



*The immigration of Romanian Roma to Western Europe:
Causes, effects, and future engagement strategies
(MigRom)*

**LANGUAGE BARRIERS AND ACCESS TO
HEALTH CARE AMONG ROMA MIGRANTS.
A CASE STUDY OF MANCHESTER, UK**



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1 Introduction

This report presents the results of our pilot study into language barriers in access to and use of health care among Manchester's Romanian Roma community, based on close collaboration between the local Roma community, health care providers, and the MigRom project's team at The University of Manchester.¹ We explore whether or to what extent Roma are disadvantaged in terms of health care access in Manchester, as compared to other migrant populations. To answer this central question, our interest was in the following questions:

- Which language provisions exist in the healthcare sector for Manchester's Roma community?
- Do language barriers affect the access to and use of primary care, in comparison with hospital services?
- How do patients, practitioners and interpreters assess communication difficulties and existing language provisions?

Our study combines quantitative and ethnographic methods. We draw on data of interpreter requests from Manchester's University Hospitals and GP practices covering the period between 2013 and 2015, on notes from MigRom advice drop-in sessions for Roma, and on the views that Roma migrants and practitioners expressed in interviews on their experiences with language provisions in medical settings in Manchester.

The Roma community, Europe's largest ethnic minority, is reported to suffer from poorer health compared to the majority population, and to be disadvantaged at multiple levels in the access to and use of health care (cf. Morris 2016: 4; Földes & Covaci 2012: 37; Hanssens et al. 2016; Orton & Sheard 2017; Pavee Point 2011: 19f.; Jarcuska et al. 2013: 427; Rosicova et al. 2011; Zeman et al. 2003; Hajioff & McKee 2000). Minority communities in general have been found to face difficulties in health care access and use, but Roma migrants are said to show disproportionately low uptake of primary care and preventive care services and to suffer poorer health outcomes (European Commission 2014: 16f; Parry et al. 2004). In their review of research

¹ MigRom ('The immigration of Romanian Roma to western Europe: Causes, effects and future engagement strategies') is a European research consortium that was set up in 2013 to investigate the experiences, motivations and ambitions of Roma migrants from Romania who have recently moved to Italy, Spain, France and the UK (cf. Leggio & Matras 2017). For an overview of the project, including briefings and reports, see <http://migrom.humanities.manchester.ac.uk/>

literature on Roma health and health care use across Europe, Cook et al. (2013: 906) find that Roma were generally less likely than “non-Roma Whites” to use healthcare advice services, preventive care, and to be registered with a GP. Limited access to medical services has been attributed to factors like poor living conditions (Földes & Covaci 2012: 37) and social exclusion of the Roma community from mainstream society (Jacob & Kirwan 2016: 3; Fundación Secretariado Gitano 2009; van Cleemput 2010). One of the main factors complicating the use of medical services for Roma has been found to be communication obstacles, due to limited proficiency in the majority language and literacy barriers (de Graaf et al. 2016: 220; Warwick-Booth et al. 2017; Morris 2016; European Commission 2014; Földes & Covaci 2012; Mladovski 2007; Poole & Adamson 2008: 9; Pavee Point 2011; Parry et al. 2004; Ivanov 2004; Equality and Human Rights Commission 2016; Lane et al. 2014). De Graaf et al. (2016) report for Roma communities across Europe that “[l]anguage barriers are responsible for misunderstandings, having a negative impact on health and health care, such as non-compliance with a prescribed treatment or late admission” (2016: 220). Parry et al. (2004) find that poor language and literacy skills can increase a lack of confidence, which may in turn prevent patients from asking for clarification when explanations from practitioners are not understood (2004: 53).

Roma have been reported to show poor histories of attending preventive care (Jacob & Kirwan 2016; Pavee Point 2014: 5; Parry et al. 2004), which may be related to a lack of familiarity with the local healthcare system, i.e. low awareness of the range of services available and lack of understanding of when to use them (Jones 2016; Warwick-Booth et al. 2017; European Commission 2014; Lane et al. 2014; Pavee Point 2014: 25; Hanssens et al. 2016; Morris 2016: 4). De Graaf et al. (2016) report that “the gatekeeping role of primary care often is not known”, and “the purpose of diagnostic and therapeutic procedures are not understood or accepted” (2016: 220). Poole & Adamson (2008: 40) point out that the access to primary care represents a significant challenge for the Roma, due to language-related problems at GP registration and a lack of familiarity with registration requirements. In Healthwatch Kent’s (2015) focus group study with Roma migrants, all participants were registered with a GP, yet most participants experienced difficulties when making appointments (2015: 10). In their study into health within the Leeds migrant Roma community, Warwick-Booth et al. (2017: 676) find that a lack of telephone interpreters when booking GP appointments caused problems with accessing primary care. Findings from a Roma

Integration Project in the Dublin suburb of Tallaght suggest that barriers to primary health care can lead to “frequent presentations by Roma to the accident and emergency department of the local hospital” (Kirwan & Jacob 2016: 163; cf. Pavee Point 2014). Similarly, Healthwatch Kent (2015) report that “[r]epeated failures to secure appointments meant that the participants were more likely to attend A&E” [Accident and Emergency] (2015: 10). Lane et al. (2014) and Poole & Adamson (2008) address difficulties around GP registration due to a lack of permanent address among Roma migrants in the UK, motivating people into contacting the A&E department in non-emergency cases. In Jacob & Kirwan’s (2016) interview study on Roma health, medical practitioners reported that members of the Roma community often attended A&E departments, in particular with young children, with health issues that could have been treated in primary care (2016: 20; cf. Warwick-Booth et al. 2017). Hanssens et al. (2016) find for the Roma community in Ghent that due to a lack of trust in medical practitioners as well as communication difficulties, Roma patients “often wait too long [...] to seek regular care, which makes small problems urgent on the long term” and may lead to “unnecessary use of emergency care” (2016: 5; cf. Pavee Point 2014: 24; Cook et al. 2013: 906). Hanssens et al. (2016) suggest that a relationship of mutual respect and understanding between patient and health care providers should be established to ensure equitable access of health care for Roma. Similar findings around language difficulties in Roma health care have been found for other countries across Europe, as reported by the European Roma Rights Centre (ERRC 2006) and a 2014 European Commission report on Roma health (European Commission 2014). The latter points to a lack of tailored prevention programmes for diseases in their own language Romani (2014: 77).

