. It would also be sustainable as those who attend the groups can become group facilitators afterwards.
- * Note: This may be in the process of being commissioned by NHS Berkshire. There is an opportunity for joint commissioning of the training phase of the programme.
- Written translated information on diabetes. Although there isn't complete literacy in this community, translated literature should be available to support those who can. Literature could also contain pictures which may help those who cannot read. Any literature developed should be done so with adequate piloting in the community.
- Further research needs to be conducted to establish if the diabetic services are being utilised by this community e.g. diabetic retinopathy services. Part of this is increasing awareness of local diabetic services which can be achieved by leaflets and via local health professionals. The community diabetic nurse had much lower than expected diabetic patients and it unclear whether this was because they are not being referred to this service or because they are attending the diabetic nurses in Frimley Park Hospital.
- Local research on Nepali diet. The community and the dietician spoke about how they still eat traditional Nepali food. The dietician adds that they also eat "British" food as well. A lot of the dietetic information may not be culturally appropriate and may need to be adapted for the Nepali diet.

Evaluation

If the expert patient programme is set up methods of evaluation could be built into its implementation. Production of leaflets and the other research suggested would suggest this recommendation had been met.

Tuberculosis

According to our figures this is more common in the Nepali community than in the wider British community. Health professionals and the community identified it as a priority.

Recommendations

NHS Hampshire is currently commissioning a community TB nurse for this area. The current suggested model is commissioning a nurse to work in the community under the supervision of Frimley Park Hospital's TB clinic nurse. When this occurs information should be given to the nurse on how to access the community groups in the area.

Nepali children in the area should be vaccinated with BCG as their parents and/or grandparents are from a country where TB is common. This occurs with infants but children who migrated when older may have missed out on this. There needs to be increased awareness of the need for BCG in these patients and it should be routinely asked during new patient registration. Children who have not had this vaccination

should be referred to the child health clinic in Frimley park for vaccination.
Written translated information on tuberculosis. FPH is also developing a patient medication guide for TB so that a picture of the drug sits alongside the directions for use. This may help those with limited literacy.

Evaluation

TB specialist Nurse role is currently being commissioned.
Numbers of children vaccinated with BCG could be counted with numbers of Nepali children in GP registers used as a denominator.

Cardiovascular Disease and Hypertension

This is commonly reported as a problem in this community by the healthcare providers and the local community. The causes of cardiovascular disease are multifactorial and the focus needs to be on the known risk factors for disease.

Recommendations

Diabetes (see above)

Smoking: Although the prevalence of this was thought to be low by most of the health professionals, the local dietician felt younger Nepali may be taking it up. During the process of this health needs assessment Hampshire Quit4Life has been put in contact with the known community groups to work with them on this.

Obesity: As well as examining dietary issues and creating culturally appropriate information extra work can be conducted on improving physical activity. Children seem to be involved in sport locally and there is provision for youth activities locally.

Rushmoor health Living is organising health walks and training volunteers to lead walks. Signposting of this service would be a good way of encouraging physical exercise as well as encouraging local Nepali to create their own health walks.

Diet (see above)

Hypertension and hypercholesterolaemia:

Increasing physical activity and appropriate dietary advice will help with these risk factors alongside medical treatment when needed.

Evaluation:

Quit for Life collect data on the ethnicity on their quitters.
Attendance at health walks and other exercise initiatives could be recorded.

Mental Health

All the healthcare providers felt that mental health issues were not diagnosed as often in this community. There are potentially many different reasons for this. The prevalence could be lower than expected, there could be difficulty in diagnosing these conditions in this community e.g. the diagnostic tools may not be as effective in diagnosing in this community. The community identified depression as a problem in their community, particularly in older women.

Recommendations

Increased awareness in the community and in the local health professionals.
Invitation to third sector to speak about mental health and wellbeing.
Expert patient groups to improve confidence in managing long term conditions which includes mental health problems.
Increase in physical activity through health walks and local exercise initiatives.

Evaluation

A comparison of figures on prevalence of mental health disorders in the community may indicate greater awareness, diagnosis or increased numbers of cases.
Presence of patients with mental health disorders at the EPP groups.

Reproductive and sexual health

Local healthcare providers felt that there were high abortion levels in this community. The female community group felt that this procedure was stigmatizing. Nepali women, when asked, also had some very clear preferences around choice of contraception, which was corroborated by some local doctors. All of the females would like more information on these issues. Gynaecological cancers were felt to be common in this community by local GPs, particularly in new arrivals who may not have access to screening previously. There was a mixed picture on whether the community was good at attending for this investigation.

