

Accessing Health Services for New Arrivals: The Refugee Perspective

North of England Refugee Service report
for Newcastle Primary Care Trust PMS Pilot Scheme
November 2002

Table of Contents

	<i>page</i>
1. Executive Summary	1
2. Introduction	8
3. Participating organisations	10
4. Analysis	11
4.1 Expectations of the UK health service	11
4.2 Information	14
4.3 Access	21
4.4 Immediate needs on arrival	27
4.5 First full assessment	29
4.6 Culturally specific or appropriate issues	33
4.7 Looking after one's own health	36
4.8 Mental health	40
4.9 Access to secondary health care	44
5. Acknowledgments	46
Appendix 1 Questionnaire	47

North of England Refugee Service
Luke Finley
November 2002

1. Executive Summary

1.1 Categorical identity and individual experience

People who arrive in the UK seeking refuge from persecution, human rights abuse, and danger to their lives in their country of origin are collectively referred to by a categorical identity, 'asylum seekers'. However, this homogenous identity is relevant only in relation to two shared experiences:

- That they share the experience of having to leave their homes under extreme circumstances
- That they share the experience of living in the UK under the UK's asylum support system

Heterogeneity is revealed when one identifies the diversity of individual experiences covered within these two precepts. In addition, there are almost 100 nationalities represented amongst the refugee population of the North East, which itself does not reveal the ethnic (cultural) and linguistic diversity within those nationalities.

While this population share many of the issues experienced by the UK's BME community, which are being addressed by service providers under the policy agendas of Equal Opportunities and Race Relations in to promote 'mainstreaming', they also have specific health needs that relate to both their homogenous and heterogeneous identities. The following factors impact on the physical and mental health of this population:

- Conditions of flight from their countries of origin (for example, the impact on health of war, torture, trauma, loss)
- The nature of their travel to the UK (such as length of time, conditions en route)
- Living conditions and lifestyle whilst awaiting a decision on their asylum claims (for example, stress, isolation, forced inactivity, income at 70% of indigenous welfare support, change of diet, climate and exposure to unfamiliar illnesses, actual and perceived discrimination, racism and prejudice from negative stigma attached to asylum seekers in the UK)
- Orientation within an unfamiliar health system and structure
- Language
- Nationally and culturally specific approaches to health and pathology
- Nationally specific contexts of diseases / immunisation programmes

1.2 The Survey

This small-scale survey involving 32 interviewees therefore aims to capture the views and actual experiences of a sample cross-section of the population who are both 'asylum seekers' and individuals, in order to identify and learn from both consensus and variation. It contains information from individuals from 22 different ethnicities/nationalities from Africa, the Middle East, Latin America, South East Asia and Europe, male and female, with ages ranging from 19 to 62. Both the general and the specific are significant in considering the planning and delivery of health services to this population within the first three months of their arrival in the UK.

The questionnaire was designed to elicit information about:

1. Prior expectations of health services in the UK
2. Comparative/range of actual experiences of health treatment in the UK
3. Range of self-identified solutions to some of the problems encountered

This report presents the analysis of responses covering the following areas:

- Expectations
- Information
- Access
- Immediate medical needs
- First full medical check up
- Culturally sensitive or appropriate service
- Looking after health in ways other than going to a GP
- Mental health
- Access to secondary health care

1.3 Summary of findings

1.3.1 Expectations

40% of respondents indicated that they had arrived with prior expectations of the UK health service, 87% of which were positive expectations. However, when asked to match experience to expectations, nearly half said their expectations had proved to be inaccurate. Overwhelmingly, this was due to longer than expected waiting times and excessive administration procedures before health services were provided.

Based on their actual experience of the NHS, positive differences between health services in countries of origin and the UK referred to specified that the service here was free, eliminating competition between clinics, with better resources and availability of medicines, better qualified staff, no discrimination in access on grounds of status, wealth or connections and was generally more effective.

Negative differences were identified relating to longer waiting times in the UK, more complicated access and more administration and paperwork before a health service was actually provided.

1.3.2 Information

Receiving information:

Content

The availability of appropriate and accessible information is a vital factor in accessing health services. 34% judged that they had received no useful information in the period after arrival. Respondents identified a range of both general and specific information that would be useful in the first 3 months, based on what they would consider telling new arrivals from their own countries of origin. One outcome could be that information could be developed by working in partnership with co-

community organisations¹, as they are aware of the specific differences between health services in the UK and their countries of origin and how these differences impact on access to services in the UK.

Delivery

Respondents also offered suggestions on how such information would best be delivered. Significantly, their comments reveal the limitations of information delivered in a written form, even when translated. While translated information was identified as vital, it is also significant that Welcome Packs alone were not favoured. There was an expressed need for information to be delivered through one-to-one contact, own language induction, and over 60% of respondents suggested delivery through co-community organisations. Where specified, the providers of useful information were not connected to the health service, which suggests that a strategy of partnership working with a range of other agencies delivering support to asylum seekers on arrival is required.

Culturally sensitive issues

Respondents also identified the importance of 'discreteness' when receiving information about intimate concerns (such as sexual health and reproduction). In such situations, the gender and age of the interpreter / health professional become potential barriers.

Offering information:

Confidentiality

Confidence about the confidentiality of information given by the service user can negatively impact on health. Over 40% of the respondents considered that UK Immigration might have access to their medical records and over 44% said that they had hesitated to disclose information to health professionals for fear it would affect their asylum case.

In addition, confidence in the strict confidentiality of professional interpreters is also required, as many interpreters are, of course, from the same co-community and locality as the service user.

The desire for a choice of interpreter with regards to age and gender was stressed.

¹ Refugee Community Organisations. The methodology involved the participation of the region's RCOs as researcher/interpreters. Those interviewed were therefore aware of the benefits gained through the support offered by such organisations. The number of RCOs in the region has grown from 5 when Dispersal began to 30, and continues to grow in number, with their aspirations and capacity to deliver support and work in partnership increasing as they develop further. Those existing relate to the largest populations of refugee communities. These RCOs represent a significant new source of partnership for service providers seeking to develop and deliver appropriate and effective services. However, there will always be communities remaining for whom no such supportive organisations exist.

1.3.3 Access

Understanding the system (45%) and the language barrier (60%) were identified as the main barriers to access.

Nearly 70% of responses identified drop-ins and home visits as a way of improving access to health services. These responses mainly relate to the problems experienced in finding the health centre, securing immediate appointments, keeping appointments, as well as preferring a more confidential environment.

The role of the Receptionist was recognised as a very important interface in accessing health services. 53% identified prior knowledge and experience of working with people from different cultures and faiths and an understanding attitude as being qualities most required for an effective receptionist. 44% identified respectfulness as a desired quality and 28% experience of working with people through the language barrier.

Respondents were specifically asked for information on reasons for missed appointments, it having been explained to them that this was a significant time and cost loss to the health service. There was considerable variety of responses, ranging from unfamiliarity with such a system, length of wait leading to forgetting, appointments clashing, unexpected news, fear of attending, being unable to telephone and language barrier to cancel, childcare, cost of travel, finding the location, through to lack of motivation. It was also mentioned that people were unaware of the cost/time implications to the health service. Nearly 50% of the respondents had missed an appointment, with 87% of those saying they had not tried to cancel. The main reason for non-cancellation was given as the language barrier. Some solutions were offered, including day-before reminders, a verbal code for cancellation, and volunteers to accompany them.

1.3.4 Immediate medical needs on arrival

78% responded that they had immediate health needs (including dental problems) on arrival, presenting a range of both physical and psychological issues. Several respondents identified the need for a full medical check up and immunisation screening on arrival.

60% of those identifying immediate needs said that those needs had not been adequately met on arrival in the UK. Responses included long waiting times/lack of assistance for registration or an appointment, no offer of a full check up, or feeling unable to discuss problems with health professional/interpreter of different age or sex.

1.3.5 First full medical check up

Nearly 50% of all respondents considered this should include as priority a personal medical history and immunisation check. When asked about their own experience of their first medical check, 50% described the experience as positive, citing a [Accessing Health Services for New Arrivals: The Refugee Perspective](#)

combination of medication, diagnostic tests, referral and considerate attitude of the health professional as their reasons. Of the 25% who cited a negative experience, the most frequent reason was the feeling that the check up had been incomplete, superficial or cursory, lacking many diagnostic tests or x-rays, although a discriminatory attitude, and discomfort with different sex/age health professional or interpreter was also cited.

Over 60% felt that this occasion was also the right time to address psychological / mental well-being issues. Several believed that these were in fact the priority issues on arrival and affected the majority of people.

This suggests that a health service for new arrivals will also need to be an effective referral point for a range of support relating to mental well-being. Referral and signposting links to source of support such as co-community organisations, befriending, faith groups and women's projects should also be developed.

1.3.6 Culturally sensitive or appropriate service

84% did not consider that they had experienced any aspect of the health service that seemed inappropriate or insensitive to their cultural background. However, the main issue identified by both male and female respondents as requiring greater sensitivity on the part of the service provider relates to the wish for same sex health professionals and interpreters. The age of the interpreter/health professional is also important, many people being unwilling to be touched by or speak with younger staff.

Respondents were also concerned where there are culturally different approaches to pathology (causality/ consequences) and the treatment of disease, with the potential to cause anxiety and a lack of confidence in the UK health service. People are also aware that some of the symptoms of diseases that are common in tropical countries may not be recognised here.

33% of all respondents said that there were treatments that would be available in their own country of origin that are not available in the UK. This was either because certain conditions were seen as uncommon in the UK or relate to culturally specific medicines not available here.

1.3.7 Looking after one's own health

59% said that they had more problems looking after their own health here in the UK than in their countries of origin. 45% cited obtaining a familiar diet as a problem, while recognizing medicines and the cost of non-prescribed medicines were also significant factors.

78% of those who found it difficult to obtain the diet they were used to were African. The African refugee population is the largest new community in the region and no specialist food stores exist at the present time. Typically people source these food items by visits to London.

When asked what they considered would improve their ability to look after their own health here, while 30% identified health information as a factor, diet, lifestyle and language were also cited. The responses relating to the need for better lifestyle described health in its holistic sense, highlighting the need for access to facilities for maintaining physical fitness, hygienic living conditions, and a 'balanced' life involving a social life, work and enough money. These all relate to maintaining physical and mental well-being.

Sources for health treatment other than the GP surgery were not being accessed effectively. 85% of respondents did not know of/how to access NHS Direct; 81% did not know of/how to access the Walk In Centre; 87% did not know of/how to access the Minor Injuries Unit and 60% were not clear about A&E services. 60% of all respondents had not used any of these services.

1.3.8 Mental health

75% of respondents identified with at least one of the conditions associated here in the UK as being symptoms of PTSD. 55% identified themselves as suffering or having suffered from depression, 57% experienced both headaches and fear, while 42% experienced insomnia.

22% of respondents had not sought help from a GP for the conditions identified. Reasons given included the feeling that the health service could not treat such problems, that they knew the causes lay in their experiences in their country of origin and that this could not be undone, or that it was a consequence of awaiting a Home Office decision on their asylum case.