Lane et al. (2014: 9) argue that, across Europe, the Roma are “some of the most disadvantaged” and marginalised people. Cook et al. (2013) and de Graaf et al. (2016) speak of the “specific needs of Roma”, and Morris (2016: 17) defines Roma migrant communities as a “hard-to-reach group for service providers”. Issues around Roma migrants have also attracted the attention of policymakers (cf. Matras et al 2015). There has been increasing attention to Roma health disparities following the Decade of Roma Inclusion 2005-2015, an initiative of 12 European countries to eliminate discrimination and improve the socio-economic status of Roma communities in Europe. Policy documents dealing with Roma migrants in Europe generally see Roma as a group that is at risk (ERRC 2006: 82). In 2013, the World Health Organization

(WHO) published a “European policy framework and strategy for the 21st century”, which singles out Roma as a migrant group with significant health disadvantages and particular needs (2013: 43). The existence of a range of health programmes specifically targeted at Roma communities across Europe suggests that certain specifics of the community require additional advice services and support (see Lane et al. 2014).

Despite this large body of generalisations, there is little concrete research-based evidence that the difficulties that Roma migrants experience in accessing health care are specific to their community, or that Roma show disproportionate disengagement from health care compared to other minorities in the UK (cf. Harkins & Egan 2012; Hajioff & McKee 2000; Gaiser & Matras 2016). Cook et al. (2013: 885) note that “much of the available health information on Roma had been derived from anecdotal evidence and community-level studies with inadequate sample sizes and poor reliability”. As Parry et al. (2004) emphasise, the lack of reliable, updated data on Roma health makes any comparison with other migrant communities difficult (cf. Földes & Covaci 2012; Lane et al. 2014: 44; Jacob & Kirwan 2016:31). Practitioners too have highlighted that data on Roma migrants and their language needs is sparse (see Pavee Point 2014: 7). The WHO’s European policy draft report from 2012 notes:

Although data on Roma health are lacking, existing evidence points to significant inequity in health system access and health status between Roma and majority populations. (WHO 2012: 62)

This reference to the lack of data on Roma health was omitted from the final 2013 version of the report (WHO 2013).

The lack of reliable data is related to the fact that defining “Roma health” is problematic. There is no universal, generally accepted definition of who is Roma (de Graaf et al. 2016: 6; cf. Leggio & Matras 2017), and the diversity of Roma communities and sub-groups, including distinct dialects and traditions, makes it difficult to identify a uniform set of beliefs and attitudes of Roma towards health and health behaviour (Ignăţoiu-Sora 2011). Furthermore, questions arise whether researchers and policymakers have made an ‘issue’ of Roma health and singled out the community in relation to aspects that are not specific to this group. Hanssens et al. (2016) suggest that there are certain barriers to healthcare access that Roma share with other minority groups, while Roma experience a number of additional barriers that are “more distinctive” for their community (2016: 1; cf. Peters et al. 2009). On the one

had, Roma can be grouped with other new arrival communities, where a lack of proficiency or confidence in speaking the majority language may generally complicate access to and use of health care (Gaiser & Matras 2016; Hanssens et al. 2016; Peters et al. 2009). What is particular to Roma communities in terms of language barriers, on the other hand, is a general lack of awareness of the Romani language among non-Roma, a lack of Romani resources – e.g. written and translated patient health information materials in Romani (European Commission 2014; ERRC 2006 for Spain), and Romani interpreters and translators (Hanssens et al. 2016: 6; European Commission 2014; Poole & Adamson 2008) – and a lack of expectation on part of the Roma people that non-Roma would know about their language (cf. Matras et al. 2016). There is a general lack of written translated materials in Romani. The language is typically and historically an oral rather than written language (Matras 1999: 482), characterised by high regional variation due to the impact of contact languages and a lack of a widely accepted standard (Matras 2014: 115; 2002; Leggio & Matras 2017). (This is however also the case for other non-standardised regional vernaculars, like West African languages).

The lack of professional interpreters for Romani often encourages the use of untrained, ad hoc interpreters such as the patients' family members and friends, disregarding the risks involved (de Graaf et al 2016; MacFarlane et al. 2009). Despite guidelines to use professional interpreters in health care settings, the use of untrained 'casual interpreters' has been reported for patients with limited English proficiency across language groups (Gaiser & Matras 2016; Wisnivesky et al. 2009; Nápoles et al. 2015; Schenker et al. 2011), and also for Roma patients in particular (Hanssens et al. 2016; Kirwan & Jacob 2016; MacFarlane 2012; de Graaf et al. 2016). Healthwatch Kent (2015) find for Roma patients in the Thanet district that

Communication in healthcare settings is very rarely through professional interpreters; patients bring, and are asked to bring, family or friends. None of the participants had been offered professional interpreters for GP consultations. (Healthwatch Kent 2015: 10; cf. Pavee Point 2014: 25)

In other cases, Romanian Roma patients in the UK use interpreter services for Romanian, although this may not be their preferred language. Jacob & Kirwan (2016) point out that "Healthcare providers should not assume that the use of a Romanian interpreter is adequate" (2016: 12). Likewise, Pavee Point (2014) emphasise the need

for access to adequate translation and interpreting services for Roma patients, noting “the potentially complex relation between non-Roma translators [or interpreters] and Roma” patients, and anti-Roma discrimination (2014: 25).