Recommendations

Translated information on contraceptive options and on cervical smears should be made available to the community.

- This may prevent women attending at the wrong time in their cycle for their smears, as one practice reported, and also inform them about the procedure.
- Contraception is also an important issue. The female focus group spoke about how they would not like group information sessions about contraceptive issues but would value individual/couple education sessions. Their preferred source of information was their GP which emphasizes who important primary care is in promoting longer acting contraceptives. Surprisingly the female groups also thought that they could not enter a pharmacy without a prescription. This means that they are not likely to be using the Emergency Contraceptive Services in their local pharmacies.

Information session delivered to female only groups might also be acceptable as the female focus group spoke quite freely about contraceptive issues when together. A Nepali nurse could be the best person to deliver this information. Additionally word of mouth is a very important mode of communication in this community and the information would be disseminated outwards.

Evaluation

Prevalence of use of contraceptives could be conducted with comparisons over time.
Number of abortions in this community could be counted.

Dental Health

According to the dentist interviewed his Nepali patients are good at preventative dental care and are as likely to attend their dental appointments as the local population. One of the local teachers did say that she thought the Nepali children had poor dental health. In the focus groups only 22% of those asked were registered with a dentist. Some spoke about not understanding the public/private dental system, some spoke about how expensive treatment was and others felt they did not need to register unless there was a problem. One person suggested that a dental checkup is part of a full medical checkup in Nepal so this might explain the low registration levels:

Recommendations

NHS Hampshire is in the process of tendering for a dental service in Farnborough with outreach to military families and the Nepali community.

A health skills course should address the importance of registration with a dentist.

Infections acquired abroad and travel advice

Local GPs felt that the Nepali community did not attend for travel advice before returning home. This could be problematic if they are bringing children home who have not developed the same immunity or have had the same vaccinations as their children.

Recommendations

This issue is about awareness. Information and tailored advertisement of the travel advice services which are offered by primary care could promote awareness.

Hepatitis B

The local gastroenterologist felt that this may have a high prevalence in this community as the prevalence in Nepal is very high. The local GPs have not noticed a large number of cases but some also think testing for this is low.

<p>Recommendations Greater awareness in the wider community Antenatal testing Awareness in the GP community Sexual health promotion</p>
<p>Heroin Use The use of heroin by young Nepali males in Rushmoor has been observed by many different sources locally. The community spoke about how they prefer to send their children to Nepal for inpatient drug rehabilitation. This has a significant cost implication as well as this service potentially being linked to Scientology which uses controversial methods for drug treatment.</p> <p>Recommendations Greater awareness of this pattern of drug use in young Nepali males in health professionals. Staff who work in emergency medicine as well as primary care should signpost patients to the local drug treatment services. Awareness sessions could be provided to healthcare staff about this issue. The drug treatment services are also working on promoting their services in the Nepali community.</p>

Health Service Issues

<p>Commissioning Services</p>
<p>Lack of accurate health data It is very difficult to identify the Nepali in routine data sources due to lack of appropriate coding. In October of this year Connecting for Health will introduce a new code which can be attached to the Nepali in the GP information systems.</p> <p>Recommendations: A project is being initiated in Rushmoor whereby the Nepali will be coded with this new code in the GP information systems. Next year a prevalence study of disease will then be undertaken in conjunction with the University of Southampton. It will allow for a relatively accurate profile of the health needs in the community and make it easier to identify priorities for action and design services appropriately. It is also a sustainable solution as it will be possible to conduct these kinds of searches again.</p> <p>Evaluation Production of report indicating this.</p>
<p>Accessing Healthcare</p>
<p>Registration with Primary Care and entitlement to Secondary Care Those in Primary Care admit confusion about the guidance relating to right to registration. Patients in the focus groups spoke about difficulty in registering with some of the local practices. This led to them registering with practices who would take them which may not be as close to them.</p> <p>Recommendations When this issue was raised by the local community during the health needs assessment the LMC and NHS Hampshire wrote to the practices clarifying this issue.</p> <p>The community groups should be advised on the procedure of what to do if registering as a patient is difficult.</p>

Patient Identity

What has been said locally:

This is a problem across all parts of the health sector. The community admitted this could be a problem when in the pharmacy and a local pharmacist has also identified this as an important issue. This problem has arisen due to the similar names, allocated dates of birth and addresses of the community.