53% had sought help for these conditions from a GP. Of those, 53% were satisfied with the attention they received, while 34% were not satisfied with the response, reasons given including that they had only been given tablets or were told by the GP that he couldn't change what happened in his country of origin. 35% of all respondents suggested a combined approach of GP (medication) and Counsellor as being the most effective response. 50% of respondents had been offered counselling, of those 66% felt that it had helped them. Of those who were not offered counselling (22%), 81% felt that it would help them.

When asked what type of help they could expect in their own country of origin, 25% responded that it would be a similar combined approach of medication, therapy and counselling. Another 25% said that either little or no help would be available. Responses also indicate that in some countries help is sought privately and secretly as a stigma is attached to mental health. Other forms of treatment related to faith-based prayer. However, responses also indicate that some people see forgetting as a healing process, in contrast to a UK talking-cure approach.

1.3.9 Access to secondary health care

47% of respondents said that they could access specialists through self-referral or direct access in their countries of origin. While this gains more immediate medical attention, it is usual to pay for this access.

45% of respondents had tried to access specialist medical treatment in the UK. 73% of these cited the waiting time from referral to treatment as being too long. However, the quality of treatment, once accessed, was considered good/successful.

*North of England Refugee Service
November 2002*

2. Introduction

The Newcastle Primary Care Trust secured funding to open a PMS (personal medical services) Pilot project for Asylum Seekers arriving into Newcastle. The project management team approached the North of England Refugee Service to commission a small scale survey of the experiences of asylum seekers accessing medical services in Newcastle in order to inform the service delivery. The North of England Refugee Service worked in partnership with the Regional Refugee Forum North East² to access these experiences and views from a wide range of ethnic/national communities. A questionnaire was developed and all respondents were given the following information about the purpose of the project:

"Newcastle Primary Health Care Trust has secured funding to open a new medical service for Asylum Seekers arriving into Newcastle (called a Personal Medical Services Pilot). This will give medical attention for the first three months to all asylum seekers who arrive into Newcastle. After 3 months people will be registered with a local GP, near to their accommodation. The managers of this project want to make sure that this new service works well for asylum seekers. That is why they have asked the Regional Refugee Forum to gather your views on how this service should best operate. They recognise that you have valuable opinions and suggestions to offer, based on your own experience of arriving here as an asylum seeker and trying to get medical attention, understand your entitlements, and understand how the health system operates in the UK."

They were also given a brief description of the service which would be available to newly arrived asylum seekers during their first three months in Newcastle.

The research commenced in July 2002.

2.1 Methodology

This piece of research was conducted using a rapid participatory appraisal method. The interviews that form the basis of this report were conducted by researchers who are themselves members of the asylum seeker and refugee community, interviewing members of their respective communities, and in a language of their choice.

This methodology was adopted on the basis that (i) the shared language and cultural background between researcher and interviewee allow for effective communication and understanding, (ii) extended contact with the co-community enables the researcher to select and approach suitable participants.

Details of who would have access to the information provided and for what purpose it would be used, were fully explained to participants.

² The Regional Refugee Forum North East is an independent body whose membership comprises the region's Refugee Community Organisations. At the time of this research this consisted of 20 organisations, 17 of whom participated in the research project.

In accordance with this principle, a major proportion of the budget for this project was allocated for (i) payment of a fee to researchers and a consultation fee to interviewees in recognition of the donation of their time and expertise to the project and (ii) payment of travel expenses for the researchers, enabling them to meet interviewees in a place of their choice.

The analysis was carried out by the North of England Refugee Service project management team.

This methodology has been successfully used in previous research projects conducted by the North of England Refugee Service:

- *'Investigating RCO's in the North East dispersal region and community based integration initiatives'* Commissioned by IRSS Home Office. July 2001
- *'Enabling 'grass roots' community groups to support the integration of Refugees'* Presentation to the National Refugee Integration Forum, January 2002
- *'Occasional Paper No.05 March 2002: Improving the Health of Asylum Seekers: an Overview'*. Participation in research commissioned by Northern and Yorkshire Public Health Observatory. www.nypho.org.uk
- *'Refugee Housing Project North East: Refugee aspirations on future housing needs in the North East of England'* for Banks of the Wear Community Projects. June 2002
- *'An overview of the Health Service in Sunderland from the Perspective of Service Users who are Asylum Seekers in Sunderland'* for Sunderland Health Authority. September 2000.

2.2 Survey sample

17 refugee community organisations participated in the research project, between them completing 32 interviews with people who had arrived in the North East as refugees from their countries of origin and are now living in the Newcastle area. The respondents represent 22 different nationalities or ethnicities, 18 of whom were male and 12 of whom were female, with ages ranging from 19 to 62 years old. The minimum time of residence in Newcastle was 4 months and the maximum 3 years.

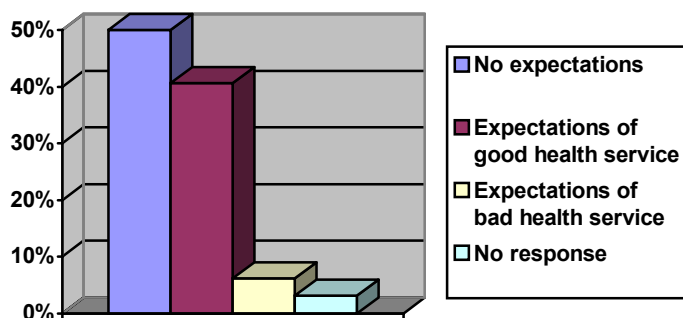
The research commenced in July 2002 and this final report completed in November 2002.

3. Participating organisations	Ethnicity of interviewee	Gender of interviewee	Age of interviewee	Length of Time in Newcastle
1. Palestinian Community Assoc.	Palestinian	M	21	8m
2. Palestinian Community Assoc.	Palestinian	M	19	1y 2m
3. Zimbabwean Community in the NE	Zimbabwean	-	-	-
4. Zimbabwean Community in the NE	Zimbabwean	-	-	-
5. NE Afghan Community Association	Afghan	M	47	-
6. NE Afghan Community Association	Afghan	M+F+2 children	24+18+? +?	-
7. Sri Lankan Society	Sri Lanka/Tamil	F	29	1y 11m
8. Sri Lankan Society	Sri Lanka/Tamil	M	39	2y +
9. African Community Advice NE	Congolese	M	27	-
10. African Community Advice NE	Tanzanian	F single mother	24	-
11. NE Angolan Community Assoc.	Black African	F	27	2y 3m
12. NE Angolan Community Assoc.	Black African	M	36	15m
13. Turkish Community Association	Turkish	M	32	8m
14. Turkish Community Association	Turkish	F	31	10m
15. Latin American Community Support Association	Black Caribbean	M	62	1y 10m
16. Latin American Community Support Association	Latin American	F	33	11m
17. Albanian Community	Kosovo/Ethnic Albanian	M	26	13m
18. NEST	Angolan	M	31	1y 6m
19. NEST	Angolan	F	26	1y
20. Eritrean Community Association	Eritrean	F	23	9m
21. Eritrean Community Association	Eritrean	M	29	11m
22. African Women's Group	Black African	F	33	2y 6m
23. African Women's Group	Cameroon	F	30	9m
24. North East African Community for Integration & Social Inclusion	Senegalese	M	22	4m
25. North East African Community for Integration & Social Inclusion	Black African	M with family	28	3y +
26. G'head African Community Assoc.	Rwandan	F	26	-
27. G'head African Community Assoc.	Congolese	M	29	-
28. Kurdish Community Association	Kurdish Iraq	-	-	-
29. Kurdish Community Association	Kurdish Iraq	-	-	-
30. Bosnia & Herzegovina Club 'Ljiljan' North East	Serbian	M	23	1y
31. Bosnia & Herzegovina Club 'Ljiljan' North East	Croatia/Serbian	M	48	-
32. Iranian Centre North East	Iranian	F m./1 child	41	4m

4. Analysis

4.1: Expectations

1. Did you have any specific expectations of the health service in the UK before you arrived here? How far were these expectations proved accurate or inaccurate?



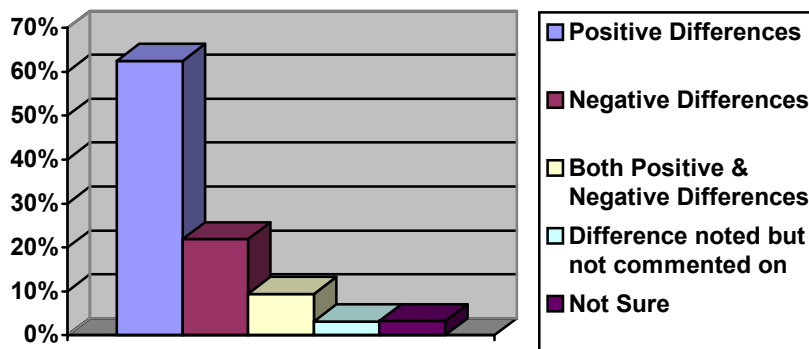
A. Prior Expectations

1. 50% of respondents had no specific prior expectations of the health service in the UK before they arrived. Included in this figure are two respondents from Latin American who added that whilst they had no expectations regarding the service they did not anticipate a free national health service.
2. Amongst those who did have some expectation before they arrived in the UK, 87% had positive expectations. The most frequent comments concerned:
 - Fast and efficient service
 - Good facilities
 - Availability of medicines
3. Where reasons were given for high expectations they were based on a perception of the UK as:
 - A 'super-power'
 - A part of Europe
 - A country with a good reputation around the world
4. Two respondents specified that they had had negative expectations. One Congolese man did not make clear the reason for this, whilst an African woman stated that she had not expected such an organised system.

B. Actual Experience Vs. Prior Expectations

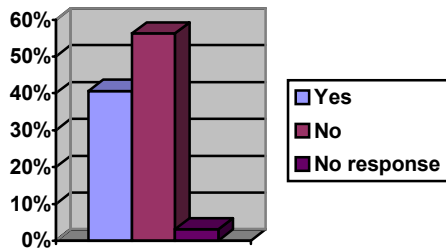
1. 46% of the respondents who identified prior positive expectations said that these expectations had been proved inaccurate, at least in some degree. Overwhelmingly, this was due to longer than expected waiting times, although one Congolese man mentioned excessive administration procedures before health services are provided.
2. The response of emergency services to injuries, availability of medicines and effectiveness of check-ups were mentioned as examples of areas where respondents felt that the service had met their expectations.

2. What are the main differences you have found between the NHS system in the UK and the health service in your own country?