Abdikeeva et al. (2013) and Ezer et al. (2017) assess the role of legal advocacy in advancing Roma Health. The authors report that, across Europe, Roma face many violations of human rights in the medical sector and sometimes humiliating treatment, which “often discourages Roma patients from exercising their right to health care”, or may negatively impact on the care itself (Abdikeeva et al. 2013: 472). The authors emphasise the needs to closing the gap between standards and implementations in ensuring equal access to care (cf. MacFarlane et al. 2012: 1).

De Graaf et al. (2016) note the importance of collecting and using specific data on Roma health, and of the “participation of the Roma in defining, implementing and monitoring the policies that aim to help the Roma people to integrate and eliminate exclusion” (2016: 221; cf. Földes & Covaci 2012: 38). Kirwan & Jacob (2016) note that “much work is needed [...] to increase understanding of the problems Roma may face in accessing services which are taken for granted by the rest of society” (2016: 159). It has been pointed out that partnerships between Roma organisations, the health care sector and Universities can help improve the access to and the quality of care for the Roma (de Graaf et al. 2016: 223; Parry et al. 2004).

The following section (Section 2) offers an overview of European, UK and Manchester policy and related measures that are relevant to Roma health, and outlines key services and provisions that specifically target Roma communities. Section 3 describes our method and discusses its rationale. Section 4 presents the findings of this research: We offer an overview of the use of Romanian interpreter services at CMFT and Central Manchester GP practices, present findings from Roma drop-in session notes, and participants’ perceptions and engagement with language provisions based on our interviews. Section 5 discusses conclusions.

2 European and UK policy on Roma health care

The Roma community has a long history of migration into the European continent, dating back to arrival of the first Roma people from India many centuries ago. Europe’s Roma communities of today have evolved from a number of migratory

movements over the centuries and decades (Kirwan & Jacob 2016). The enlargement of the European Union in 2004 and 2007 has encouraged increasing migration of Roma within the EU and to the UK. This has led policymakers to devote particular attention to Roma communities, since they are believed to experience “extreme poverty, discrimination and exclusion” (Roma UK Strategy 2011: 1). As Cemlyn et al. (2009: 48) note, “[r]educing health inequalities has been placed alongside health gain as a core objective of Government health policy in recent years”. At UK and European levels, “Inclusion through participation” has been articulated as a policy objective for the Roma community (European Commission 2011; cf. Kirwan & Jacob 2016:169).

In 2011, the European Commission adopted a *Framework For National Roma Integration Strategies* to define their approach to Roma inclusion, which was adopted by all of members of the European Union (European Commission 2017). The framework is aimed at addressing inequalities between Roma and majority populations, with a focus on education, employment, healthcare, and housing. Following this, the UK adopted an integrated set of policy measures within the UK’s social inclusion policies (Roma UK Strategy 2011). The UK policy paper reports that Roma, Gypsies and Travellers experience “harassment and hate crime and in many places, lead separate, parallel lives from the wider community” (Roma UK Policy 2011: 4). Furthermore, the document emphasises the need to improve health outcomes for Roma. In 2014, The European Public Health Alliance issued a “Position” on Roma Health in Europe, which addresses Roma inequalities in health (EPHA 2014). In 2014, the European Commission published a ‘Roma Health Report’ to present the results of a study on the health status of the Roma populations across EU member states (European Commission 2014). A 2016 report assessing the implementation of the EU Framework for National Roma Integration Strategies describes health inequalities experienced by Roma as an “ongoing challenge” (European Commission 2016: 12). Accordingly, “[f]urther efforts are needed to reach out to these vulnerable people” (2016: 12). For the UK, it is argued that the “[c]ommunities’ participation in health and social care initiatives should be scaled up” (2016: 89).

Under the EU Framework for Roma integration, an increasing number of civil society organisations have been established in Europe and the UK (e.g. in Leeds, Glasgow, Derby, Luton, Sheffield, East Anglia, and Manchester) to develop Roma advocacy, mediation, community engagement and policy development (European Commission 2016: 88). Several public and third sector programmes and advice

services have been set up across the UK and Europe to provide targeted support for Roma communities around accessing and using healthcare (cf. Földes & Covaci 2012: 38). Pavee Point, a non-governmental organisation initially established to support Human Rights for Travellers Communities in Ireland, set up a Roma Support Group in 2000 (Pavee Point 2011). In 2007, the South East Glasgow Community Health and Care Partnership agreed to funding for a small number of dedicated Slovak support workers in Govanhill, near Glasgow, to liaise between the growing local Slovak Roma community and public service providers (Poole & Adamson 2008). In 2011, a project was set up to encourage engagement with preventive care among Roma residents through employing bilingual outreach workers (Harkins & Egan 2012). The Tallaght Roma Integration project (TRIP) was established in 2009 in response to a number of issues highlighted during a community consultation process with a Roma community living in a suburb of Dublin (cf. Jacob & Kirwan 2016). A major concern for the Roma community that emerged from this consultation process is access to health care services. TRIP has established the Roma Primary Care Initiative to improve healthcare access for Roma and facilitate better understanding between mainstream services and the Roma community (cf. Jacob & Kirwan 2016). This includes the provision of targeted free mobile GP services alongside with Romani interpretation services, and an information and support service staffed by trained local Roma volunteers. In Southern England, Redbridge Public Health provided funding in 2011/2012 for a project to support health care access for “hard-to-reach groups, including the Roma community”. A weekly drop-in session service was set up in Loxford, an area with a large Romanian Roma population, to provide information and advice for the local Roma community (Morris 2016: 17).

