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# Work and Health of Somali Migrants in Bristol

Report for Bristol City Council's Public Health Department

by Wellspring Healthy Living Centre and Bristol Somali Resource Centre

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## About the authors

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## Summary

In March 2011, when the most recent Census was taken, 4,947 of Bristol's residents stated they were born in Somalia and 5,004 said Somali was their first language. The majority of these migrants have arrived to the UK since the late 1980s as war refugees. More recently significant numbers of Somalis moved to the UK from other EU countries, mainly the Netherlands, Denmark and Sweden. While unemployment in most migrant groups in the UK is lower than average, unemployment and economic inactivity rates of the Somali community are amongst the highest of all ethnic minorities in the UK. The ethnographic part of this research suggests this is also the case in Bristol. Somali migrants usually work in low-skilled and poorly paid service jobs, and part-time work is particularly common. Respondents were not given full-time working hours because they were treated as casual workforce employed on temporary, agency or so-called zero-hour contracts, or they choose to work part-time because of their family commitments. Self-employment was common but it seemed to be limited to transportation (taxi drivers) and retail services. All these types of work can be classified as precarious employment, as they provide no guarantee of regular income and returning to such work after illness often proved impossible. When they lost jobs, Somali workers struggled to get back into employment. They also often took long-term sick leave, usually in relation to preventable health conditions. The lack of appropriate health and safety training seemed to be an underlying issue in several cases of work-related illness, but some respondents also lost temporary jobs following accidents that happened outside of work. The majority of migrants had a positive experience of the NHS services. The poor labour market participation, lack of transferable skills, low English skills and limited access to training seemed to be the main welfare issues reported by the respondents. None of the respondents worked for less than minimum wage but the hourly rate did not exceed £8. All respondents claimed social security benefits, either due to low income, unemployment, or ill health.

## 1. Introduction

In recent years there has been a growth of interest in links between employment and health. Consecutive governments implemented several policies designed to reduce workers' sickness and improve wellbeing at the workplace, such as the Work-Life Balance Campaign launched in March 2000, or more recently the Workplace Wellbeing Charter. However, the changing nature and increasingly complex patterns of employment, as well as the unregulated influx of migrant workers, make it difficult to ensure workers' health. As Wilson Wong neatly put it, when commenting on the research on the British labour market carried out in 2011 by the Work Foundation:

“The trend in jobs in the UK is to generate more poor quality jobs with all the proven issues of ill physical and mental health – another huge cost to the public purse.”<sup>1</sup>

Many labour market economists agree on what those poor quality jobs are and who undertakes them. Professor Guy Standing, who for 30 years researched labour market for the International Labour Organization, defines these jobs as precarious since they do not provide basic economic security. Precarious employment generally comprises temporary jobs, part-time jobs if working hours do not reflect the workload, bogus self-employment, outsourced white-collar jobs and unpaid internships.<sup>1</sup> It also includes all cash-in-hand work and, increasingly popular in the UK, the so-called zero-hour contracts. Such jobs are often undertaken by migrants.<sup>2</sup> They usually give no guarantee of work to employees and no guarantee of sick pay in case of illness or an accident. There are two somewhat counterintuitive aspects of precarious work that are worth highlighting: firstly, it is not always poorly paid, and secondly, it does not necessarily equal exploitation in the sense that workers may undertake it voluntarily, albeit often for the lack of viable alternatives or due to significant, though short term, incentives it offers. In any case, the negative impact of precarious employment on the worker's health or welfare seems likely in the long term.

This report summarises findings of one of three studies commissioned by Bristol City Council to look into the links between health and work in three groups of local residents who are likely to be in such employment: Polish and other Eastern European migrants, Somali migrants – so the two largest migrant communities in Bristol – and British workers in flexible or non-salaried work.

The situation of Somali migrants is particularly dire with many reported health issues and, in particular, alarmingly low employment rates in this community. While in general “the employment participation rates of

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<sup>1</sup> Wong (2012) p. 11.

<sup>2</sup> McDowell, Batnitzky and Dyer (2013). Also see Standing (2011) p. 13-14.

the non-British born population ... are substantially higher (9 per cent higher in 2008) than for British-born people”,<sup>3</sup> Somali-born migrants have “some of the lowest employment rates of any migrant group in the UK”<sup>4</sup> and some of the highest rates of economic inactivity.<sup>5</sup> It is therefore not surprising that the ratio of Somali-born claimants of social security benefits, including Jobseeker's Allowance (JSA) claimed by the unemployed and Employment and Support Allowance (ESA) for those with long-term illness, is higher than that of any other ethnic minority in the UK.<sup>6</sup> Various sources also indicate that the majority of employed or otherwise economically active Somalis are either in unskilled and precarious jobs with limited opportunities for progression, or are self-employed in labour intensive businesses so their social mobility is also very restricted.<sup>7</sup>

Such patterns of employment often affect employees' wellbeing. Long working hours, particularly associated with self-employment, may adversely impact on physical and mental health, and have a bearing on workers' family life, as shown in this research. This aspect is particularly important for the Somali community, as their families are amongst the largest in the UK, along with Afghani, Bangladeshi and Pakistani. A 2009 research study found that while just 0.3% of British-born families have five or more children, in the Somali community this ratio stands at 10.8%<sup>8</sup>. The impact of precarious work on family life will be felt more acutely in the latter community. In addition, according to a recent report by the Joseph Rowntree Foundation, the “high incidence of unemployment in spite of visible small business activity ... exacerbates the social segregation of the Somali community, given that workplaces can constitute a potential space for interaction across communities.”<sup>9</sup> In this sense, the impact of economic inactivity and precarious work on the Somali community can be seen and analysed on three interconnected levels: personal health, family wellbeing, and community cohesion. All these topics have a public health dimension.