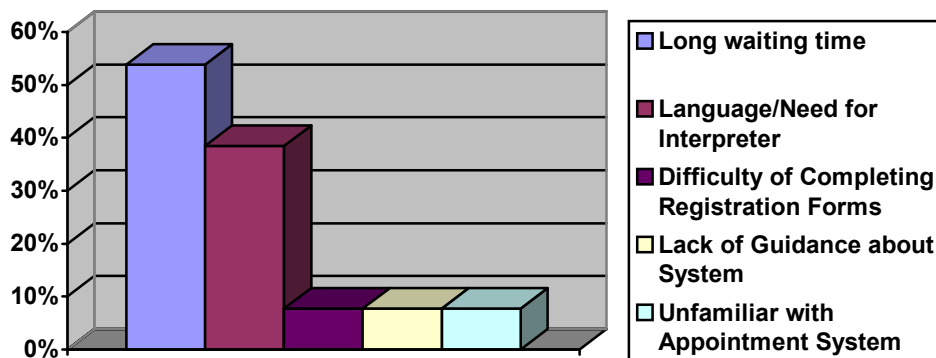


1. As the graph shows, 63% of respondents cited positive differences (ie, the NHS compared favourably with the health service that they were used to in their own country), 22% suggested negative differences, and 9% had a mixed reaction. Only one respondent, a Sri Lankan woman, said that she was not sure of any differences.
2. Positive differences referred to were:
 - Free service
 - Better resources
 - Availability of medicines
 - General Effectiveness of the service
3. Negative differences were identified relating to:
 - Longer waiting times in the UK (only one respondent, an Iranian woman, said that service was quicker in the UK)
 - More complicated access than in the respondent's own country
 - More administration and paperwork
4. 22% felt that staff were better here. Points mentioned included:
 - They are better qualified
 - They are more attentive
 - There is more consensus of opinion between health professionals in the UK
 - As the health service is free in the UK, the problem of doctors being mainly interested in attracting potential patients to their private clinics is absent
 - There is no discrimination on grounds of wealth, status or 'connections'. Some respondents said that in their own countries, speed and quality of treatment could depend on nepotism or bribery.
5. Two respondents (both female black Africans) mentioned the care that pregnant women receive in the UK, but whilst one felt that they received more care and attention here, the other (who was herself pregnant at the time of the interview) was clearly concerned about the greater occurrence of birth by caesarian in this country.

3. Has this made it difficult to access health services here or to look after your own health? In what way?



Among the 41% of the total sample who answered yes to this question, the reasons given were as follows (some respondents gave more than one answer):



1. One respondent, a Congolese male, who had been in the UK over 3 years, was more critical, saying that when he arrived, in addition to the language barrier, he believed that some NHS workers were not doing their job properly, making refugees feel more isolated.
2. Three respondents suggested reasons for why the long waiting times made it more difficult to access the health service and affected health:
 - It discouraged people from seeking medical help
 - It meant that illnesses tended to worsen before being treated
3. 39% of those who answered no specified that access was easier or the service better in this country, although one was also critical of the waiting time to see a specialist.
4. The respondent who previously raised her concern about caesarian operations answered no to this question, but reiterated this worry.

4.2: Information

4. What do you think would be the most useful information about health and health services for someone who has just arrived in the UK & Newcastle?

Though 12.5 % gave no answer or said that they didn't know, most of the other respondents made at least one point in answer to this question. The responses can be split into suggestions for information to be given, for the delivery of the information, and for action.

Information

Figures are given as a percentage of those who answered the question (ie, 87.5% of the total sample).

- Information on GPs and surgeries: where to find them, how to register, what services they provide (Mentioned by 57%)
- General information on how the NHS system works and how to access medical help (32%)
- Information on the need to see a dentist, how to register, etc. (18%)
- Information on entitlements and the right to free treatment (15%)
- Information on hospitals and specialists/specific services (15%)
- What to do in an emergency (11%)
- Information on vaccinations (11%)
- Warnings about waiting times/poor treatment (11%)
- Information about the availability of interpreters (7%)
- Information on the need to keep appointments (7%)
- Information on opticians/eye tests (7%)
- Information on the HC2 exemption form (7%)
- Information on chronic diseases; STDs; what to do if not satisfied with treatment; family planning for women; information for pregnant women (4% each)

Delivery of Information

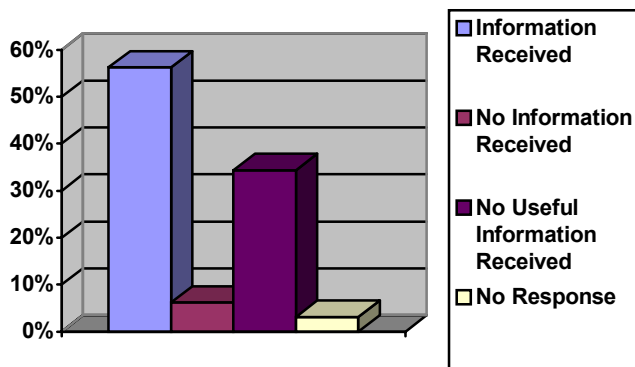
1. Three respondents specified that information should be in new arrivals' own language
2. Several comments suggested the limits of what can be conveyed in written leaflets and the need for an opportunity for more in-depth and two way communication about health issues:
 - One Kurdish respondent suggested that an appointment was needed to give new arrivals proper advice.
 - One African man proposed a simple introduction pack containing useful information and telephone numbers and inviting new arrivals to attend an own-language 'induction' regarding health services.
 - One Afghan family suggested 'an introduction to hospital', perhaps implying something like an accompanied visit.
 - A Rwandan woman stressed the need to encourage new arrivals to learn English and begin communicating for him/herself
 - "...would be best for [new arrivals] to attend health workshops and events to highlight specific health issues" (28 year old African male)

- Two respondents (both Angolan) also commented on the appropriate time to provide information, one saying within the first week and the other within the first month of arrival.

Action

- Several respondents were more concerned with what treatment should be provided for new arrivals at this early stage than they were with information. 25% of the total sample specified that a medical test, check-up or assessment (or, as one African man put it, a 'health MOT') should take place at this stage.
- One of these respondents, an Iranian woman, specified that after the health check there should be follow-up treatment for any problems identified therein, and referral to the relevant specialists where necessary, within the first two months.

5. What information did you receive that was useful?



- 6% of respondents said specifically that they had received no information at all.
- 22% answered simply 'none', an ambiguous response in that it could mean no information was received, or that information was received but that the respondent did not feel that it was useful. Four other respondents have been counted in the 'no useful information column', making a total of 34%:
 - A male respondent from Senegal specified that the information he had received was not useful as it was in English and he couldn't read it.
 - One Eritrean male had not received any information for 4 weeks, until he registered with a GP.
 - An African male (interviewed with his family) said that the information they had received had been very basic and most of it not relating to Newcastle.
 - A respondent from Zimbabwe received no information regarding free treatment and therefore waited two months to get a GP.
- Of the 56% who had received information of some use, the information mentioned was quite diverse. Most of it concerned the right to medical care and how to access services, particularly those provided by GP surgeries. Only one respondent specified that information had been received in her own language. (This was Farsi. The Iranian community is the second largest national population amongst refugees in the North East and Farsi is therefore

one of the more established refugee languages in the region.) Other responses included:

- The importance of keeping appointments
- The right to an interpreter
- Information about TB tests
- Information about smear tests
- Information about ear tests for children
- Information about immunisation for children
- Information about the HC2 exemption form

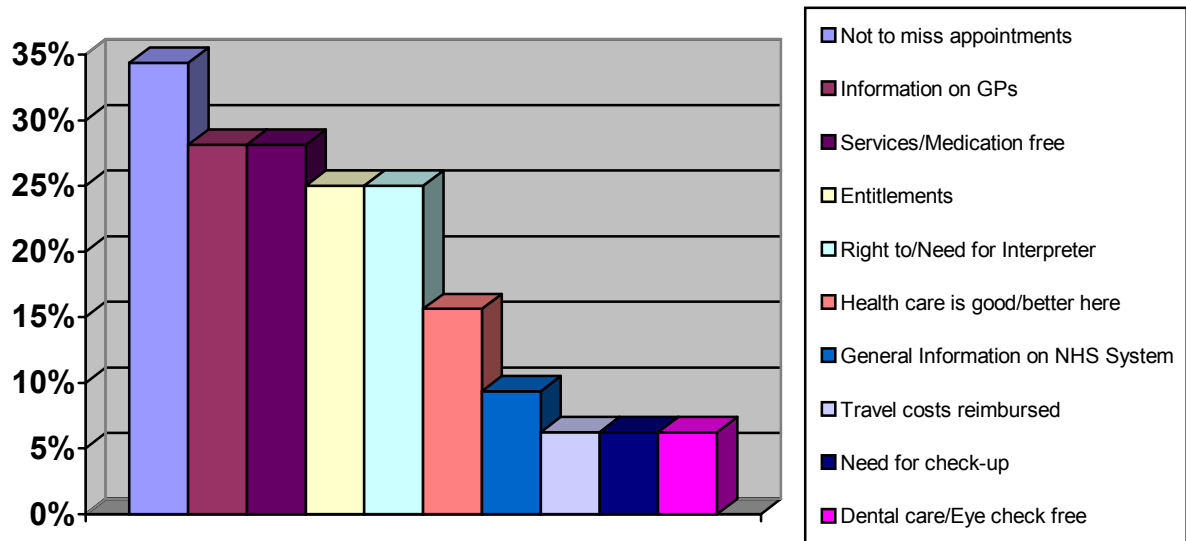
4. Several respondents also specified from whom they had received their information. These sources were:

- An asylum team worker
- The NASS staff
- A Health Visitor
- Respondent's housing provider and N.E.R.S.
- Respondent's friends
- In two cases, member of respondent's community organisation. A woman from Latin America felt that she was lucky to have met someone from her community, as she would not otherwise have received any information. The other, a Serbian male, said that he had received no written information and had relied on the member of his community to help him get registered.

These responses are significant in that, where specified, the provider of useful information is, in all but one case, someone not directly connected to the health service.

6. What would you want to tell a new arrival from your own country about health & health services here? (examples: information on entitlements (interpreters), not missing appointments, right to be seen by a GP, how to get medication & costs etc.)

1. Again, most respondents gave more than one answer to this question. The most frequent responses are represented in the graph below:

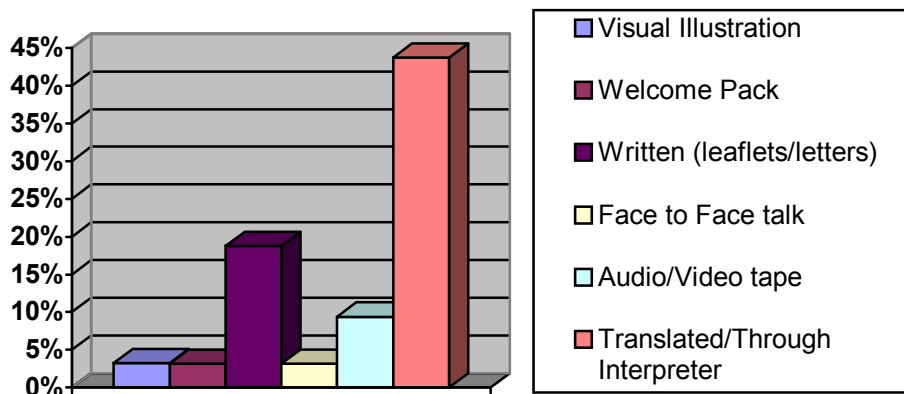


2. The graph shows all responses that occurred more than once. Other responses that arose only once were:
 - The need for appointments except in emergency
 - The fact that some dentists now impose a fine for missed appointments
 - The availability of specialists for mental or other health problems
 - That it is best to have a local GP
 - That the doctor will not prescribe anything for colds or flu (male Afghan in late 40s)
 - The need for an HC2 exemption form
 - An African male respondent wanted to tell new arrivals to contact his community group for further information, advice and support
3. Of the respondents who wanted to tell new arrivals either that the health service here is good or that it is better than in their own country, an African woman and a Turkish man made other points alongside this relating to entitlements and the importance of not missing appointments, suggesting that the system only works well once the new arrival understands how it works and how to access it.
4. Two respondents (one Zimbabwean, one Kurdish) gave no answer to the question, whilst two others (both Sri Lankan), said that they themselves did not have enough information on health services to answer the question.