In addition to dedicated advice services, Roma community health workers or health mediators have been employed in several European countries (Schaaf 2011; Hanssens et al. 2016). Health mediators are members of the local Roma community who are trained to liaise between the community, health practitioners and local health authorities, in order to help improve access to health care for Roma. However this service has, to our knowledge, not been offered in England.

There have been efforts at the NHS to improve health care access for newly arrived Roma communities; yet, as noted by Lane et al. (2014), “Department of Health / NHS does not include Gypsies, Travellers or Roma as one of their 16 ethnic minority categories monitored by the NHS” (2014: 44).

Orton & Sheard (2017) review policies aiming to improve the situation for Europe's Roma and explore the "assumptions that shape how the 'problem' of Roma health and wellbeing" is understood in policy proposals. The authors suggest that policies produced by EU institutions have situated the concern for Roma health and wellbeing within a wider drive for economic growth. "Policy solutions frame improvements in Roma health as a means to improve overall productivity of the region, rather than as an end in itself" (Orton & Sheard 2017; cf. Orton & de Cuevas 2017). Kirwan & Jacob (2016) note that "Roma living in many European countries encounter structural racism and are regularly exposed to prejudicial policies" (2016: 158).

2.1 Local policy measures for Roma in Manchester, UK

The first Roma migrants from Eastern Europe began to settle in Manchester in the mid-1990s, most of them as refugees. Following EU expansion and the extension of freedom of movement to Eastern European citizens, the size of Manchester's Roma community has increased with the arrival of Roma from Hungary, Czech Republic, Poland, Latvia and Lithuania from 2004 onwards, and Romanian Roma migrants from 2007 onwards. Census data is generally believed to significantly under-report Roma ethnicity (Matras 2015; cf. Warwick-Booth et al. 2017), and accurate information on the size of Manchester's Roma community is sparse. Romanian Roma mostly reside in the neighbouring areas Gorton South, Longsight and Levenshulme in South Manchester. Some have settled in other parts of the city, i.e. Moss Side, Moston and Cheetham Hill, and in other districts of Greater Manchester, such as Salford and Oldham.

In 2009, in response to political pressure, Manchester City Council decided to coordinate a dedicated policy toward Roma. Manchester's 'Roma Strategy' was launched to alleviate tensions and to ensure Roma were in a position to engage with public services, while at the same time facilitating the collection of information about the community (cf. Cools et al. 2017; Matras et al. 2015). The City Council's department for International New Arrivals, Travellers, and Supplementary Schools (INA/T/SS) took on a lead role in implementing certain aspects of the strategy, in collaboration with the two independent voluntary sector organisations The Black Health Agency for Equality (BHA) and The Big Life Group. Roma were generally

depicted as a group with special needs and dependency on external support (see e.g. Murphy 2013). In a series of publications (e.g. Matras, Leggio & Steel 2015; Cools et al. 2017; Matras 2015; Matras et al. 2015), the MigRom team has described the events leading to the formation of Manchester City Council's Roma Strategy and the involvement of BHA.

Cuts in public spending threatened the scope of INA/T/SS activities and therefore also those of its partner and sub-contractor BHA, and the Roma Strategy was gradually downscaled toward the end of 2011. Matras et al. (2015: 36) note that "the team's effort to flag its unique expertise became linked to an attempt to make a case for continuous funding". As the funding for the BHA outreach project 'Routes' was coming to an end, the organisation argued that a withdrawal of funding would have a negative impact on essential services that it provides. It says: "Any reduction in funding or stopping funding altogether will have a disproportionate impact on INA and therefore race" (Murphy 2013: 112). To support that statement, BHA claims that data indicates that "there is a higher prevalence of Hepatitis A and B among Romani and also a higher prevalence of tuberculosis and asthma" (2013: 117). The source provided is an opaque reference to the "European Commission". In fact, BHA's immediate source appears to have been the website of the organisation Equality on 'Roma Health'.² There, reference is made to a Council of Europe document (Council of Europe 2003), which in fact reports that in some Roma settlements in Eastern Slovakia and Romania there are higher rates of diseases including those mentioned by BHA as a result of poor sanitary conditions and discrimination in access to health care. The BHA's insinuation that there was an acute health problem among Roma in Manchester, which only BHA was equipped to handle, thus amounted arguably to scaremongering and at the very least to an assertion that remained unsubstantiated by any evidence.

To amplify its need for funding for Roma interventions, BHA then commissioned external reports to certify its expertise and flag "its emerging good practice in the field" (Lever 2012: 6). Arguing that the aim of Manchester's engagement with Roma was "to investigate claims of criminal activity whilst maintaining social cohesion" (Lever 2012:14), there is a suggestion that Manchester's Roma Strategy was a direct reaction to Operation Golf, and that INA/T/SS team took the allegations made by Operation Golf at face value. Lever's (2012) list of

² See <http://equality.uk.com/Health.html>. Last accessed 12 September 2017

recommendations pertains exclusively to the need to provide funding and to guarantee the involvement of “third sector agencies” in the process (2012: 27).

To secure further funding in early 2013, the team applied for a grant from Manchester City Council’s Equalities Funding Programme. In its application, BHA argues that statistics indicated a rise in teenage pregnancy in the Gorton South area coinciding with the arrival of Roma. It also claimed that 12% of teenage mothers who engaged with a local advice centre were from the Roma community, though no actual numbers were provided. In a subsequent report the number was identified as merely four, though the time frame remains unknown.³ The application goes on to say: “The main factors attributing to disengagement of young [Roma] girls from education are early marriage and teenage pregnancy”. BHA asks for funding for “assertive outreach” in the Roma community. It also argues that special protocols were needed to “identify and track hard to reach girls” and allow to “share information regarding ‘at risk’ young people in relation to criminal activity, school drop-out”, and proposes to set up a “Romani Wellbeing Strategic Group” (BHA application to Manchester City Council; cf. Matras et al. 2015: 37). In November 2013, BHA was invited to attend the City Council’s Communities Scrutiny Committee to report on its project. As recorded in the minutes, BHA informed the committee that the rate of teenage pregnancies among the Roma was “disproportionate”, and that this was “influenced by cultural expectations”. The narrative on safeguarding as a Roma cultural issue was, through replication in different occasions and the City Council’s 2014 ‘State of the City Report: Communities of Interest’, turned into a public statement.