The aim of this report is to methodically record the work-related experiences of local Somali migrants in the form of case studies so they can be analysed and practical recommendations can be made. These case studies focus on migrants whose health has already been affected by work and aim to answer two research questions:

- *How do Somali migrants in Bristol work?*
- *What is the impact of such work on their health and wellbeing, and their economic welfare?*

As per Wilson Wong's observation above, any negative implications of such work come at a cost to publicly funded, local and national services such as Bristol City Council, the Department for Work and Pensions (DWP), the National Health Service (NHS), and others.

## 2. Methodology

<sup>3</sup> McDowell, Batnitzky and Dyer (2013), p. 123.

<sup>4</sup> Evans and Page (2012), p4.

<sup>5</sup> Khan (2008).

<sup>6</sup> Bentley (2012), p.4 & 10.

<sup>7</sup> See for example Harris (2004), p. 39-43.

<sup>8</sup> Rutter and Latorre (2009), p. 21.

<sup>9</sup> Hickman, Crowley and Mai (2008) p. 116.

Wellspring Healthy Living Centre, a public health charity based in Barton Hill, Bristol, was commissioned by Bristol City Council to research the links between work and health of Somali migrants living in the city. The research included a literature review, developing a questionnaire, interviewing 8 migrants whose health was affected by their work, and writing up and analysing these 8 case studies. The study was carried out in partnerships with Bristol Somali Resource Centre who identified and interviewed the Somali workers. The scope of the study covered different aspects of work: full and part-time employment, as well as flexible forms of work specifically common amongst Somali migrants such as self-employment, temporary and agency work, and zero-hour contracts.

As the study focused on the local area, the literature review presented in section 3 of this report is brief. The aim of the first part of this chapter is to provide background information on Somali migrations to the UK, to succinctly summarise main trends and topics being researched nationally, and to discuss available statistical information on work and health of Somali workers. The second part of chapter 3 provides an overview of the demographic and statistical data on Somali migrants in Bristol.

The ethnographic part of the research aimed to identify how migrants work and how this work may affect their health. The case studies presented in section 4 of the report were recorded during semi-structured interviews, which “focus on specific themes but cover them in a conversational style. They are often the best way for learning about the motivations behind people’s choices and behaviour, their attitudes and beliefs, and the impacts on their lives of specific policies or events.”<sup>10</sup> We chose a semi-structured interview as the best method to capture migrant workers’ experiences because, while topic-specific, it also allows respondents to speak freely and therefore may uncover facts and trends not foreseen by researchers. This is particularly useful when the existing literature is scarce, or when respondents are required to talk about sensitive topics, in this case income, family life, health, mental wellbeing, and sometimes bullying and abuse.

Some respondents were identified amongst former or existing clients of Bristol Somali Resource Centre and asked to take part while others were recruited through word of mouth.

Although the rates of unemployment and economic inactivity are exceptionally high for Somali men and women alike, men are still around three times more likely to be economically active than women.<sup>11</sup> Therefore, 6 out of 8 participants were male. The age of respondents chiefly reflects the demographics of Somali-born migrants in Bristol, although no young people were interviewed. This is mainly because young Somalis face unique barriers to employment, and many of them were born in the UK so they are not migrants. Capturing their experiences would require a somewhat different research approach.

All interviews were conducted in Somali in a private space and were audio-recorded. The respondents were rewarded with £25 payment for their time. All case studies were anonymised.

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<sup>10</sup> Raworth et al. (2012), p. 1.

<sup>11</sup> Khan (2008) p. 8.

The analysis in section 4 summarises the key work and health-related problems typical for Somali migrants in casual and low-skilled jobs, as identified in the case studies. Due to insufficient statistical information it is difficult to precisely assess how common these problems are, but an overview of available data sheds some light on the level of deprivation and health inequalities amongst Somali migrants.

### 3. Background on Somali migrants

Somali migrants have been settling in the UK since the nineteenth century. There were several large migrations, the most recent one triggered by a violent civil war in the late 1980s and early 1990s. Even though the exact figures are a little unclear, the scale of this migration led to the UK often being cited as the country hosting the largest Somali population outside Somalia.<sup>12</sup> This claim is not correct insofar as it does not take into account massive refugee camps in the Horn of Africa: well over 400,000 Somalis live in Dadaab camp in north-eastern Kenya alone.<sup>13</sup> The 2011 Census recorded 101,370 Somali-born residents in England and Wales, of which the vast majority – 99,484 – live in England and the remaining 1,886 in South Wales, mainly Cardiff and Newport.<sup>14</sup> These figures, however, do not include ethnic Somalis born outside Somalia: in neighbouring African countries and the Gulf states; those born in the EU who then migrated to the UK; and, last but not least, the still rising number of Somalis born in Britain. In addition, some argue that the “generic term ‘Somali’ is a misnomer, since ‘Somalis’ can come from Djibouti, Kenya or Ethiopia as well as the former Italian and British Somalilands” and stress the importance of regional and clan loyalties.<sup>15</sup> Yet, while it is undoubtedly important to recognise that Somali migrants are far from being a homogenous and entirely cohesive community, and that their descendants may have multiple ethnic identities, in this report we focus on those who identify themselves as Somali, speak Somali, and were born in Somalia.