7. How do you think this information would best be given to someone who has just arrived? (In what form? Who by? Do you have any examples of what worked best for you?) (examples: leaflet, audio tape, video tape, information from community leader, etc.)

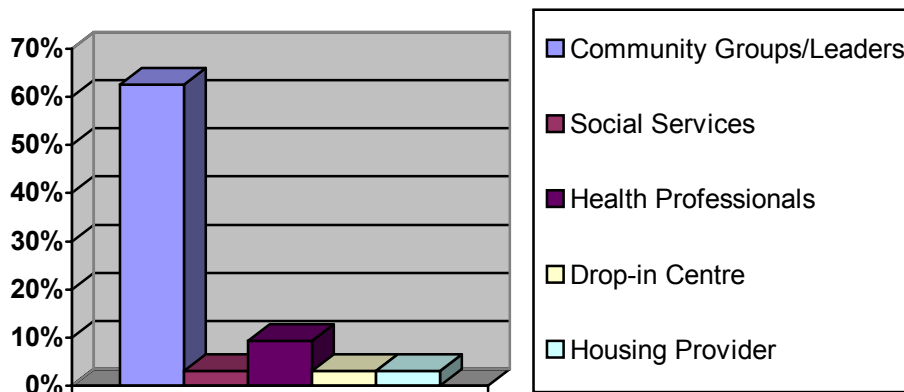
1. As previously, most respondents gave more than one answer to this question.

In what form?



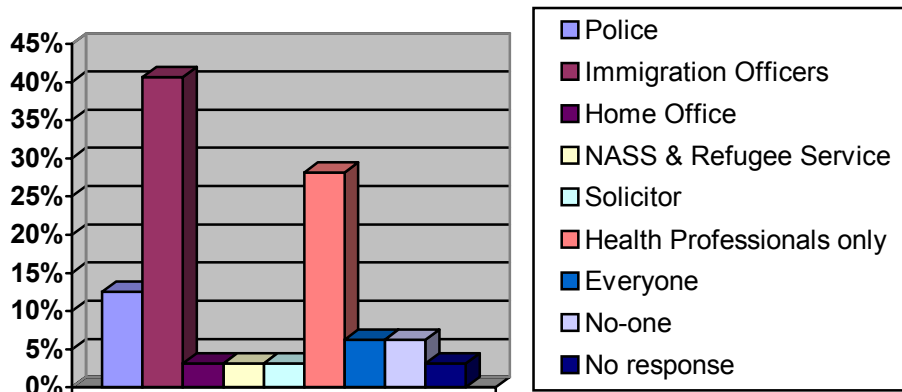
- As the graph shows, whatever form respondents wished the information to take, there was a strong demand for the information to be in translated form or given through an interpreter.

Who by?



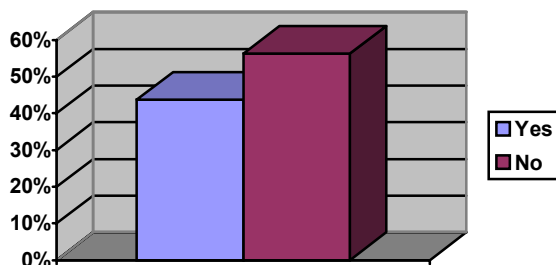
- Again, although some respondents mentioned more than one of the above, there was a very clear preference for the information to be given via community groups, their members or leaders. One Zimbabwean and one Kurdish respondent specified that this was to reduce the problem of language barriers.
- The most striking point was that nearly all of the answers favoured some combination of written (and usually translated) information in the form of leaflets or welcome packs, or visual illustrations or video material, backed up by a human contact on hand to answer questions and explain matters in more depth, usually a member of the new arrival's community group, as shown above. Very few respondents seemed content with either written information or verbally transmitted information on its own.

8. When you arrived, who did you think might have access to your medical records? (examples: police, immigration officers)



1. One Palestinian man stated that he still did not know whether the police and immigration officers had access to his records or not.
2. Of the two respondents who answered 'everyone', one, a member of the Zimbabwean community, gave as a reason 'because I am a foreigner'.
3. One black Caribbean respondent, who thought that police and immigration officers had access to records, made the point that he came from a country where the authorities had access to any information they wanted.

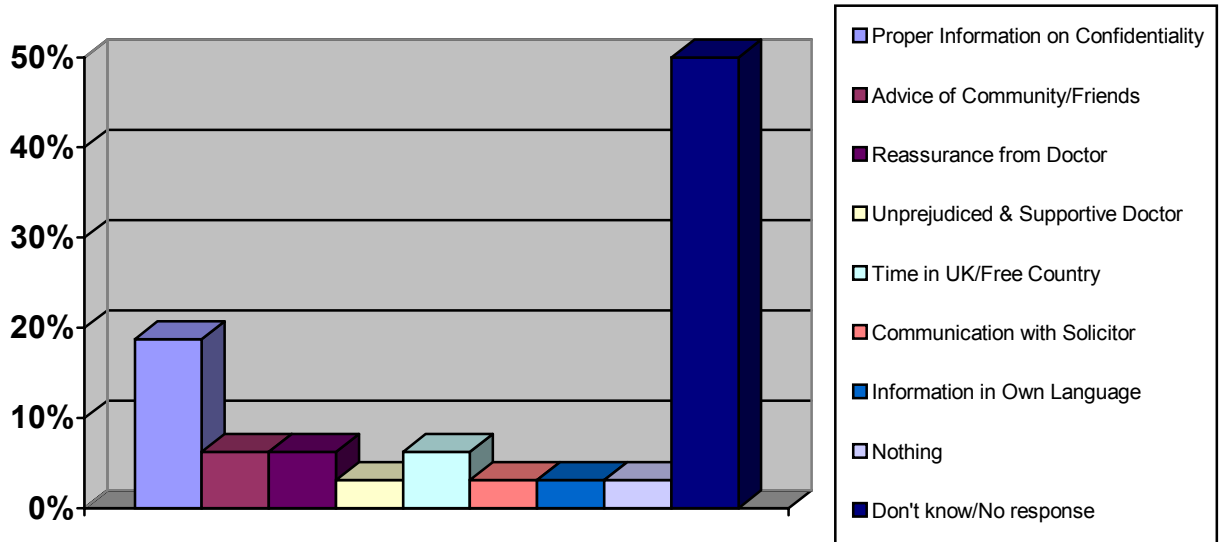
9. Did you ever hesitate to give information to the doctor because you were worried it might affect your asylum case?



1. The graph shows that answers to this question were split fairly equally between the positive and the negative, with 44% saying that they had hesitated to give information to the doctor in case it affected their asylum case, and 56% saying they had not.
2. Two of the respondents who answered 'yes' gave reasons:
 - One Zimbabwean respondent feared that if he was ill he would be sent home.
 - A Kurdish refugee pointed to a fear or impression of receiving discriminatory treatment: "When I met [the doctor] I felt some inequality"
3. One of the respondents who answered 'no', a Palestinian, made it clear that he was only giving this answer because the situation had not arisen, and that

if it did he would not give the doctor any information which might affect his case.

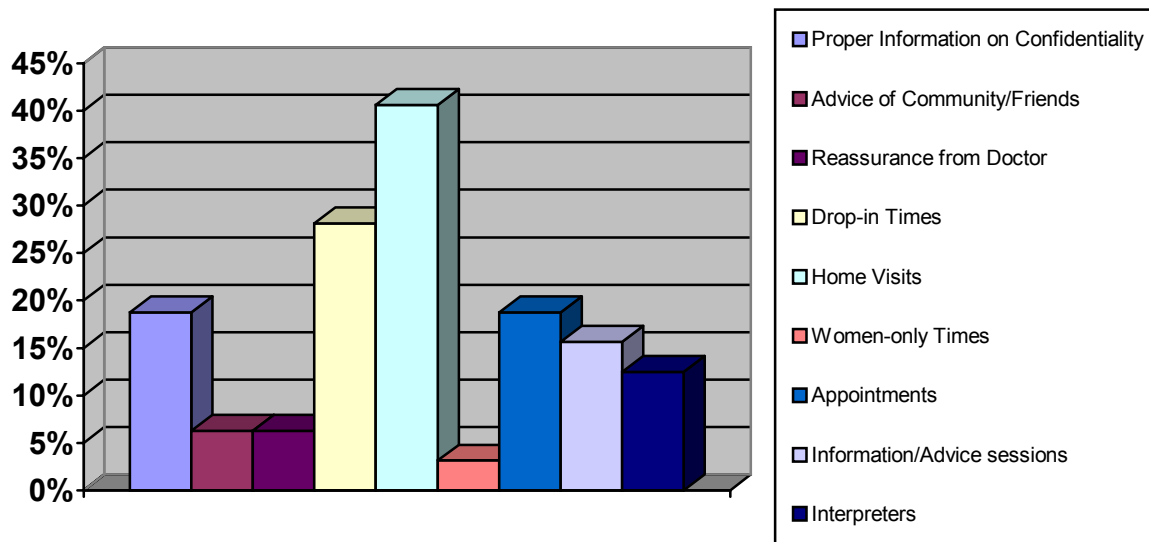
10. What would have helped you overcome these fears?



1. As the graph shows, the most common answer given was the need to provide new arrivals with proper information about the confidentiality of medical records.
2. However, all of the responses seem to suggest two basic factors: firstly, the need for proper information and orientation in an unfamiliar system; and secondly, the need for the health professional concerned to have an understanding attitude – ie, an awareness that new arrivals may well be suffering from such fears.