In its interim project report to the Council, from June 2014, BHA claims that “Roma in the UK and on continental Europe have developed a deep-rooted mistrust of outsiders, limiting forms of interaction and engagement with social care providers”. It then recommends that the BHA’s remit and funding for the intervention should be extended in order to draw on the expertise and “trusting relationships” that the BHA team has established in its own work with the Roma.

The Romani Project/MigRom team at The University of Manchester obtained a statement from Manchester City Council in reply to a Freedom of Information Request in January 2015, which said that the City Council does not hold information on the number of teenage pregnancies among the Roma or any other community in the city.

³ The MigRom project received the BHA Final Report, authored by Jennifer Davies and Julie Davies, from Manchester City Council Equalities Team on 27.06.2014.

The suggestion by BHA that casual observations on individual and isolated cases constitute a sufficient evidence base on which to postulate that there was an inherent link between Roma culture and teenage pregnancies, between pregnancies and school drop-out, and between these and criminality, and that this link required a uniquely dedicated intervention for which the City Council should provide funding, remained unchallenged, at least in public, by the City Council, until a report from June 2015 (see Matras et al. 2015).

Issues of perception and prejudice were related specifically to deeply entrenched images of Roma as an inherent threat to others and a threat to themselves due to their alleged reluctance to engage in ‘productive’ work, to submit to institutions and norms, and to commit to family and residence structures that are easily transparent to outsiders. (Matras et al. 2015: 39)

Realising that the principal issues revolved around perception, the City Council gradually downscaled its intervention and resolved that the Roma did not constitute a threat to “community cohesion”.

Since September 2013 the MigRom project has, in partnership with the Manchester City Council and SureStart Longsight, offered weekly drop-in sessions to provide targeted advice and referral support to Roma. The service is the first and only advice and support service led by members of the Roma community and run in the community’s languages, Romani and Romanian. The Roma drop-in sessions are open to Roma migrants from all backgrounds, but it has been used mainly by Roma migrants from Romania. Unlike other dedicated services for Roma, this service is client-based and responsive, rather than intrusive. The MigRom outreach workers feed back observations to the research project and the City Council.

In April 2015, the MigRom’s Manchester team, working through the joint Steering Group of the University of Manchester and Manchester City Council, helped establish a Roma community group, “Roma Voices of Manchester”, based on the loose grouping that had by then been in place. Manchester City Council recognised Roma Voices of Manchester as a channel for direct dialogue with the city’s Roma community (cf. Leggio 2017: 134).

Another organisation involved in projects around Roma health care in the UK is TS4SE, a non-profit co-operative that aims to “support the integration of new communities” and “improve communication and understanding across communities and services” (TS4SE 2015). TS4SE have been involved in projects around Roma

health care and have developed a range of freely accessible online resources and tools for healthcare providers, covering different aspects of Roma health and ‘lifestyle’ of Roma communities in the UK. The materials are useful in providing information to challenge popular myths and misconceptions about Roma, but they do not provide any practical advice on how to help facilitate access and use of healthcare for Roma migrant communities.

2.2 Language Provisions for Roma in Manchester health care settings

Language provisions and advice services that target Manchester’s Roma community to facilitate health care access and use are sparse. The main translation and interpreting agencies that provide services for CMFT and Manchester’s GP practices started offering services for Romani only a few years ago. The website *translatorscafe.com*, a platform for self-declared “professional” interpreters and translators to advertise their services, records only one translator for Romani in the city.⁴ On their profile, the user claims to have worked in health care settings, but with no reference to any formal qualification. In 2010, the Romani Project at The University of Manchester, in collaboration with the Big Life Group and Manchester City Council, facilitated a training programme for younger members of the Roma community to work as freelance interpreters; however, they have not necessarily gained practical experience in medical interpreting and translation.⁵

Choose Well Manchester (<http://www.choosewellmanchester.org.uk>) is an online resource provided by NHS North, Central and South Manchester CCGs to help patients choose the right care and offer self-care advice. There are a number of videos and downloadable information documents available in a variety of languages, excluding Romani. *Choose Well Manchester* has since its inception added a small number of information videos in nine languages, informing about GP registration, the role of pharmacists, and how to make a dentist appointment. The selection of languages draws on input from The University of Manchester’s Multilingual Manchester project provided in 2010.⁶ However, although Multilingual Manchester had originally suggested to offer a Romani version of the videos, no such video is

⁴ Last accessed 25 September 2017

⁵ For an overview of the Romani Project see <http://romani.humanities.manchester.ac.uk>

⁶ For an overview of the Multilingual Manchester research unit see <http://mlm.humanities.manchester.ac.uk>

available on the website. The video labelled ‘Romani’ is actually in Romanian, which at the same time is an example of how practitioners routinely confuse ‘Romani’ with ‘Romanian’ (cf. Matras 2015).

3 Method and rationale

We focus on Manchester’s community of Manchester’s community of Roma migrants from Romania. For a differentiated picture, our approach relies on triangulating a variety of quantitative datasets, ethnographic interviews and observation and benefits from access to unique datasets (cf. Matras & Robertson 2015).