#### 3.1. The national context

The first Somali migrants arrived to the UK in the 1890s from a newly established protectorate in the north of today’s Somalia, which was referred to as British Somaliland. These earliest communities were very small in numbers. They settled in the port cities of Cardiff, Liverpool, London, Hull, Bristol, and South Shields, and were predominantly comprised of single men, chiefly dockworkers and seamen. Since the 1960s Somali women gradually started arriving too, along with male economic migrants, and the pattern of Somali migration shifted away from ports towards the industrial centres, such as Sheffield and Manchester. At the same time there was an influx of young Somalis coming to study in the UK. However, with the decline of the merchant navy and the recession in the 1970s, most of these migrant workers lost their jobs. After that time, Somalis arriving to Britain were almost exclusively refugees. In the 1980s the Barre regime in Somalia had started to collapse and the civil war that ensued has tormented the country until present times.<sup>16</sup> By 2001, when a Census was taken,

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<sup>12</sup> Harris (2004), p. 24.

<sup>13</sup> [www.guardian.co.uk/global-development/2013/jan/25/insecurity-dadaab-refugees-kenya-somali](http://www.guardian.co.uk/global-development/2013/jan/25/insecurity-dadaab-refugees-kenya-somali)

<sup>14</sup> All Census data from <http://www.ons.gov.uk/ons/guide-method/census/2011/index.html>

<sup>15</sup> Evans and Page (2012), p. 2.

<sup>16</sup> Harris (2004), p. 22-24. Hickman, Crowley and Mai (2008), p. 25.

Britain had 43,515 Somali residents, and they were mainly refugee men, women, and families.<sup>17</sup> Over the last decade this figure has more than doubled with the arrival of more migrants from the Horn of Africa, sometimes as refugees but mainly under family reunion rules and, most importantly, due to internal migration within the EU. The number of asylum seekers from Somalia dropped more than tenfold from its peak in 1999 when 7,495 new claims by Somali refugees were filed, what then comprised 11% of the total claim count.<sup>18</sup> This fall was more than made up by the EU migration. It is estimated that between 10,000 and 20,000 Somalis arrived in the UK in the decade after 2000 from the Netherlands alone.<sup>19</sup> Many “moved to places where there was already an established Somali community such as Bristol, the East End of London, Liverpool, and Sheffield” but these migrants also explored parts of the UK that had not seen significant numbers of Somali migrants before, most notably the Midlands.<sup>20</sup> Thousands of Somali migrants have also arrived to the UK from other EU countries including Sweden, Finland, Norway, Denmark, and others. Some of them “migrated to Britain to join their families from whom they were separated as refugees”<sup>21</sup> whilst others may have been attracted by better job prospects, English language, the more benign attitudes towards migrants and Islam, or they simply felt they would be safer in a country with a large Somali minority. The phenomenon of this secondary, onward migration is fairly easily explained by the fact that European law requires refugees to claim asylum in the first EU country they enter. In the 1990s many Somalis migrated to the Netherlands and the Scandinavian countries somewhat by chance, simply because these were the countries where they had means to travel. Only after getting EU citizenship in these countries, which is a lengthy process – for example in the Netherlands it takes around 10 years – they were able to move to the country of their choice: the UK.<sup>22</sup>

However, the UK reality did not necessarily live up to such high expectations. As regards employment, which is frequently cited as the reason for a move from elsewhere in the EU, any hopes of well paid and secure jobs were somewhat dashed by the labour market. As already stated, the rates of working age unemployment and economic inactivity in the Somali community are among the highest in the UK.<sup>23</sup> As of 2008,

- Unemployment rate in Somali men was 41.4%
- Unemployment rate in Somali women was 39.1%
- Inactivity rate in Somali men was 31.4%
- Inactivity rate in Somali women was 84.2%<sup>24</sup>

It is therefore not surprising that, despite far from being the UK’s largest ethnic minority, in absolute terms the Somalis constitute the largest group amongst recipients of Jobseeker’s Allowance (JSA) with over 7,660 claims as of February 2011, and are the fourth-largest minority amongst those receiving Employment and Support

<sup>17</sup> [http://news.bbc.co.uk/1/shared/spl/hi/uk/05/born\\_abroad/countries/html/somalia.stm](http://news.bbc.co.uk/1/shared/spl/hi/uk/05/born_abroad/countries/html/somalia.stm)

<sup>18</sup> <http://migrationobservatory.ox.ac.uk/briefings/migration-uk-asylum> and <http://www.guardian.co.uk/news/datablog/2010/jun/26/non-eu-immigration-uk-statistics>

<sup>19</sup> Liempt (2010), p. 1. See also Evans and Page (2012), p. 2-3.

<sup>20</sup> Liempt (2010).

<sup>21</sup> Hickman, Crowley and Mai (2008), p. 25.

<sup>22</sup> Liempt (2010), p. 11-12 and Harris (2004), p. 24.

<sup>23</sup> Exceptions include Chinese migrants, many of them students, and migrants from Iran and Iraq who often are recently arrived asylum seekers.

<sup>24</sup> Khan (2008).



Allowance (ESA) and incapacity benefits with over 7,370 claims. As regards Lone Parent benefits, the Somalis are again the top nationality with around 7,920 claims.<sup>25</sup> These figures paint a grim picture of joblessness, ill health, and broken family ties, often due to displacement.