4.3: Access

11. What do you think would make it easier for a new arrival to gain access to the health service? (examples: drop-in, appointments, women only times, length of appointments, home visit)



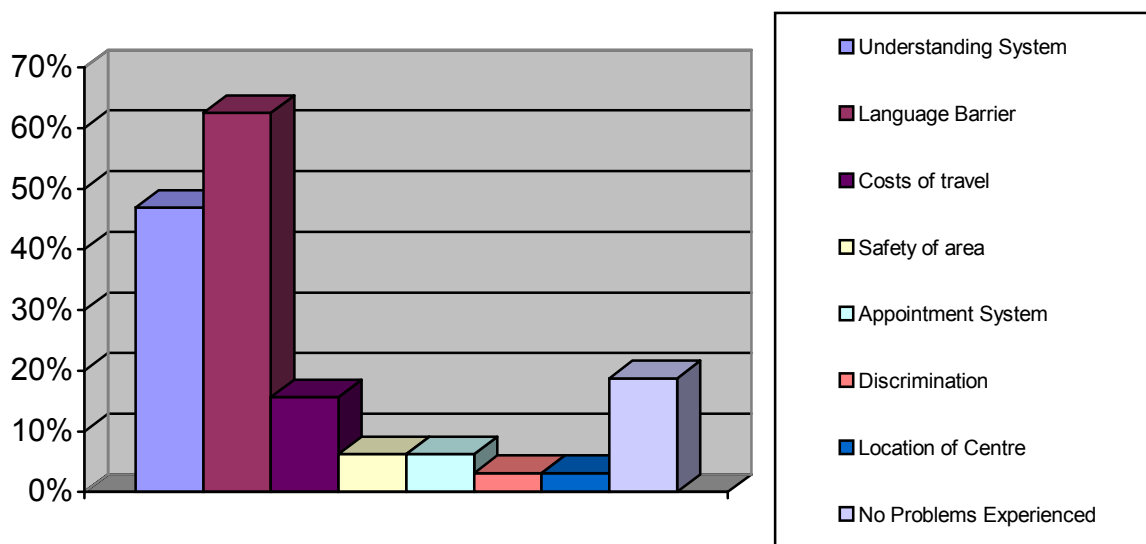
1. Again many respondents gave more than one answer, and the graph summarises these, but some respondents made additional comments that are not presented in the graph.
2. Of those who favoured drop-in times, one Palestinian man commented that this would be especially good for dental treatment, meaning patients would not have to wait and suffer without medicines in the meantime. One respondent from Angola specified that in some circumstances drop-in times would be useful for "registration, screening and assessment" prior to an appointment with a doctor.
3. Of those who favoured appointments as the preferred way of getting treatment, one Afghan man specified that same day appointments would be preferable.
4. Of those favouring home visits, a black Caribbean respondent preferred this option as "[asylum seekers] worry about speaking in front of others". Another felt that a home visit was only necessary the first time
5. Two (both Sri Lankan) made the point that qualified interpreters should be used (in contrast to the practice of taking along friends or family members to interpret and the various problems attendant on this). One of these two (a woman) specified the need for same sex interpreters.
6. A Congolese male interviewed with his family, expressed the need to have a choice with regard to the gender and age of the interpreter.
7. Five respondents, rather than suggesting changes to the way patients are seen, felt that providing preliminary information about the way the health service would be more beneficial for new arrivals. A Turkish woman, who suggested that not knowing where to go and the language barrier are the two main problems for new arrivals, suggested that information of this sort could be provided on a home visit; a black Caribbean man suggested an

initial appointment for the same purpose. Two African respondents felt that advice would be best given through visits by community leaders.

12. What knowledge, skills and training and personal qualities do you think the Receptionist should have to be most effective for someone coming into the clinic? (Examples: experience of working with black & ethnic minorities/people who don't speak English/people of different faiths, patience, communication skills, respectfulness, etc.)

1. Again, most respondents gave multiple answers to this question. The points most frequently mentioned were as follows:
 - Knowledge of/Understanding attitude towards/Experience of working with black & ethnic minorities, people of different faiths, and other minorities or cultures (Mentioned by 53% of the sample)
 - Respectfulness (44%)
 - Patience (32%)
 - Experience of working with people who don't speak English, an understanding of language barriers, language skills (28%)
 - Communication skills (19%)
 - Helpfulness (16%)
 - Tolerant, non-discriminatory attitude (13%)
 - Kindness/sympathy (13%)
 - Friendliness (9%)
2. Also mentioned were the need for slow, clear speech and to be a good listener; the need to be well-informed and qualified; enthusiasm and the ability to put people at ease.
3. All of the responses seem to point for the need for a receptionist who is not just inherently patient, tolerant and open-minded, but also someone with understanding and experience of the particular problems in accessing health services associated with being an asylum seeker, such as the language barrier and the lack of knowledge of the how the UK health system works.

13. What are the main problems you have experienced in accessing a health centre? (Examples: safety of area in which centre is located, costs of travel, disability, language, understanding of system etc.)



- As the graph shows, the most frequent responses to this question centred on problems experienced in understanding the unfamiliar health service and in overcoming language barriers. 38% of respondents replied that **both** of these factors were problems. Only one person, from Zimbabwe, who said that understanding the system was a problem, added that the problem was soon overcome. Additional comments made by the respondents in these first two categories included:
 - Embarrassment caused by not understanding signs in hospitals or by not feeling able to express oneself in English
 - The need to be accompanied by a friend
 - Lack of help from NASS – one Sri Lankan male complained that he was not registered with a GP for nearly a month after arrival, and that NASS did not help until 'someone intervened'.
 - Interpreters not always provided when they are needed.
- Of the two for whom appointments caused problems, an Albanian male answered that it was understanding the appointments system that was a problem, while the other, an Afghan man, said that appointments more than a week ahead were a problem, though he did not say why this was.
- One person, also an Afghan male, implied that discrimination was an issue, saying that 'neglect towards asylum seekers' was the main problem.
- Of those who said that they had not experienced any problems, two respondents, one a Turkish and the other a woman from Latin America, added further comments. Both gave the proximity of their surgery as a reason for their lack of problems in accessing health services, and the former also said that interpreters were provided.

14. People missing appointments is a major problem for the health service. Interpreters must still be paid, and other people are waiting for appointments. They want to know if there are any ways to reduce the number of missed appointments. What different reasons are there for missing an appointment?

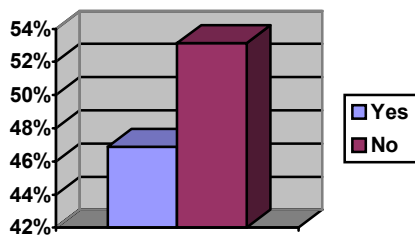
Reasons for missing appointments

1. This question drew a considerable variety of responses, most of which referred, at least in part, to the unfamiliarity of the appointments system.
 - 22% of respondents stated explicitly or otherwise suggested that lack of information about this system was to blame and the appointments procedure was not being explained to new arrivals.
 - Two respondents drew attention to the danger of forgetting appointments specifically because of the long wait between making the appointment and the actual date for attending it.
 - Three respondents mentioned the problem of appointments clashing; one of these specified that they may clash with court hearings.
2. Difficulties caused by language barriers were mentioned by five respondents, two referred to not knowing about the availability of interpreters, two to the difficulties involved in canceling by telephone and one to not being able to read letters received in English.
3. Lack of knowledge of the locality or the transport system was given as a reason by five respondents.
4. Two referred to financial difficulties, with both mentioning the lack of childcare and one the costs of traveling to an appointment.
5. Some respondents seemed more inclined to place blame for missing appointments on the asylum seekers themselves, with four people giving reasons such as carelessness, negligence or simply 'not bothering' (which may relate to apathy amongst people in the limbo that awaiting the outcome of an asylum claim creates). However, one of these responses does seem to hint at a broader problem: '[Asylum seekers are] people without duties and they do not bother about it'.
6. Other respondents also mentioned wider problems in the lives of asylum seekers as a reason why appointments might be missed:
 - Fear that attending medical appointments will affect asylum case
 - Fear of meeting new people
 - 'Unexpected problems that often occur in life of asylum seekers, e.g. receiving solicitor's letter on same day.'

Remedies

7. Several respondents suggested ways to remedy the problems that they listed as reasons for missed appointments:
 - Three suggested reminding patients of appointments, possibly on the day before.
 - An African woman suggested volunteers to accompany new arrivals who don't know how to reach the hospital alone
 - An Iranian woman made two suggestions: a code that could be given over the telephone in order to alert the health service to a cancellation, thus avoiding the difficulty of canceling for those who speak little or no English, and a fine system like that used by some dentists but applied to all appointments.

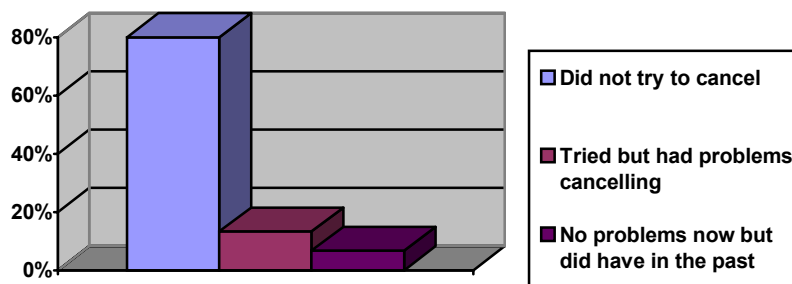
15. If you ever missed an appointment, were there particular reasons for why this happened? (What were they?)



- Reasons given for missing appointments were as follows:
 - Not knowing the area/location of surgery
 - Appointments clashing
 - Forgetting
 - Not knowing about availability of interpreter
 - Arriving late from college
 - Fear that attending would affect asylum case
 - Waiting for a support worker/refugee assisting service who did not arrive
 - No access to childcare
 - Appointments are too long
- Of those who said they had not missed appointments, an Iranian woman said that she always informed the surgery if she could not keep an appointment, and a Black Caribbean man said that as a doctor himself he understood the implications of missed appointments.
- One other, a man from Senegal, said that people should be made aware of what it costs the health service per day, believing that this would help to reduce the number of missed appointments.

16. Did you try to cancel the appointment? Did you have any problems in doing this?

- Some of those who had not missed an appointment also answered this question, showing that they had been successful in canceling, although one of these, a Kurdish respondent, did mention that he/she had had language problems doing so.
- For the 47% of the total sample who had missed an appointment, the answers are shown in the graph below:



3. Of those who did not try to cancel their appointments:
 - A third said that this was because of the language barrier.
 - One respondent said that she didn't know the system.
 - One respondent arrived late. This respondent, an African woman, added that when she did arrive she was given advice on not missing appointments.
 - An Albanian man who had tried but failed to find the surgery at which he had an appointment added 'but if I wanted to cancel, who would understand me at the surgery?'
4. Both of the two respondents who had tried to cancel but had problems doing so said that this was due to language difficulties. One also added that canceling was harder because she did not have a telephone.
5. The respondent who said that he no longer had problems canceling but that he had done in the past, an African man who had been in the UK for over three years, said that the difficulty had been in explaining himself on the telephone.

4.4: Immediate Medical Needs

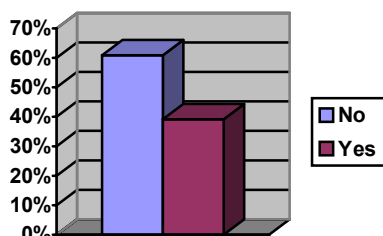
17. What were your own immediate medical needs when you first arrived in this country? (the health service needs to understand the full range or variety of health problems that people arrive with)

1. Responses to this question were many and varied, as listed in full below:
 - Psychological situations: headaches, thinking too much
 - Dental check, blood test, war injuries
 - Flu because of cold weather here
 - Headache
 - Terrible stomach problem – not cured for 5 months
 - Immunisation and full medical check-up
 - Problems with sleep because of trauma in own country
 - Full medical check-up including HIV and blood sugar level test
 - Full medical check-up
 - To find nearest GP
 - To be seen by GP as medication was needed
 - Was pregnant so needed immediate attention
 - Problem with wrist
 - Needed contraceptive pills (couldn't get because no same sex doctor available)
 - High blood pressure
 - Anxiety; teeth problems
 - Depression
 - Dental care
 - Epilepsy
 - TB; diabetes
 - On and off fever (malaria)
 - Nothing serious
 - None, as I was used to having medicals in my own country
 - None
2. That five respondents (four of them African and one Afghan) expressed the need for a full medical check-up highlights the fact that new arrivals in the UK are likely to have medical needs relating to flight and the conditions that they have fled, some of which may have gone unmet for some time.
3. Some of the health needs identified could be particular to asylum seekers as a group, including:
 - Illnesses which were tropical or no longer common in the UK (malaria, TB)
 - War injuries
 - Psychological factors – sleep problems, headaches, anxiety, etc. One Sri Lankan man specified that this was due to trauma experienced in his own country.
4. A Turkish woman made a link between her immediate health needs and problems of cultural differences. She had needed contraceptive pills but was not willing to ask her male doctor for them.
5. The need for an HIV test was mentioned by one Congolese man.
6. 22% of respondents said that they had had no immediate health needs, or felt that any needs they had had were not serious enough to be worth

mentioning. Of these respondents, three were African, one was Kurdish, one Serbian, one Latin American and one Sri Lankan.