Our quantitative datasets reflect interpreter use in Manchester health care settings, which we compare with other datasets on language (Census 2011, School Census 2015) and M-Four interpreter request data (Manchester City Council Translation and Interpreting Service, 2012-2013). Central Manchester University Hospital NHS Foundation Trust (CMFT) keep records of interpreter requests according to hospital department by language. Data on interpreter use at Manchester’s GP practices are collected by the Manchester Integrated Care Gateway (cf. Gaiser & Matras 2016: 24). We had access to data on interpreter requests (face-to-face and telephone interpreting) at CMFT for the financial years 2013/2014, 2014/2015, and 2015/2016. In addition, we had access to data on the use of interpreter services at Manchester’s GP practices.

For an ethnographic perspective we draw on many years of experience in engaging with Manchester’s Romanian Roma, through inclusion in the community since 2009. In addition, we conducted a longitudinal survey based on notes from MigRom drop-in consultation sessions, covering the years 2013, 2014 and 2015. The data we analysed consisted of anonymised notes taken during and after the drop-in sessions by outreach workers leading at the drop-in consultation, who are employed by The University of Manchester’s MigRom project. The anonymised notes, which were obtained from the MigRom project, record clients’ approaches at the drop-in consultation sessions and give a general overview of the cases, the difficulties clients encounter and the steps taken. Our research thus benefits from a unique dataset that reflects issues flagged by community members as being important and can therefore offer important insights into the barriers experienced by community members.

We also conducted qualitative interviews with fourteen Roma migrants from

Romania, who were all clients at the drop-in consultation sessions. Our interviewees had moved to Manchester between 2005 and 2013. Eight of the interviews were carried out between June and December 2015, and the remaining six interviews were conducted in December 2016. The interviewees' English proficiency varied, and bilingual outreach workers were present to interpret where participants did not have sufficient knowledge of English.

In addition, we interviewed a number of General Practitioners that we know have Roma people among their patients, as well as one professional interpreter who has offered interpreting services for Romani. These interviews with health professionals and interpreters, as well as the eight interviews with Roma from 2015, were conducted as part of a larger study on language barriers in Manchester's health care sector (Gaiser & Matras 2016). All interviews were semi-structured and took between ten and fifteen minutes. Our questions addressed participants' experiences with potential communication difficulties in accessing and using health care, as well as their awareness of and engagement with interpreting services in medical settings. With consent from the participants, all interviews were audio-recorded and transcribed.

For a more comprehensive picture, we draw on casual observations on the situation of Roma migrants in the city since 1996, on frequent contacts with Roma migrants in connection with the Romani Project since 2001, on our own observations through interactions with the City Council and related agencies around issues affecting Roma migrants since 2006 and more intensively since 2009.

4 Use and perceptions of language provisions among Romanian Roma in Manchester

The following sections present our findings from quantitative data analysis of interpreter requests at Manchester's CMFT and GP practices, from an analysis of notes taken during MigRom drop-in sessions for Manchester's Roma community, as well as findings from qualitative interviews with Roma community members, practitioners and an interpreter for Romani who has worked in health care settings.

4.1 Use of Romanian interpreter services in Manchester health care settings

The data on interpreter requests shows no requests for Romani interpreters at CMFT and GP surgeries, neither for face-to-face nor for telephone interpreting provided by external interpreting agencies, as the data we had access to cover a time period before Romani interpreting services was first offered at Manchester health care outlets. We focused on requests for Romanian interpreting services in order to see whether there was any disproportionate engagement or disengagement with any of the health care outlets. One must remember that the data we look at, i.e. interpreter requests for Romanian, will reflect requests from Roma as well as non-Roma speakers of Romanian.

At CMFT, Romanian is the 10th most frequently requested language, with 1540 requests hospital-wide between April 2014 and March 2015. Considering the size of Manchester's Romanian speaking population as suggested by other datasets (School Language Census 2015; M-Four interpreter requests), this scale of need for Romanian is not unexpected. Comparing the use of Romanian interpreters across hospital departments, we find some evidence of frequent reliance on A&E for Romanian speakers. However, as discussed in Gaiser & Matras (2016: 40), there is no indication that this is due to limited access to GP services; in fact, we the data record high demands for Romanian interpreter services in primary care environments. Our findings support what Warwick-Booth et al. (2017: 675) report for Roma migrants in Leeds, where the most popular source for medical help or advice was the GP.

In Central Manchester's GP practices, Romanian is the third most frequently requested language. The rather low use of Romanian interpreter services at CMFT overall can be attributed to the fact that the group of Romanian speakers in Manchester tends to be a rather young population that is less likely to need hospitalisation (Gaiser & Matras 2016: 62). Overall, the CMFT and GP datasets on interpreter requests reflect an active use of interpreter services by the community across health care outlets rather than frequent use of A&E due to limited GP access.

Ashcroft surgery in Levenshulme, a GP practice located close to an area where a sizeable community of Romanian speakers and Romanian Roma reside, shows a particularly high demand for Romanian: Romanian is the second most frequently requested language after Urdu, with 389 requests from March 2014 – Feb 2015. Romanian is also among the top languages in School Census data for schools in the

area (see Gaiser & Matras 2017: 55). Romanian shows a disproportionately high demand for interpreters (26.2%) when compared with the presence of Romanian-speaking school children in the area (1.2%). This suggests that there is a high demand for and high use of health care facilities compared to the size of the population. We assume that much of the demand for Romanian interpreters in this area stems from the local community of Romanian Roma migrants (some of whose children are identified by the schools as speakers of Romani rather than Romanian as ‘first language’). Similarly, interpreter request data for Longsight Medical practice in Longsight and Robert Darbshire Practice in Rusholme, which are GP surgeries located in neighbourhoods that also show a large presence of Roma people, record relatively high demand for Romanian interpreting services. Thus, in our data there is no evidence that Roma people overuse emergency care and underuse preventive services, which was suggested previously for other cities in Europe (see for instance Földes & Covaci 2012; Fundación Secretariado Gitano 2009; Kirwan & Jacob 2016: 163).