Joblessness among the Somali migrants was even higher in the 1980s and 1990s, when unemployment rates were estimated at 70-80%.<sup>26</sup> To some extent this may be explained by the experience of seeking asylum, whether in the UK or other EU country. In the UK asylum seekers are not allowed to work until their claim has been successful, and then have to “deal with the consequences of enforced long-term unemployment”.<sup>27</sup> Issues related to the transfer of skills seem to be another factor. As it typically happens to migrants, the Somalis are likely to be offered jobs not matching their previous experience. The result is that “male Somali refugees are often reluctant to take jobs incommensurate with their previous occupations in Somalia, and stay out of work.”<sup>28</sup> A study from East London found that out of 20 Somali women interviewed “only one was in secure employment. Others had casual work as interpreters, cleaners, or other low paid service workers. None of those with professional qualifications - including teachers, health workers, a doctor, and a chemist - had been able to pursue their career in the UK.”<sup>29</sup> Other factors that complement this picture are related to the lack of language skills, irrelevance of certain professional skills such as herding or farming in the UK context, lack of understanding of British laws and procedures and, last but not least, institutional racism.<sup>30</sup>

### 3.2. Somali migrants in Bristol

In Bristol, the 2011 Census recorded 4,947 residents born in Somalia and 5,004 residents stated Somali was their first language. According to these figures the Somalis are the second-largest ethnic minority in Bristol, after the Poles, and fourth-largest community amongst British local authorities, after Birmingham and London boroughs of Brent and Ealing.<sup>31</sup> As elsewhere in the country, the Somali community in Bristol has a high child birth rate with 330, or 5.1% of all births in the city, in 2010. This rate has been stable since 2006, fluctuating from 310 to 341 births a year. The vast majority of Somalis in Bristol live in the central and eastern parts of the city, mainly in Lawrence Hill, Ashley, and Easton.<sup>32</sup> National Insurance Number (NINO) data indicate in recent years Bristol received a further influx of Somalis: the number of new registrations for Somali-born residents increased from between 150 and 330 in 2003-2009, to 560 in 2009/2010 and to 900 in 2011/2012. Although in most cases NINO is obtained at the start of employment, the increase in Somali applicants does not necessarily indicate a surge in economic activity in the community. Due to lack of data it is unclear what proportion of applicants obtained NINO to claim social security benefits, and how this figure relates to the inward migration of the Somalis within the UK and EU.

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<sup>25</sup> Bentley (2012), p. 10.

<sup>26</sup> Harris (2004), p. 39.

<sup>27</sup> Hickman, Crowley and Mai (2008), p. 94.

<sup>28</sup> Harris (2004), p. 40.

<sup>29</sup> Sales and Gregory cited in Harris (2004), p. 41.

<sup>30</sup> Harris (2004), p. 41-42. See also Evans and Page (2012), p. 4.

<sup>31</sup> Presentation on the 2011 Census by Jayne Mills from Bristol City Council.

<sup>32</sup> Bristol City Council (2011).

As regards their health, a recent report by Alex Hall for NHS Bristol assessed Somalis as having high to medium health needs.<sup>33</sup> Despite their numbers being broadly similar to that of Polish migrants, Somali patients were much more likely to need the support of interpreters and translators from the City Council and the NHS alike. The main health concerns noted in the report are related to tuberculosis, Hepatitis B and malaria, and vitamin A and D deficiencies. Female genital mutilation is also mentioned as affecting the community's female members, and increased rates of caesarean section.<sup>34</sup> However, the ethnographic work carried out in January 2013 in Bristol for this report suggests that mental health, work-related health problems, and other links between health and employment also deserve significant consideration by statutory public health providers and commissioners, including the Council and the NHS.

## 4. Case studies

Case studies are presented in the order in which interviews were carried out. They preserve as much detail as practically possible while ensuring participants' anonymity.

### 4.1. Case study 1: Warsame

Warsame is a Somali man in his early 40s. He is now a British citizen. He lives in Bristol with his wife and 3 dependant children. He has 4 more children who are grown up and have moved out.

Some years ago Warsame worked in a warehouse distribution centre. He had that job for a couple of years and his duties included cleaning, packing and order picking. For that, he earned £200 per week. His wife did not work, she looked after their children. During that period, the family claimed child benefit, child tax credit and working tax credit totalling £270 per week. They also claimed full housing benefit, but no council tax benefit. On one occasion, Warsame was asked to repay £549 housing benefit overpayment but had no other problems with his benefit claims. At work, however, it was more difficult. Warsame did not receive any health and safety training and he simply carried out his work without knowing the risks involved. Two years into the job he fell down and seriously injured his back. Since then he has been experiencing constant back pain and could not lift. Warsame also has other ailments, including recurrent headaches, poor eye sight, stress and physical weakness which he thinks were all caused by years of hard manual labour. Despite all this, he was not successful in his claim for incapacity benefit and, for two years after the accident, he received Job Seekers Allowance (JSA) at £86 a week. As soon as he felt better he joined Security Industry Authority (SIA) training to start a new career as a security officer, where the work would not be as hard and no lifting would be involved.

Finding work was not easy, but Warsame finally got a job as a security officer in supermarkets. He works around 25-27 hours a week and earns £600-700 per month. On top of that he receives child benefit and tax credit totalling £207 a week. Warsame contributes £35 per week towards rent and pays £53 for council tax each month, and the rest is covered by benefits. Although he is determined to continue working, the recurring

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<sup>33</sup> Hall (2012), p. 2.

<sup>34</sup> Ibid., p. 20.

back pain means Warsame struggles to stand for long hours. He also has a bad relationship with his current supervisor who takes advantage of Warsame's limited language skills. Booking annual leave is always problematic and on several occasions Warsame did not get his sick pay. To cap it all, he is not eligible for the 30 hour element of working tax credit as he only ever works between 25-27 hours a week. Although he asked for more regular work, his employer has never offered him a contract for fixed hours. Warsame has also encountered racial abuse from customers for being African, and his colleagues repeatedly told him to go back to his native country. This abuse, and especially the lack of support from his employer, causes him a lot of distress.