*** Don't ask question 18 if no immediate medical needs were given for question 17.*

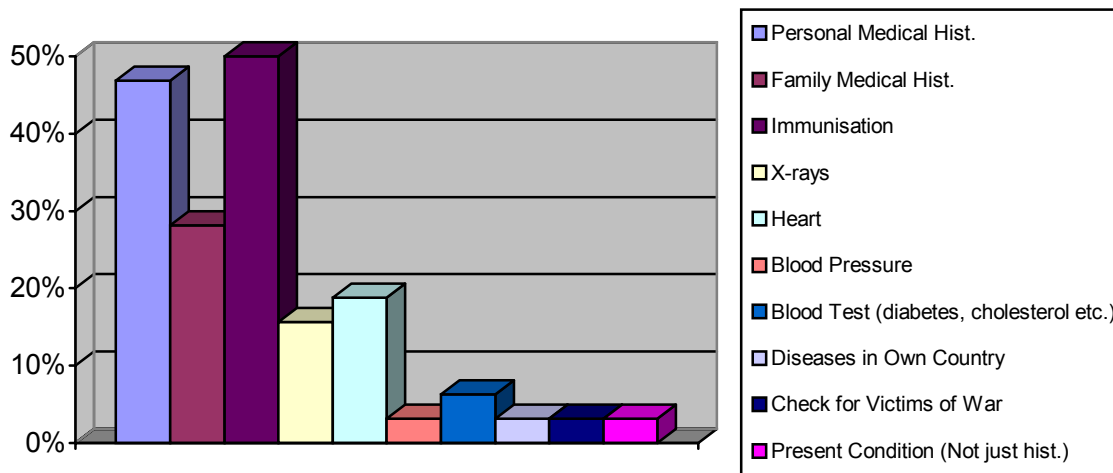
18. Do you feel that your immediate medical needs were adequately met when you first arrived in the UK? Who provided the medical attention and what happened?



1. 72% of the total sample answered this question. The remaining 28% either gave no immediate health needs for question 17 or did not answer the question.
2. Of those who felt that their immediate medical needs were not met, the reasons given were as follows:
 - Long waits for appointment, or had no GP at all. The black Caribbean respondent said that he had not been seen for three months whilst in London, and had only got a GP since coming to Newcastle. The Albanian man said that he had waited three weeks for a doctor's appointment and four weeks to see a dentist. One Zimbabwean respondent answered 'no' because the appointment was such a long time away that he/she got better in the meantime.
 - Doctor didn't have time to do a full check-up
 - A Turkish woman said that her needs were not met as she could not discuss her needs with a male doctor.
 - A Zimbabwean respondent complained of flu because of the British weather in question 17, and felt that his needs had not been met because he was told there was no medicine for flu.
 - Given tablets but they have not been effective (for sleep problems/nightmares).
3. Of those who felt that their immediate health needs had been met, three specified that this was because they had received medication.
4. One person specified that help had been supplied by her accommodation provider. Another had called the police, who had arranged for medical assistance in an emergency (the emergency was not specified).

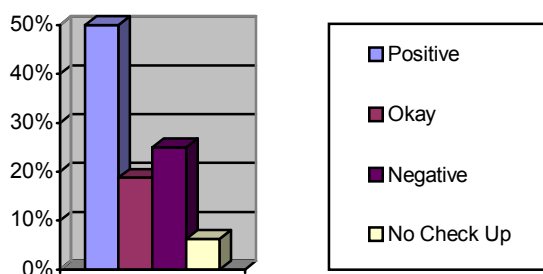
4.5: First Full Medical Check Up

19. On your first full medical check up, what do you think are the most important things to check? (examples: immunisation, family or personal medical history, heart, x-rays, etc.)



1. Again, the overall frequency of each answer is shown in the graph above, but most respondents made more than one answer. Most favoured some combination of a check up of the current state of health with examination of personal and family medical history.
2. The importance of checking matters which may be particular to asylum seekers is again raised, not only by the fact that 50% of respondents wanted immunisation to be checked but also by the respondents who mention the need to check diseases common in the new arrival's own country, and the need for a special check up for victims of war.

20. What was your experience of your first medical check-up? Was it good or bad? Why?



1. Within each category there was considerable variation in the intensity of the answers to this question – positive responses ranged from 'good' to 'very

good' to 'excellent', whilst negative answers ranged from 'not good' to 'bad' to 'very poor'.

2. Amongst those whose experience was good, 81% of respondents gave reasons for this. Reasons relating to quality of service were:
 - Appropriate medicine prescribed
 - Blood test given
 - Found out what (if anything) was wrong
 - Referred to hospital

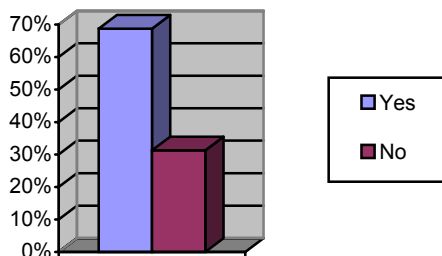
Reasons relating to attitude of health professionals were:

- Helpful
 - Kind
 - Considerate
 - Friendly
 - 'The doctor asked simple questions and made me feel comfortable' (Senegalese male)
3. A Serbian male (the respondent who felt that his check up had been excellent) described the check up as 'very professional', a description that seems to encompass both the attitude and the treatment experienced.
 4. One respondent, a Zimbabwean, felt that his check up had been a good experience as a result of the fact that s/he had had all medical conditions treated in his/her own country.
 5. Of those whose answers have been categorized as 'okay', four were women and two men. Some made additional comments:
 - A Turkish woman said that 'compared to my own country I was quite satisfied'.
 - A Sri Lankan woman whose overall experience was okay commented that it was embarrassing to give personal details to a stranger, and this had been compounded by the presence of a male interpreter.
 - One other respondent, an Eritrean woman, said simply that she felt uncomfortable as it was her first time.
 6. Most of the comments from those whose experience had not been good centred on their feeling that the check up and treatment was cursory or incomplete:
 - The doctor from the Caribbean said that he was told his blood pressure was okay when, as a doctor himself, he knew that it was not at the proper level
 - An Angolan man mentioned a hearing problem but said that nothing was done about it.
 - Another Angolan male respondent said that the doctor had refused to do a complete check.
 - The Albanian male respondent's comment suggested a rushed and superficial check up: 'blood pressure, height, weight and go'.
 7. Another complaint, made by a Zimbabwean respondent, was that it was not explained what was happening. The same respondent also objected to the check up being done by a person of the opposite sex.

21. What would have made your first check up a better experience?

1. Not surprisingly, most of the answers to this question came from those who had recorded bad experiences in the previous question, although two of the respondents who had had good experiences, and one of those who had had no check up at all, also made suggestions for improvement.
2. Answers concerning the quality of treatment were:
 - Better/more equipment and staff
 - Blood test and x-ray
 - Health examination and analysis. This response was from the Angolan man who previously said that the doctor refused a full check up. The respondent said that all that he did was to fill in a card with details of his family medical history, and pointed out that the examination was needed as 'I am coming from a different country with lower health standards and medical care'.
3. Answers concerning the attitude of health professionals were:
 - Explanation of what is being done and why
 - The Caribbean doctor commented about his poor experience of the check up that 'I feel that it was not so much incompetence as discrimination'
4. Answers relating to cultural factors were:
 - Same sex doctors/interpreters; this was mentioned by three respondents, with a fourth, a Congolese man, implying that health professionals should at least be sensitive to this factor, as he was uncomfortable with a female doctor touching his chest without asking.
 - Interpreters
 - Doctors of roughly same age
5. There was some contradiction as to whether it was preferable to be alone or accompanied during the check up. One Palestinian man was not concerned about a same sex doctor but wanted to be seen alone, whilst an Angolan woman specified that she would have preferred to have an interpreter and 'someone to go with'. There is not enough evidence to say whether this is a cultural factor, a gender difference, or merely something over which people wish to exercise a personal choice.

22. Do you think that this is also the right time to discuss any psychological issues?

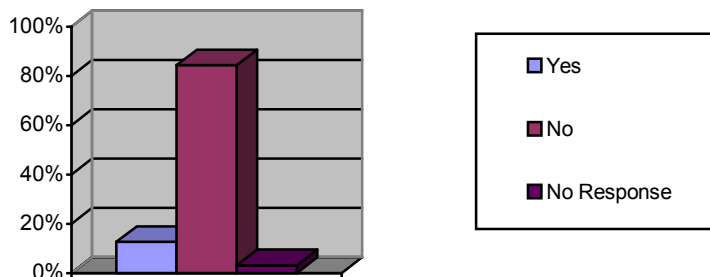


1. Of those who answered yes to this question, three respondents' answers suggest that this may be the most important thing to discuss at this stage:

- A Tanzanian woman (a single mother) said this explicitly, also relating the importance of this need to the fact that asylum seekers have frequently left family behind.
 - The Caribbean man pointed out that 'most people arrive in a state of panic'.
 - A Latin American woman believed that 'All asylum seekers have psychological issues to talk about and many keep them secret for a long time.'
2. A Turkish woman pointed out the need to be assured of confidentiality first, and an Angolan respondent (the same man who was refused a full check up) cautioned that discussion of such matters would have to be coupled with a full medical check up to 'reveal the degree of psychological issues'.
 3. Of those who answered no, two felt that it was simply too soon to discuss such issues, and another respondent expanded upon this, suggesting that the right time would not be until after submission of an asylum claim.
 4. One respondent, an African woman, hinted at a cultural difference, saying 'I don't want those bad memories back in my head', in contrast to the notion that discussing and confronting such memories is part of a recovery process.

4.6: Culturally Sensitive or Appropriate Service

23. Did you experience any aspect of the health service that seemed insensitive or inappropriate to your cultural background?

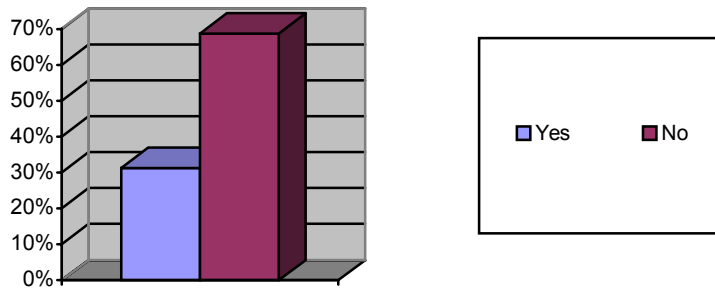


1. As the graph shows, the majority of respondents – 84% - answered in the negative. However, three of these respondents added further comment:
 - A Congolese man answered 'not personally', perhaps suggesting that he knew of or believed there were others who had experienced service that they felt was culturally insensitive or inappropriate.
 - A Sri Lankan man answered no but added that his wife would have preferred a female doctor.
 - A female Turkish respondent also said that she 'sometimes' needed a female doctor, but that she had been able to arrange this when necessary.
2. Of the 13% who answered 'yes', two added comments:
 - A male Zimbabwean respondent felt that a female doctor discussing condoms and STDs with him was inappropriate.
 - A black Caribbean man felt that doctors in the UK were in such a hurry that patients may become nervous and flustered.