4.2 Roma-initiated requests for support in accessing health care: Health-related support at MigRom consultation sessions

The notes from MigRom Roma consultation sessions reflect the community’s need for assistance in the access to and use of healthcare services in Manchester. Between September 2013 and August 2014, 93 individual families accessed the drop-in service for advice and support. 9% of queries in this year were related to health (Matras et al. 2015: 44), while others related to taxes & benefits, training & employment, schooling, and housing. Between September 2014 and April 2015, altogether 87 individuals accessed the drop-in session. Similar to the first year of the drop-in service, just under 10% of all queries were related to health.

Queries about health came mainly from new arrival families and from older members of the community, who sought advice due to their low levels of English proficiency. Clients approached the advice centre with queries related mainly to appointment making with their GPs, dentists or specialists at the hospital (82% of all queries on health). 18% of all queries on health were related to GP registration. There are records of a case in which an entire family was not registered with a GP for 6 months due to language difficulties. In another case, a woman who was eight months pregnant had not seen a doctor for the entire duration of her pregnancy. She

approached the MigRom consultation to ask for help with GP registration. This is similar to cases recorded for the Glasgow area (Pavee Point 2014: 5), where pregnant Roma women have delayed treatment and went to seek medical advice only during late stages of their pregnancy. A small number of clients attended the drop-in sessions to ask for clarification about the UK health care system, as they had arrived in the UK only recently and felt that they did not understand how the system worked.

A number of clients said they did not feel confident making appointments with health outlets over the phone. Other Roma community members approached the drop-in to ask for support in registering their recently arrived relatives or friends with a GP. This suggests that even longer-established community members, who have been in the UK for several years and are familiar with the workings of the NHS as well as local advice services like the drop-in sessions, do not feel confident enough to register their relatives with a GP without the help of others. A number of clients reported difficulties with getting a dentist appointment: they had previously been deregistered from their dentist after they had missed an appointment, which was due to a misunderstanding based on communication difficulties with administration staff. These clients approached the advice service to better understand what had happened, and why. Some individuals reported that it had been impossible for them to register with a local GP, as they did not have any proof of address, and they did not feel confident enough to explain their situation to a GP in English. One client reported a case where a GP surgery had advised them to go to A&E for an asthma inhaler, as the client did not have proof of address and was therefore unable to register with a GP. Some Roma community members reported that they preferred trying to deal with health issues themselves and refrained from seeing their GP, as it would have taken too long to get an appropriate interpreter for a GP appointment. Reportedly, there had been several occasions in which they had already felt better by the time they had got an appointment with the interpreter.

Other clients attended the drop-in session as they needed help to understand letters from hospitals and their GP. The letters were in English, although their patient records included information about the patients' need for interpreter. There seems to be a lack of awareness among clients that translation services are freely available to NHS patients.

The relatively high number of requests for assistance in setting up appointments with GPs and specialists suggests a high awareness of health care provisions in

general, while indicating a lack of confidence around language skills and perhaps more broadly in interaction with formal institutions (cf. Matras et al. 2015: 46). The strong engagement of Roma with the MigRom consultation sessions for support with access to medical care shows that community members make use of supplementary advice provisions to be able to properly access and use health care services; at the same time, the fact that community members seek support with GP registration and appointment making also shows their dependence on such supplementary services to access healthcare. This indicates the possibility that other community members, who might not be aware of such advice services, may have experienced difficulties with health care access, or may not have registered with health care providers at all. It must be noted that the need for supplementary services or additional support from family and friends to access and use health care has been found across language groups in Manchester and is not specific to the Roma community (cf. Gaiser & Matras 2016).

4.3 Participants' perceptions of and engagement with language provisions

Our interviews with Roma community members and health practitioners suggest that language difficulties can create a barrier to accessing and using health care services for Roma migrants living in Manchester, but there do not seem to be any barriers that are specific to Roma people as compared to other of the city's migrant communities. Yet, the negative perception of Roma described above for local authorities seems to be shared also by practitioners. General Practitioners in Manchester have suggested to us that Roma generally tended to wait longer than non-Roma migrants to register with a GP after their arrival in the city. Furthermore, health professionals have flagged Manchester's Roma community in relation to inappropriate use of A&E services. However, there is no indication that such statements are based on systematic evidence.

In our interviews, all participants reported that they were registered with a local GP, and the interviewees had completed GP registration within weeks of their arrival in the UK. Ten out of fourteen interviewees reported to routinely use or have used professional interpreters for their GP appointments. All participants who felt like they needed an interpreter for their GP consultations said they had actually made use of the interpreter service offered at their GP surgery. There is a high level of satisfaction with the interpreter provisions available to patients. Those interviewees who use interpreters find the services easy to access. Some of our participants actually pointed out that they

preferred using professional interpreters to using ‘casual interpreters’. This is unlike the preferences of members from other language communities, expressed in fieldwork for our larger study on language barriers in Manchester health care settings (Gaiser & Matras 2006: 82). Some of our interviewees reported that, occasionally, they took a family member or friend along to the surgery, for example if it was a short-notice appointment and there was not enough time to arrange an appropriate face-to-face interpreter (and telephone interpreting was not the preferred option).

Some of our interviewees, who had been in the UK for several years at the time of the study, had used professional interpreters in the first few years after their arrival; as their English had improved, they felt comfortable communicating with their GP without interpreters. A small group of participants reported to use professional interpreters for what they perceived as more complex, serious health issues, but they said they felt confident enough to speak to their GP about what was perceived as less serious without the support of an interpreter. This shows that the Roma migrants’ reliance on language provisions is transitional, and that increased confidence with English and familiarity with the system will reduce their dependency on such provisions (cf. Gaiser & Matras 2016).