Recommendations:

Promote the use of the NHS number as a way of confirming identity. Some of the community group's members were unaware of what it was and how to obtain it. When asked, one community group said they were happy to use if needed.

As part of this health needs assessment process information on how to obtain the NHS number was sent out to the community groups in Rushmoor.

A representative from Frimley Park Hospital has also presented to a community group about the importance of the NHS number

Evaluation:

Initiation of a local pharmacy project to address this with evaluation methods built in.

Transport to appointments

What as been said locally:

Some Nepali reported difficulty getting to hospital appointments due to not being able to afford transport.

Recommendations:

The PALS service in Frimley Park was contacted and provided a list of volunteer services which provide transport. This will be disseminated to community groups and health professionals.

Communication in Healthcare

Interpretation Services

This was the main priority of both local GPs and the community. There is a telephone translator service but it is not generally used by the GPs for reasons such as time limitations during a typical consultation, lack of privacy, and it was perceived to cost money. Those in focus groups spoke about having to rely on family members to interpret for them. This was not entirely acceptable to them as the elderly and women spoke about having to wait until a relative was free from work to accompany them. The women's focus group also spoke about how their husbands might not understand all that has been said by the doctor and that they end up with incomplete explanations. It should be emphasised that not all practices have the same problems with English language skills in their Nepali patients. Some practices have such a small number of Nepali patients it does not significantly impact on them and some practices found that their Nepali patients have good English language skills.

Recommendations:

A review of the interpretation services needs to happen across the practices in Rushmoor and the community, to identify the most appropriate way to deliver an interpretation service. This is as all the practices have very different needs because of different skills and different patient groups. This could ensure more buy in from the local health professionals.

Secondly when recruiting locally it should be taken into account that the Nepali community have preferred sources of local information. This means that advertising for health posts should be through the local Nepali newspaper as well as cascaded through the community groups if possible. This will ensure that applications to healthcare posts are representative of the local population.

Evaluation:

Utilisation of the interpretation services should continue to be measured.

Translation of health information

Overall there is a lack of translated documents in Nepali. Some practices have devised their own and had them translated by volunteers. It is a complex issue as women from the women's focus group were keen to point out that elderly females from their community may not be literate in their own language. This means pictorial aids will also be valuable and a mixture of methods for health promotion need to be employed, particularly in dealing with these vulnerable groups. Additionally a local pharmacist also described the difficulty in communicating instructions for medication use to this community. This difficulty was corroborated by the community.

Recommendations

Leaflets relating to the following areas are a priority:

- NHS number
- Information about the NHS locally and how to utilise services
- Tuberculosis
- Diabetes
- Cardiovascular disease
- Sexual health topics
- Dietary advice

It would also be useful to employ some social marketing techniques with this community to identify the best way to communicate with this community. NHS Hampshire will be undertaking a project to do this. Initiation of a local pharmacy working group which will develop simple aids which will improve understanding of instructions for medication use.

Evaluation

Measurement of number and use of leaflets. Results from piloting of leaflets.

Health promotion activities

What has been said locally:

The local Nepali community spoke about how little health information they receive.

Recommendations: NHS Hampshire communications department are going to conduct some more research on social marketing to this community.

When considering conducting a health promotion campaign the preferred sources of health information which were described in the consultation with the community should be used.

Health knowledge, beliefs and behaviours

Knowledge of health Services:

What has been said locally:

The community spoke about how they were unsure how the NHS works and how to access services. Several aspects were particularly difficult for them. All were confused about how NHS dentistry operates and why it incurred charges and GP services did not. There were a few people in all of the focus groups who did not know to call 999 in the event of an emergency. Interestingly most of the women in the female focus group did not know they could access the pharmacy without a prescription.

Recommendations:

A health skills course for new migrants should be delivered. This would include information on the local services available and how to access them appropriately. It could also include some clear preventative messages around alcohol/smoking/drug use as well as emphasizing the importance of registering with a GP/dentist.

It could be developed as a new course or it could be delivered within the framework of the Skills for Health programme.

Evaluation

This should be built in as part of the course and information should be gathered on what the participants thought of the course. Objectives measures such as levels of physical activity etc. could also be gathered. Outcomes measured depend on the content of the course.