His current problems are not severe enough to prevent him from working, but Warsame feels that things could be much better. He tried to find a better job, but his ill health and limited language skills make this difficult. To improve his physical health Warsame wanted to join a local leisure centre, but with his current income he cannot afford it. His relationship with the GP is not good either, and he only visits if his condition and back pain gets worse.

#### 4.2. Case study 2: Bushra

Bushra is a single mother in her mid-20s and lives with her child in the inner city of Bristol. She arrived as a refugee from Somalia. As she has no formal qualifications, the only work she could find was a cleaning job. She has worked on a number of premises cleaning floors, toilets, stairs, and kitchens. She used to work morning and afternoon shifts on two different sites with the same contractor, in total 30 hours per week for which she earned £185. While she was at work, her friends and distant relatives in Bristol looked after her baby and Bushra never claimed the childcare element of working tax credit. To top up her income Bushra claimed working tax credits at £69 per week, while her rent and council tax was chiefly paid by benefits from the City Council.

Her work was a struggle. Neither Bushra nor her co-workers, all of African descent, got paid on time, and their wages were often incomplete. In addition, workers were routinely refused pay rises when they asked for them. At work, Bushra used a variety of strong cleaning detergents without knowing the potential health risks. She sometimes worked without gloves as they usually were in short supply, and thus, and her skin would get irritated. There was very little training on health and safety, and none about the use of detergents. All training was brief and focused on getting the work done, rather than staff wellbeing. It was conducted in English even though the vast majority of workers, including Bushra, had limited language skills.

Sometimes, when Bushra worked without gloves, the detergent would get into her eyes. In such cases she was given eye drops and was told to rinse her eyes with plenty of water, and get back to work. She was not aware of her contractual sick pay regulations, so she continued to work despite being unwell. In her free time she had several GP consultations, but the medication she was prescribed did not clear her eye pain. Eventually, after she came back from annual leave, she was told her contract was terminated and her job given to someone else.

After this Bushra signed up with several recruitment agencies, and one of them hired her as a cleaner. In this job she worked hard and had to lift industrial vacuum cleaners. Five months into the job she was promoted to a supervisory position with a token pay rise to £193 per week. In the new role Bushra was supposed to manage two English workers but they refused to accept her as their supervisor. In addition, other cleaners mocked and verbally abused her, and eventually her contract was terminated by the agency. The company never investigated these incidents and left Bushra feeling she was fired because other cleaners refused to accept her as a supervisor.

This experience caused a lot of stress, and in addition Bushra developed headaches, backache and muscular pains due to lifting in her most recent job. She feels let down by her employers, but she never formally complained as at the time she did not know how. Currently she is unemployed and claims JSA at £71 a week, along with child benefit and tax credits totalling £77.30 per week. She cannot afford any holidays and she is not involved in any health-related activities or visits any leisure centres.

#### 4.3. Case study 3: Barre

Barre is a Somali man in his early 40s and a father of six. One of his childhood ambitions was to be a civil engineer but this never happened. He had to flee his country in 1996, at the height of the civil war. He arrived to Holland in 1997 and spent nearly 10 years there as an asylum seeker and refugee. While waiting for resident status in Holland, Barre was allowed to take up employment. He soon found a job in a warehouse. "I always wanted to work and be independent. If an opportunity is presented to me I will make good use of it", he says. He started sending money to his children who back then were still in Somalia, so they could afford food and clothing, and were going to school. This made Barre proud. Later he got a job with Holland's largest flower grower and distributor. "That was the best paid job I've ever had... I was getting €350-360 per week."

In 2007, soon after getting his Dutch citizenship, Barre moved to the UK. He came to Bristol, where a lot of his friends were already settled. Before long, he started work for an industrial cleaning company in South Gloucestershire. He worked four nights a week, from 7:30 p.m. to 5:30 a.m., and earned about £210. He thought it was not much for his efforts, and less than his wage in Holland, but it was enough to cover basic needs. However, he respected his work and never had any major absences, even though the work environment was physically demanding and the night shifts long. It was agency work, which Barre did not mind as long as it was ongoing and could be relied upon. In April 2010, three years into the job that was his first in Bristol, Barre lost balance and fell, and a two-metre-high stack of trays crashed on top him. As a result, he suffered an injury to the left knee, his back, and lost a front tooth; the knee injury was the worst one. So far he has had one surgical operation on the knee and he is still getting physiotherapy. Although he thinks his treatment was helpful, his doctor told him that the knee will take at least one more year to completely recover. At the moment, Barre limps and has to use a walking stick.

He is not working at the moment. As an agency worker, he only got statutory sick pay. Currently he gets £194 a fortnight in Employment and Support Allowance (ESA) and claims housing benefit for his single bedroom flat.

He is trying to get compensation for his injuries through solicitors, but the case is still ongoing. Barre estimates his injury reduced his disposable income by around 30 to 40%. He still supports his family, who now live in Ethiopia, and so he would like to get back to work as soon as possible.

#### 4.4. Case study 4: Ahmed

Ahmed is a Somali man and a British citizen in his early 40s. He came to the UK in 1992 on a family reunion visa to join relatives who had lived in Cardiff since the 1950s. In 1994 Ahmed moved to Easton in Bristol to look for work, as at that time jobs were hard to find in South Wales. He wanted to bring his wife and a child from Somalia and hence, under the immigration rules, he was required to provide evidence that he can support his family financially if they join him in the UK. The family was reunited in 1995 after court ruled in their favour.