Our interviews confirm our findings from the drop-in consultations notes in that communication difficulties complicate primarily the first stages of accessing health care. There seems to be a (perceived) dependence on family members and friends during GP registration and appointment making, even though participants were generally keen to make use of the professional interpreter services during GP consultations. Patients encounter language difficulties in communicating with administrative staff since they are often unaware of the possibility of using professional interpreters for health-care related procedures outside the consultation room. Others had experienced difficulties arranging an interpreter for when they wanted to book appointments with their GP. This study confirms Warwick-Booth et al.’s (2017: 678) findings for Roma in Leeds, where participants felt that arranging interpreters for the first stages of health care access was generally easier in hospital environments than in GP practices.

Our interviewees reported that they needed assistance in filling in registration forms and patient histories from people who were more familiar with the health system and more proficient in English (cf. Poole & Adamson 2008 for Glasgow). In addition, the great majority of our interviewees felt like they were reliant on the help of family

members or friends to make appointments (cf. Healthwatch Kent 2015). Those participants who felt confident enough to call their GP surgery themselves for administrative issues reported that they sometimes helped their friends or family members. This suggests that mutual support is common practice among Roma community members to overcome language barriers to accessing health care.

Ad hoc creative solutions like the use of Google Translate during consultations help community members overcome language barriers and facilitate effective health care. A number of interviewees reported to be reliant on the help of multilingual reception staff and health practitioners. It is well-known in Manchester's Roma community that there is a Romanian speaking GP at a GP practice in Longsight, which has encouraged community members to register with this particular surgery. To avoid conversation with administration staff in surgeries where staff cannot speak the patient's preferred language, several interviewees reported to use multilingual check-in computers at their surgery. However, interviewees were not always aware whether the digital check-in service was offered in their preferred language. These participants felt comfortable enough to use the English version, but they preferred dealing with written rather than spoken English.

The interviews with health practitioners suggest that GPs and GP staff seem to generally adopt a lax attitude toward relying on 'casual' interpreters, i.e. the patients' friends and family members whose feel more comfortable speaking English and who may be more familiar with the UK health system and the relevant GP practice.

Our interview with an interpreter/translator for Romani highlights issues of confidentiality that are associated with interpreting in health care settings. Our interviewee reported that, due to the rather small community size and strong networks within the Roma community, Roma clients had expressed concerns about the disclosure of sensitive information and the spreading of rumours in the community. Also, there may be cultural issues, for instance preferences regarding the interpreter's (and health practitioner's) gender. Our Romani interpreter/translator also said in the interview that Roma people did not always trust service providers, which may complicate interaction with health professionals. Regarding the effectiveness of the booking system, our interviewee said he had experienced issues with the language requested for interpretation, which turned out not to be the client's preferred language (cf. Warwick-Booth et al. 2017 for similar findings for Leeds). On one occasion, our interpreter had been booked for Romani, although the client actually spoke Slovak but

not Romani; in another case, Romanian was confused for Romani, the language actually requested.

There is no evidence that a lack of interpreter provisions or experienced difficulties in making appointments motivates patients to contact the A&E department in cases in which primary care would have been more appropriate. Interviewees did not perceive any difference between accessing and using language provisions at GP surgeries as compared to hospital environments. There does not seem to be a general lack of understanding of the UK health care system that would result in inappropriate use of A&E services. Our Roma participants were aware of urgent care services like walk in centres, which is unlike participants from other migrant communities whom we interviewed in a previous study (Gaiser & Matras 2016). Our Roma interviewees reported to have learned about those services mainly from family members and friends, or from the drop-in advice service. None of our interviewees had heard of *Choose Well Manchester* or used NHS websites to learn more about the types of services available to them. This is in part attributable to problems related to IT access and digital literacy, as suggested by our interviewees; however, there seems to be a general lack of knowledge about and familiarity with online NHS advice services like symptom checker advice etc.

Our interviews confirmed previous findings that information about language needs provided by patients upon registration seems to be disregarded in written communication with the patient. Several interviewees said that they had received patient letters from GP surgeries and hospital departments in English, although they had indicated their need for interpreters upon registration or hospitalisation.

5 Conclusions

Roma are generally perceived as having greater difficulties than other migrant groups in accessing and using health care services, as illustrated by the range of dedicated health advice services across the UK and Europe. However, for Manchester's Roma community, this research has not found any evidence for particular needs that would be specific to Roma migrants, as compared to other migrant communities living in the city (cf. Gaiser & Matras 2016). In fact, the present study suggests that Roma community members take active steps to overcome language barriers. Our findings based on qualitative interview data as well as quantitative data on interpreter use show the Roma

community members' intensive engagement with existing advice services to be able to access and use health care. There is no evidence of disproportionate engagement or disengagement of Manchester's Roma people with health care, in comparison with other migrant populations. There are no indications that a lack of language provisions or a lack of understanding of the UK health care system is impacting Roma patients' choice of service outlet. However, our interviews and the drop-in session notes confirm previous findings for Roma communities in other cities regarding difficulties with GP registration and appointment making (Poole & Adamson 2008; Pavee Point 2014; Hanssens et al. 2016). While we have found a generally high level of awareness of language provisions among our Roma interviewees, this study highlights problems related to the lack of awareness of interpreters during the early stages of accessing care.

Closer collaboration between health care providers, University researchers, and the local Roma community is needed to increase understanding of the barriers in accessing and using health care (cf. Parry et al. 2004; de Graaf et al. 2016; Kirwan & Jacob 2016). Yet, health interventions should avoid singling out Roma by targeting the community exclusively and outside of mainstream services (cf. Morris 2016: 3; ERRC 2006). There is no evidence that Roma have particular needs or are prone to disengagement from health care services, and Roma should be regarded as any other migrant group. In addition, efforts should be made to engage with services to alleviate particular negative perception of Roma.

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