Different consulting behaviour- expectations/investigations/threshold for presentation

What has been said locally:

Local health professionals felt that this community had high expectations around having immediate access to appointments and investigations and were reported as having a low threshold for presentation to medical professionals. The community did not understand having to wait for appointment or investigations. More specifically they also worried about their communication with their doctor and whether he/she understood what they were saying, they felt that they did not really understand how to use the health service, and quite a few did not know what to do if they had several medical problems for one appointment or how to get the results of investigations.

Much of the health behaviours described can be explained by the fact that the community are not confident in how to utilise the health system e.g. one focus group did not know they could enter a pharmacy and ask for health advice and others did not know what number to call for the emergency services saying "we don't know what to do in an emergency".

Recommendations:

This could be delivered through a short course for migrants on how to access services. This could be through a Skilled for health programme. See this website for details.

http://www.continyou.org.uk/health_and_well_being/skilled_health/what_skilled_health

East Berkshire Primary Care Trust is about to commence this programme for their Nepali community.

This should be supported by the development of appropriate literature.

Adherence to treatment

The view from the health professionals on this was mixed. Three of the practices felt it was poor in this community and two practices felt it was good.

Recommendations

This will be addressed by other recommendations related to communication and developing skills and confidence in managing medical problems.

Concurrent treatment in Nepal

What has been said locally:

Local health professionals felt that this practice was harmful as it made providing follow up to patients difficult and the different approaches to management of illnesses in Nepal and England complicated matters. The community reported that those who could afford it might do it to avoid waiting lists and for "full health checks".

Recommendations:

This is likely to continue but could be safer if patients were reminded to bring back details of what treatments they have undergone while in Nepal. A correct handover of medical information would prevent duplication of investigations.

Thus the recommendations above can be seen to encompass four main areas. These are as follows.

<p>Patient education and enablement</p>
<ul style="list-style-type: none"> • Expert patient programme: This could encourage self management of conditions such as diabetes, mental illness, cardiovascular disease etc. This may also improve adherence to treatment. • Increased awareness of how to use the health system. This could be delivered through the Skills for Health programme. • Translated information: This could be useful for topics such as diabetes, TB, contraception, sexual health issues and health service information. • A pharmacy project to develop specially developed medication use instruction sheets is being led by local pharmacists. • Awareness activities in the community and for health professionals (where appropriate) which address issues such as mental illness, appropriate use of health services (including the importance of bringing back reports of investigations or treatment which occurred in Nepal), travel advice, infections such as TB and Hepatitis B, substance misuse, smoking and alcohol. This could involve the third sector as well as NHS organisations such as NHS Quit 4 Life. • Encouragement of Nepali lead physical activities such as health walks. This could be through community organisations and Rushmoor Healthy Living
<p>Safe access to services</p>
<ul style="list-style-type: none"> • Rights to free at the point of use healthcare: The rights of Nepali residents to register have been clarified with local healthcare professionals. • Identity: Promotion of the use of the NHS number as a method of confirming identity. Local pharmacists are initiating a project for the more routine use of the number in pharmacies. Community organisations have been contacted and asked to promote knowledge of this. • Transport: Dissemination of Frimley Park Hospital's PALS list of voluntary organisations which offer free transport to appointments. • Communication: Review of interpretation services in primary care by NHS Hampshire alongside the Nepali community. The use of media preferred by Nepali to advertise healthcare posts alongside the usual sources to ensure recruitment is representative of the locality. Use of similar media to convey health messages. Additionally a social marketing project is to be conducted by NHS Hampshire.
<p>Research</p>
<ul style="list-style-type: none"> • Data on prevalence of diseases. This project has been initiated by attaching a "Nepalese" code to Nepali patients in GP information systems. This will allow for direct measurement of prevalence of disease. • Diabetes and diet: More research needs to be conducted on Nepali diet in the area as this will allow for the development of culturally appropriate dietary advice. More information on Nepali and diabetes (service use, complication rate etc.) should be collected.
<p>Specific service developments</p>
<ul style="list-style-type: none"> • Several services are being commissioned currently • Community TB nurse for the entire Rushmoor Community is currently being commissioned. • Dental Service with a Gurkha outreach component is currently being commissioned. • A community development worker with a focus on substance misuse issues has been recruited by Rushmoor Borough Council. • New born Nepali children are immunised in a local community paediatric clinic in Rushmoor. Other Nepali children under the age of 16 who have missed this should be followed up and offered BCG vaccination.