24. Can you make any suggestions as to how this could be improved?

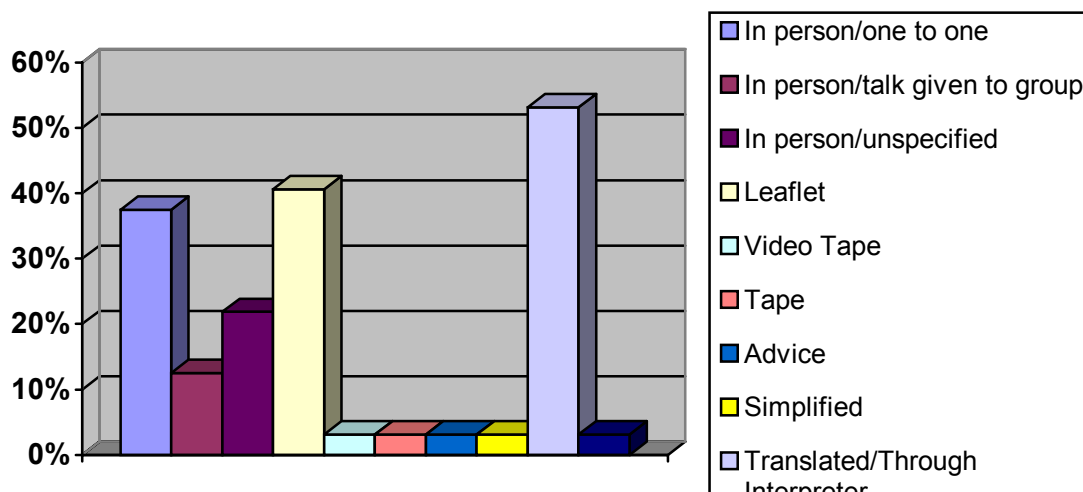
1. All of those who answered 'yes' to the previous question made suggestions in answer to this question.
2. The most frequent response, mentioned by 6 respondents, concerned the need for greater sensitivity to different cultural norms regarding male-female relations, with 5 of these responses specifying the need for same sex doctors or interpreters.
3. The other responses concerned better communication and exchange of information between asylum seekers and the health service. In some cases answers focused on providing better information so that asylum seekers know what to expect, and in others on ensuring that the NHS and its staff are and well-informed about cultural differences and sensitive to the need to allow for these differences wherever possible.
4. One respondent suggested more time for consultations, perhaps implying that a more relaxed and in-depth consultation would enable doctor and patient to understand each other better and thus help to alleviate difficulties caused by cultural differences.

25. Is there any treatment or medicines that you could get in your own country that you cannot get through the health service here?



1. As the graph shows, 31% of respondents said that there were treatments that they could not get through the health service in the UK that would have been available in their own country.
2. There were 8 respondents who elaborated on this:
 - Two referred to medication for illnesses unknown or uncommon in the UK (malaria, tropical diseases generally).
 - Three referred to herbal or 'traditional medicines' (respondent's own description)³ not used in the UK.
 - One Palestinian man said that in his country, unlike in the UK, medicines such as tranquillisers were given to patients 'before examination is complete'.
 - A Zimbabwean man referred to treatments for colds and flu being unavailable through the health service here.

26. How would you prefer very personal information – for example information/advice about sexual health or contraception – to be given to you? (examples: translated leaflet, audio tape, video tape, one to one talk with male/female health worker, talk to a group by a health promotion specialist, etc.)

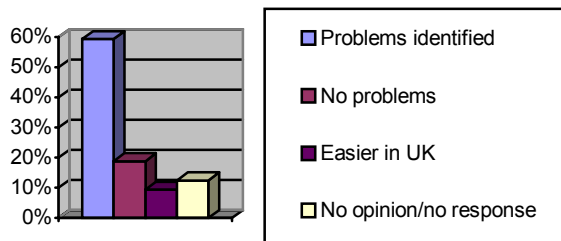


³ Here 'traditional' refers to culturally specific understandings of disease and its treatment.
Accessing Health Services for New Arrivals: The Refugee Perspective
 North of England Refugee Service report for Newcastle PCT PMS Pilot
 November 2002

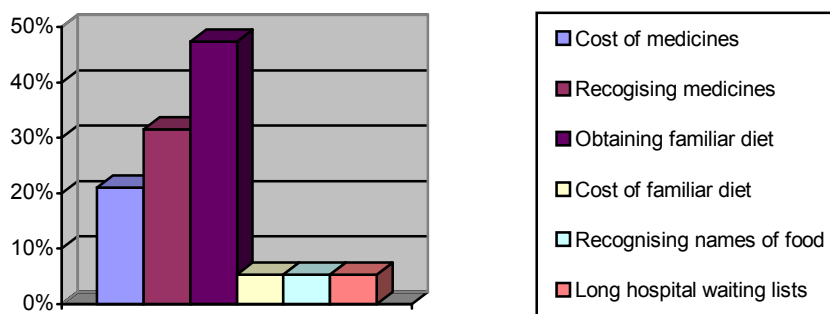
1. The single most frequently-made point was the need for information to be translated or interpreted, a point made by 53% of respondents.
2. One respondent, a Sri Lankan woman represented by 'simplified' on the graph, made the point that information should be 'suitable for people with little understanding of health matters, especially sexual health and contraception'.
3. A similar trend prevailed to that found in responses to Question 7, in that numerous respondents (22% overall) suggested a combination of translated written, audio or visual material with the opportunity for one-to-one or group discussion, rather than simply advocating one or the other.
4. 38% of respondents specified that health specialists or health workers should provide the information.
5. Two respondents raised the issue of confidentiality. A Palestinian man favoured one-to-one communication, as this allowed greater confidentiality, whilst a Turkish man said that he would prefer to arrange an interpreter for himself to be assured that it was someone who he could trust.

4.7: Looking after your health in other ways than going to a GP

27. How easy or difficult do you find it to look after your health here? (reasons? Examples: cost of obtaining medicines, recognizing equivalence in medicines between own country & UK, type of diet eaten in UK, etc.)

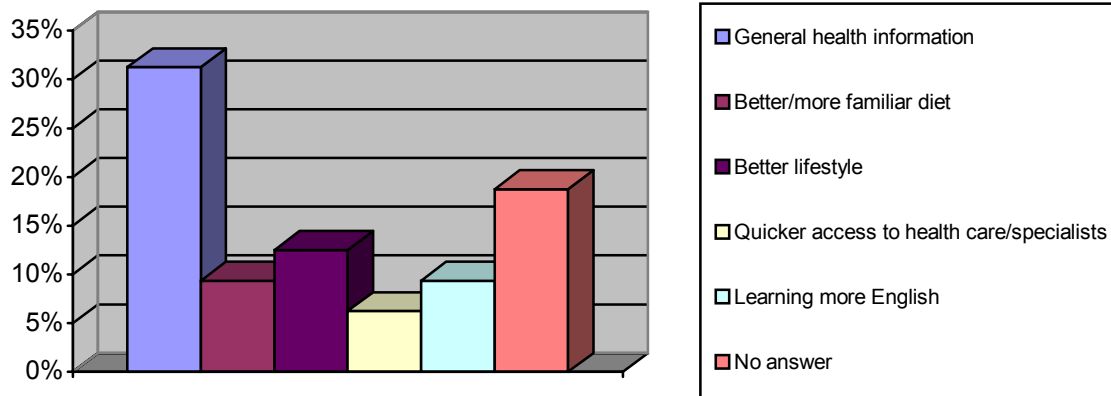


- Of those who said that either that they found it easier to look after their health in the UK or that they had no problems doing so, three gave reasons, but two of these related to the health service here rather than looking after one's own health:
 - A Turkish woman said that access to GPs and treatment was quicker in the UK.
 - A Kurdish respondent said that it was easier because the NHS is free.
 - One respondent, a Sri Lankan woman, said specifically that she had no problems obtaining medicines or food that she was used to.
- 59% of respondents did identify problems that made looking after their health more difficult in the UK. Their responses are represented in the graph below (given as percentages of those who identified problems):



- As the graph shows, the most common problems relate to the differences in diet, although the cost of obtaining medicines was also a significant problem.
- 78% of those who found it difficult to obtain the diet they were used to were African, as might be expected of a region with very small African or Caribbean populations.
- One of the respondents who mentioned the cost of medicines pointed out that pharmacies only accept the HC2 exemption form for prescriptions: no assistance is provided towards the cost of non-prescribed medication.

28. What do you think would improve your ability to look after your own health here?



- The graph shows all responses that occurred more than once. Other responses which were mentioned by only one respondent each were:
 - More information on medicines
 - Community support (having caring friends and neighbours)
 - Better financial situation
 - Ability to go to London regularly to buy suitable food
 - Open access clinics
 - Acceptance of HC2 exemption form for non-prescription medication
 - 'Health authority should fight more for our inclusion because today I feel more included than I felt last year.' (African male respondent)
 - A change of weather
- Of those respondents who wanted more information on health, the health service and health living, three specified that it should be supplied in their own languages.
- The responses counted in the 'better lifestyle' column include comments such as:
 - Access to gyms, swimming, etc.
 - Better 'personal habits'
 - Living in a clean environment
 - 'Balanced lifestyle, i.e. work, money, social life – this is beneficial both mentally and physically.' (African male respondent)
- Two respondents felt that learning more English would improve their ability to look after their own health, for different reasons:
 - An Eritrean woman felt that knowledge of English would help her to understand more about the British way of life and diet.
 - An Albanian man said that it would help him to explain himself and to talk on the 'phone in case of emergency.

29. For the following four services, please answer: What is your understanding of the service?

(i) NHS Direct

- 63% either said that they had little or no knowledge, or gave no answer to this question. A further 22% answered the question but either knew only what the

abbreviation stood for, or had misunderstood what the service was. Therefore, in effect, 85% would not know how to access the service effectively.

- Three further respondents pointed to the need to speak English in order to use the service; two of these respondents (both Palestinian) believed that the service was only available to native English people.
- The most accurate description of NHS Direct came from a Senegalese man: 'Direct line where you can get help or support'.
- The Caribbean respondent (a doctor) said that he knew the principles of the service but did not believe that diagnosing by telephone was a good idea.

(ii) Walk in Centre

- This time 81% either stated that they had no knowledge of this service or did not answer the question. One further respondent answered only that this service was available to anybody.
- Three respondents thought that the name referred to a doctor's surgery, or a community health centre where a GP could be found.
- The remaining two respondents (an Eritrean man and an African woman) accurately described the Walk In Centre as a 'clinic where no appointment is needed.'