In that period Ahmed had a number of low-skilled jobs through employment agencies. He worked for bakeries in Avonmouth, then for dry cleaners in St. Werburghs, and also had jobs in Bristol. Although they were all temporary, he remained employed most of the time. Later he started working for a lens manufacturer in north Bristol, but he left in 1996 to take up a permanent role with an electrical appliance company. There, he worked full-time on rotating shifts as a machine operator making panels for various appliances. Ahmed earned £200-250 per week after tax, which he said was good income at that time and enough to sustain his family which over time grew from three to seven. The family also received child benefit and, as he was the only earner, housing benefit. He enjoyed his work as the environment was good and some of his friends also worked there. The company employed a multinational workforce, which Ahmed liked, and relationships between workers and managers were also very good.

In 2003 Ahmed was on his afternoon shift work from 2.00 p.m. to 10.00 p.m. when a press machine that he was operating accidentally caught his left hand and severed half of his index finger. He says this was bad luck as the company provided health and safety training and equipment. For example, it was mandatory to wear safety boots, protective gloves and goggles. He received first aid at work, then was sent to hospital and later discharged. He underwent an operation to remove a severely damaged part of the finger and was off work for three months with sick pay, although he could not recall what type of sick pay he received and whether it was under his written contract or discretionary payments. Ahmed thinks he received an amount equal to his weekly wages for the first two or three weeks, and slightly less until the end of the third month. In addition, and after a year of legal argument, Ahmed accepted £20,000 as compensation from the employer. When he recovered he returned to work as machine operator. However, two years later he was made redundant due to the company scaling back its operations. He received £2,500 in redundancy pay. By that time Ahmed had worked for the company for 10 years and thought he had a secure job.

Having lost the job, Ahmed says he lost confidence and started getting increasingly depressed. He started chewing khat at least three or four times a week, a habit he did not have before. He reflects it was due to stress, first with the injury and then losing a job shortly after he recovered. A couple of years ago Ahmed

stopped chewing khat and now is actively looking for work and spends the rest of his time helping his five children with school work. His wife works 20 hours per week, and on top of that they get child benefit, working and child tax credits and housing benefit. Their total income is £350-400 per week for the whole family, and they hope to send the eldest child to university.

#### 4.5. Case study 5: Farah

Farah is a Somali man who has lived in Bristol for the last 13 years. Initially he worked at a food processing plant for three years and lived with friends in a shared house. His work duties in the factory included packing and sorting the products. He earned around £220 a week, which was his only source of income. He sent part of his wages to his family in Somalia. He worked all the time without interruption to be able to sponsor his family to join him in the UK. He received indefinite leave to remain and, shortly after, the Home Office granted a family reunion permission for his wife and six children.

Farah left his job at the food plant to join the NHS as a housekeeper. His job mainly included cleaning at hospitals and other medical institutions. He had positive reviews in his annual appraisals, and that resulted in pay rises. Farah believes that he was treated fairly, just like other staff during his time at the NHS, and he received contractual sick pay too. His working hours were around 30 to 40 hours a week and he earned £190-250 each week after tax. He has claimed working tax credits, child benefit and tax credits totalling £391 per week. He contributed £20 for rent per week and £33 for council tax per month, the rest being paid from benefits.

After eight and half years at the NHS, Farah decided to become a taxi driver to earn higher wages. He passed all necessary tests and handed in his notice to the NHS to work full-time as a taxi driver. However, two days before the end of his notice period, Farah had a serious car accident in which he broke his leg and suffered a serious back injury. He could not start his self-employment work, while the NHS terminated his contract as per his resignation letter.

Farah was not familiar with the benefit system, but was told to apply for incapacity benefit. He got frequent correspondence from the Department of Work and Pensions regarding his application, but received no payments for the first five months. Luckily, the council paid his rent and council tax bills. During that period, tax credits and child benefit were the only source of family income as Farah's wife did not work. After getting legal advice, and having recovered from his injuries, Farah withdrew his claim for incapacity benefit and applied for JSA, as at that point he was already but the benefit was not backdated as he fit for work by that time. He has never received any benefits for the time when he was recovering from the accident.

Following the accident, Farah's health deteriorated and he experienced episodes of anxiety. His main concern though was the back injury and sleeping disorder. To improve his health Farah joined a local leisure centre where he only has to pay £17 in monthly subscription.

Now Farah feels better. He cannot lift heavy objects or stand long hours, but he can drive a car. He started working full time as a taxi driver, although due to his back problems he has to take frequent breaks during the

day. After paying tax, car lease and servicing, license and office fees, and petrol, he earns £800 per month. In addition he is getting tax credits and child benefit. Although it is not exactly how he imagined, Farah is enthusiastic about his self-employment and hopes to continue working in the foreseeable future.

#### 4.6. Case study 6: Ladan

Ladan is a Somali woman in her late 50s who lived in Malmo, Sweden for 15 years and moved to Bristol in 2004. She fled Somalia around 24 or 25 years ago, although she cannot remember the exact date. Initially she arrived in Saudi Arabia where she stayed and worked for a couple of years before heading to Sweden to be reunited with her husband and eight children who already lived there. In Saudi Arabia she did not have a work permit and worked illegally, cash in hand, mainly in casual domestic jobs such as cleaning. Back in Somalia she used to be entrepreneur and run her own restaurant in Mogadishu, while her husband worked as a minibus driver. After Ladan moved to Sweden, she struggled to find work. "I applied for cleaning job at a local school where my children went, but they asked me if I have qualification. In Sweden even cleaners must have qualifications to be cleaners", she says.