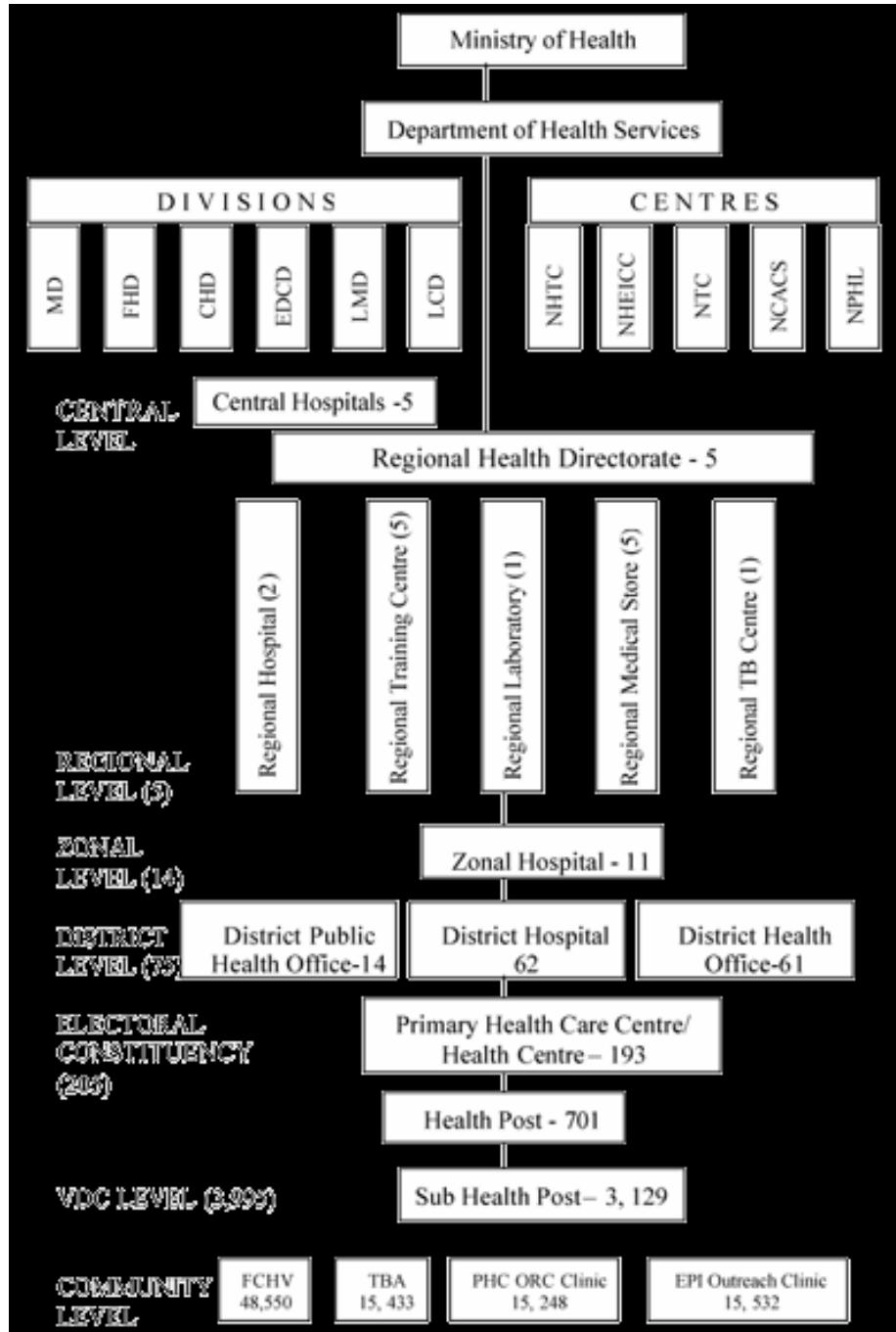
Conclusions

This health needs assessment provides an initial outline of what the major priorities for health are for this community. It should be emphasized at this point that the Nepali community is quite heterogenous in Rushmoor. This research has identified several vulnerable groups within this community who need targeted interventions which will have the effect of reducing inequalities. The vulnerable groups include the elderly, the recent arrivals from Nepal and women in general. Young people are also vulnerable as the patterns of drug use indicate. Interventions for these groups are a priority.

The recommendations should be implemented through the Public Health team in NHS Hampshire in close partnership with primary and secondary care in Rushmoor as well as the other local healthcare organisations. Communication should be encouraged between those who are working with a similar community in East Berkshire PCT as it may provide opportunities for sharing ideas and allow for cost sharing initiatives.

Appendix

Diagram of the Nepali Health System



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