In 2004 Ladan left Sweden, where her now grown up children and husband still live, and came to Bristol. Ten months after arrival she started working as an office cleaner with a local contractor. Her position was permanent but part-time, and she worked 25 hours per week and occasionally covered additional shifts for her colleagues. Each month she earned £500-550, and had additional income of £200 pounds from working tax credits. She worked at two sites on short morning and afternoon shifts, and was happy with this. Although her English was very limited, Ladan got on well with her supervisors. "I just used to do my job well ... and that was it. There was no great deal of talking", she says.

A couple of years ago, walking along Stapleton Road in Easton with a friend, Ladan got caught up in a street brawl. A person fleeing the scene bumped into her, and Ladan fell and fractured her right arm. She was helped at the scene and then taken to hospital, where she underwent surgery. Doctors inserted metal plates to support the fractured bone. "Now I can't hold cleaning equipment as such vacuum cleaners, because vibration coming from them upsets my arm. I can't do much of the work that I used to do", she says. Following the accident, she also developed high blood pressure. She is now off work and aside from housing and council tax benefits, she receives ESA. She gets regular physiotherapy exercise and her arm is improving, but her ability to work is still reduced.

#### 4.7. Case study 7: Abdi

Abdi is a Somali man in his early 50s. He was granted asylum in the UK in 2003 and has lived in Bristol ever since. During the asylum process he stayed in several hostels, and moved to permanent accommodation in Easton after getting his refugee status. He worked for different companies over the years, and his most recent employment was at Rolls-Royce plant as an engine leak controller. He worked there for four years earning £300-400 a week. Whenever he needed time off due to illness he received full sick pay, though he was generally in good health while he worked for Rolls-Royce. His wages were the only source of Abdi's income

and he still managed to send remittances to his family in Somalia. He was contracted for 40 hours a week and he also frequently worked overtime to boost his income. He recalls getting a pay rise once a year, although it was minimal.

In 2008 Abdi got British citizenship and managed to bring his wife and seven children to the UK. Shortly after, he started a grocery and butcher business. He worked long hours to establish it, and this had an impact on his family life. At some point Abdi hired an assistant to help him with the business, but it did not last as there was not enough income to pay the worker's wages in the long term. Therefore, Abdi worked long hours nearly every day, even when unwell, and soon felt his health was deteriorating. He complained about tiredness and stress, and his GP diagnosed him with high blood pressure and diabetes. As his illness was at least partially caused by his hard work over the previous four years, Abdi he decided to sell the business at a loss. He does not regret that decision and says that working less, and taking the medication for diabetes and hypertension prescribed by the GP have helped him a lot, although he does understand his condition is chronic.

Now Abdi has time to regularly attend a local leisure centre where he uses the gym and takes swimming lessons. He pays a £31 monthly subscription, and this is the only leisure activity he can afford. He has not been away on holiday for the last 10 years. He currently works 24 hours per week as a café assistant, and for that he earns £592 per month. He also receives child benefit and tax credits worth £450 per week, and the council pays most of his rent and the council tax bills. Ahmed is satisfied with his current working hours, as he is able to help his sizeable family. He is determined to keep working, but not as hard as when he was self-employed managing his own business.

#### 4.8. Case study 8: Ali

Ali is a Somali man in his mid-40s. He is a Dutch citizen and came to UK in 2000. He was born in Somalia but left in 1994 at the height of the civil war. Initially he spent some time in Russia and Eastern Europe and arrived in the Netherlands in 1998 where he spent some time in refugee camps. During his stay there Ali did some seasonal work on farms, mainly tomato and fruit picking. Unlike in the UK, in the Netherlands asylum seekers are allowed to work. After arriving in the UK Ali stayed in London for a couple of years. He did temporary work for employment agencies and had a few spells of unemployment when he claimed JSA. In 2006 he joined his relatives and friends in Bristol and currently he lives with his wife in Baron Hill.

In Bristol Ali he had two jobs. One was with a catalogue company in east Bristol, where he was a warehouse operative. He processed orders and boxed catalogues for dispatch. Initially he was full-time, earning £180 a week. However, after some time he decided to start his own business, an Internet café and phone shop. Since his wife helped him run the business, Ali kept his warehouse job but reduced his hours there to 16 a week. He used to work a morning shift at the warehouse, finishing about 1.00 p.m., and then he swapped with his wife at the shop; the wife, in turn, went to look after the home and cook. This way, they kept the shop open for business each day. The business quickly started bringing in profits of around £400 pounds a week, and Ali left his part-time work to develop the business further. "It was a great experience for me to run my own business



and be my own boss. I was the one to deal with the suppliers, landlord, bills and customers on the shop floor... It was lot of work but it gave me confidence and was an opportunity to use my past business experience from Somalia where, while a student, I worked in family jewellery shops during afternoons and weekends". Despite working long hours to set up his business in Bristol, Ali did not complain: "I sometimes spent 12 hours there and was still full of energy. This is how I used to feel in my shop", he says.

However, things have changed for Ali when he had a stroke which paralysed his left hand and leg. The stroke was linked to his high blood pressure as an underlying condition. He was in hospital for eight days where he underwent laser surgery to remove a blood clot from his brain. After the stroke Ali experienced physical weakness coupled with memory loss. He was not capable of running the business, and his wife had to spend much time caring for him at home. When discharged form hospital, Ali started physiotherapy sessions at Frenchay which helped him to some degree regain movement in his leg and arm. Ali thinks he is making a good recovery. He feels depressed sometimes as his capabilities are now limited, but he does regular exercise at home and occasionally goes to a gym.

Following his sickness Ali had to sell the business and he experienced long-term unemployment. He believes that now that he is in his mid-40s, with a health condition and no particular work skills, his employability is limited. His entrepreneurial experience is an asset, but Ali is not well enough to start his own business once again. For the last three years he has received housing benefit, as well as disability living allowance and incapacity benefit totalling £250 a week. His income dell at least one-third compared to what he used to earn before the stroke.

## 5. Analysis

Several key themes emerged during the interviews. Among the 8 respondents:

- 2 had six children, 2 had seven children, and 1 respondent had 8 children.
- All 8 were in precarious employment at some stage.
- 2 said they received either no or insufficient health and safety training and/or equipment at work.
- 3 complained about their relationship with employers, mainly problems with incomplete wages payments and booking annual leave.
- 3 were in stable, salaried employment at some point (2 factory workers and an NHS worker) but they left to start their own business in a hope to increase their income.
- 1 planned to start self-employment but this was prevented by a serious accident.

At the time of the interview:

- 2 were in precarious employment and/or underemployed, i.e. working part-time despite willing to work full-time.

- 1 was in fairly secure work, although self-employed.
- 3 were out of work claiming health-related benefits.
- 2 were out of work claiming jobseeker's benefits.
- 4 used local leisure centres, gyms or exercised at least occasionally.
- 4 said their GP or other NHS service helped them with their health problems.
- 2 said their GP or other NHS services were not helpful.
- 7 complained about their health, of which:
  - 6 complained about physical health, mainly hypertension (3), headaches (2), back/muscular pain (2), diabetes (1), exhaustion (2), knee injury (1).
  - 3 complained about mental health, mainly stress (3), and depression and anxiety (1).
- 3 said their English skills held them back.
- 2 complained about racial abuse from employers, colleagues or clients.
- 2 continued to work despite being unwell, either due to lack of sick pay or due to being self-employed.
- 5 arrived in the UK as refugees or on family reunion visas.
- 3 moved to the UK from another EU country (2 from the Netherlands and 1 from Sweden).
- 3 were sending remittances to their families overseas.

As stated in section 2 on methodology, these findings generally reflect the respondents' perceptions and beliefs. The sense of unfairness, or inadequacy of support they received, may at times be exaggerated.

The key findings are consistent with literature. The most striking and recurring theme was the difficulty that Somali workers faced when trying to get back to work following illness or redundancy. 5 out of 8 respondents were out of work at the time of their interview. The case of Ahmed, who developed khat dependency and remained unemployed for over 6 years after his factory closed down, is perhaps the best example. Others also reported mental health problems after losing work, or were negative about their jobs prospects. It may be related to the fact that they were in low-skilled occupations to begin with, and losing such work may thwart any hopes of ever having a fulfilling job. Most Somalis, like other migrants, also end up in skills trap. Often without transferable skills, and with insufficient English, they are unable to progress at work. This affects their confidence and motivation. As a result, the challenge of looking for a better job, improving work skills, and looking after family at the same time may simply be overwhelming.

All respondents were employed at some stage and then lost their jobs for three main reasons:

- Redundancies, either with compensation if permanently employed, or without if temporary workers.

- Sickness or accident, either at work or outside work.
- Leaving work to start a business (two shop owners and a taxi driver).

The fact that 4 out of 8 respondents decided to leave fairly stable work to become self-employed seems to confirm the common claim that in general Somalis are entrepreneurial. However, the prevalent business model is to either become a taxi driver or to open a shop catering to other migrant communities such as groceries or an Internet cafe. These are all labour intensive businesses with little growth potential and, just like temporary jobs, they provide a limited level of economic security. This vulnerability is best seen in the case of Farah, who gave up his job to become a taxi driver but found himself in hardship after an accident.

Another important factor is the size of Somali households. With a large number of children, there is usually just one earner in the family. This means that, in case of the breadwinner's illness, such families suffer disproportionately. In addition, exceptionally high average household size seems to limit the migrant's ability to gain new skills and progress in employment – several respondents stated they were happy to work part-time to spend more time with children.

Only 2 respondents earned more than the minimum wage, which is in stark contrast to the wages of Polish migrants interviewed in our earlier study.<sup>35</sup> Somali respondents undertook the most basic jobs, with practically no opportunity for progression and the lowest wages, and this too seemed to affect their motivation. Given long gaps in employment history usually caused by the experience of seeking asylum, the lack of relevant and transferable skills, ill health, and the exceptional level of family commitments, Somali migrants face an immense challenge to break into meaningful employment.

## 6. Conclusion

A report published in 2008 suggested “a need for more targeted interventions at the local level to ensure that Somali populations are able to benefit, for example from jobs created through regeneration activity. More support should also be given to innovative projects that work with Somali women to undertake ‘small steps’ that may result in labour market participation.”<sup>36</sup> Such an approach is even more pertinent in the current economic climate. Somali migrants occupy some of the lowest rungs of the economic ladder. Their attempts to establish businesses show that there is plenty of skills, motivation and untapped potential in the community, but the confidence is fragile. There is an urgent need for activities engaging Somali migrants with the wider community, and promoting their access to secure and meaningful employment with opportunities of learning and progression. Equally important is promoting good practice amongst employers so they understand the needs of their Somali workers, invest in training them, and support them to remain in employment.

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<sup>35</sup> Jablonowski and Piotrowska (2013).

<sup>36</sup> Hickman, Crowley and Mai (2008) p. 116.

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