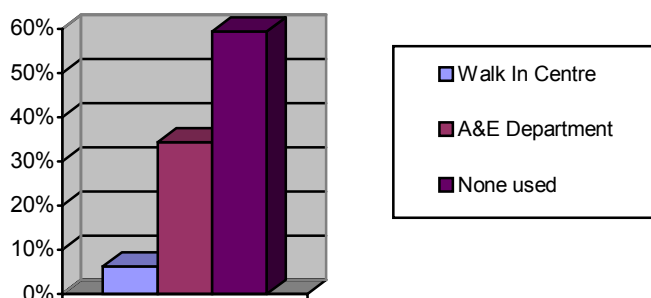
(iii) Minor Injuries Unit

- 53% had no knowledge or gave no answer. A further 34% gave accurate answers but did not provide any more information than the name 'Minor Injuries Unit' already conveys, so it is hard to know how good their knowledge actually was. Therefore, 87% would not know how to access this service effectively.
- Two respondents (both Angolan, a man and a woman) knew that treatment was provided by nurses rather than doctors.
- One, a Bosnian man, said that the Unit was part of A&E.
- One respondent said only that the service was the same as in his own country.

(iv) Accident and Emergency Department

- 19% had no knowledge, or gave no answer. 41% gave accurate answers but only insofar as the name of the department describes what it does. Again, this is equivalent to 60% being unable to access the service efficiently.
- Three respondents said only that they understood it or had used it without elaborating, and again one respondent (not the same one) said only that it was the same as in her own country.
- Three respondents knew that the service is attached to hospitals. One knew that it was the service connected with '999' calls.
- Two respondents specifically mentioned that children can be taken there if they have an accident. One of them, a Sri Lankan man, also knew that the department is open round the clock, as did one Zimbabwean respondent.
- One respondent described the department as 'very slow', and another commented that the staff there 'work under enormous pressure'.

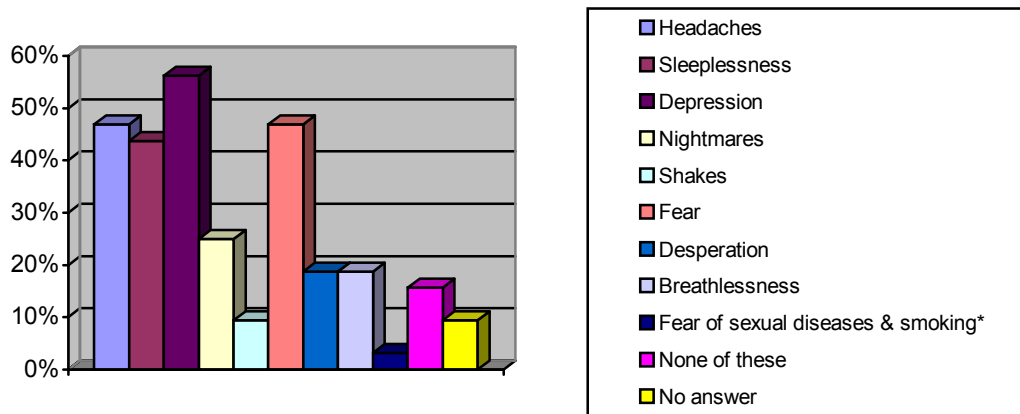
30. Have you used any of them? If so, which, and what did you think of them? Can you suggest anything that would make them work better?



1. Of the two respondents who said they had accessed the Walk In Centre, a Congolese man did not comment, whilst an Angolan man said that it had been fine.
2. Of the 34% who had accessed A&E, just under half were happy with it. Two specified that this was because of the treatment, one because 'the staff work very hard', and one because she was seen quickly.
3. Of the other respondents who were not so happy with the service, 5 said that this was because of long waiting times.
 - One of these respondents, a Palestinian man, suggested 'segregation of different cases' (presumably according to how serious they are?) to speed up the service.
 - One Afghan man complained of being asked the same questions by numerous members of staff 'which makes the patient fed up.'
4. A Sri Lankan woman said that the problem she had with the service was that there was no interpreter available and she spoke no English.
5. Of those who answered that they had not used any of the four services, one suggested more doctors at A&E, as well as pointing out that asylum seekers don't use NHS direct because of the language barrier.

4.8: Mental Health

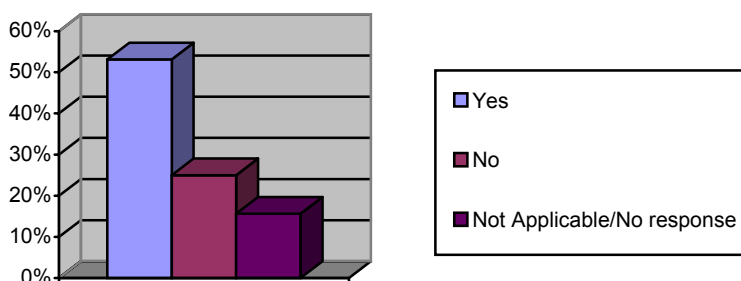
31. Do you suffer from, or have you suffered from, any of the following: headaches, sleeplessness, depression, nightmares, shakes, fear, desperation, breathlessness?



*This point was added by a male Palestinian respondent.

- 75% of respondents identified with at least one of these conditions.

32. Have you ever sought help for this from a GP?



- 53% of respondents had sought help from a GP for conditions that could be associated with mental health.

33. If you answered 'no' to question 32, why not?

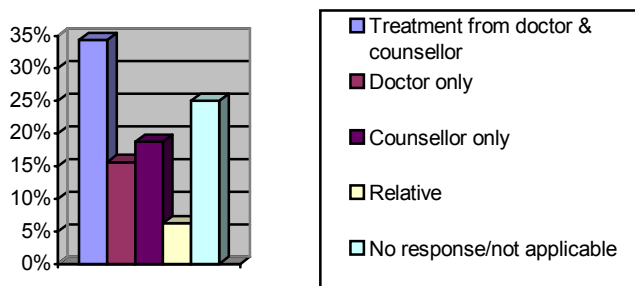
1. Most of the responses here seemed to concern different perceptions as to what kind of problem the above symptoms represented and how to deal with the problem. Two respondents, a Bosnian and an African man, believed that the doctor would be unable to help. Four respondents took such symptoms for granted as asylum seekers.

- 'I don't think its important as all asylum seekers suffer from these ailments' (Latin American woman)
 - 'I already knew where my nightmares were coming from – [...] worries about the asylum claim' (Black African man)
2. A Congolese man felt that he needed a specialist rather than a GP, but had not apparently requested or been offered referral.
 3. One Palestinian man answered: 'Not permanent resident – stranger', suggesting lack of knowledge about entitlements, or possibly a belief that cultural differences or perhaps discrimination in the health service would prevent him from receiving appropriate treatment.

34. If you answered 'yes' to question 32, what was the response? Were you satisfied with the attention you received and did it help?

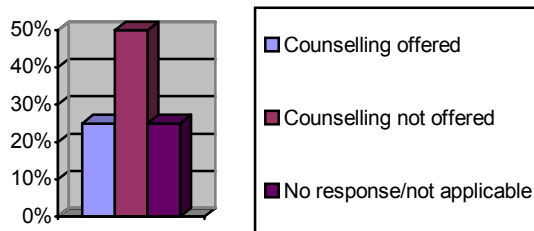
1. 53% said that they were satisfied with the attention that they had received:
 - One Angolan woman experiencing headaches, depression, nightmares and fear specified that her GP had helped.
 - One Zimbabwean man said that the tablets prescribed and counseling arranged for him for headaches, sleeplessness and depression had helped.
2. The remaining 34% were not happy with the response. These respondents were generally more forthcoming with reasons:
 - A Palestinian man said that the doctor had taken an interest, but that his help had been limited to advising the respondent to stop smoking.
 - A Tanzanian woman was not satisfied with being told to take paracetamol for headaches, sleeplessness and fear.
 - An Albanian man felt that 'the help was a sort of trial', with different tablets being tried out on him.
 - One Afghan man who had suffered from depression was not satisfied, saying: '[The] doctor told me he can't change facts in my country and said it was something caused by these problems, and is not curable'.
 - Two respondents (both Sri Lankan and both saying that they suffered from all of the symptoms listed in question 31) said only that they had been prescribed tablets.

35. What do you think would have helped you deal with these problems? (eg. Treatment, counseling) What person would you prefer to give you any help needed? (eg, doctor, counselor, relation)



1. A Latin American woman commented: 'All asylum seekers need a bit of counseling'
2. One African man said that counseling would help but 'the real help will come from the Home Office'.

36. Were you offered counseling for such problems? Do you think that counseling would help? (by discussing your problem/how you feel with a trained therapist)



1. Of those respondents who were offered counseling:
 - Two thirds felt that it had helped them.
 - An Iranian woman, who had suffered from headaches, sleeplessness, depression, nightmares, fear and breathlessness, had not taken up the offer as she felt that the medication she was receiving from her doctor was helping.
 - An Afghan man said that it did not help; he would have preferred medication for depression but said that the doctor did not give him anything.
2. Of those respondents who were not offered counseling for their problems, the majority, 81%, felt that it would help.
 - Two of these respondents (both Kurdish) said that they were not offered it because they did not need it, but felt in general that counseling would help people with such problems.
 - Two others (both Palestinian) stated that counseling was preferable to taking drugs.
 - An Albanian man felt that counseling would help but 'was not offered...until I insisted on it. The doctor looked at me blankly'.
3. Two of those not offered counseling, a Turkish and a Sri Lankan man, did not apparently feel that it would have helped, though both had recorded suffering from several of the problems in question 31.

37. What type of help could you expect in your own country?

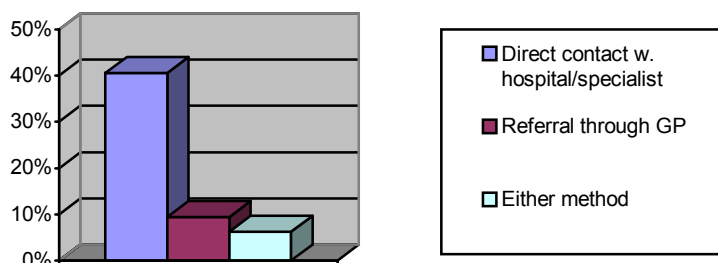
1. 25% said that help would be similar to the help offered in the UK: some combination of mental health specialists, therapy, counseling and medication.
2. Another 25%, Two thirds of whom were from Africa, said either that little or no help would be available in their own country, or that it would be worse or 'no better' than in the UK. However, one African woman made the point that she did not have the same problems in her own country.

3. Two other respondents, one Sri Lankan and one African man, also made the point that they did not have the same problems in their own country.
4. A Turkish woman pointed out that a doctor in her own country would be able to help more because she could talk in more detail in her own language.
5. Other respondents referred to differences (material and cultural) between the approach to treatment for such problems in the UK and their own country:
 - A Latin American woman said that services were private in her country (presumably creating a financial barrier for many) but suggested that people did not tend to seek such help anyway for fear of what others would think of them.
 - An Eritrean woman said that the help available in her country would consist of 'prayer and counselling', highlighting the fact that people from some other countries would still tend to turn to the church, in contrast to the now largely secular approach to counseling in the UK.
 - An Albanian man commented that he did not 'want to make any comparison – just want to forget where I come from and my past and concentrate on the future'. This draws attention to the fact that while the tendency in the UK would be to see remembering, and talking about traumatic experiences or negative feelings, as a positive part of a healing process, the norm in other cultures is sometimes just the opposite.

4.9: Access to secondary health care

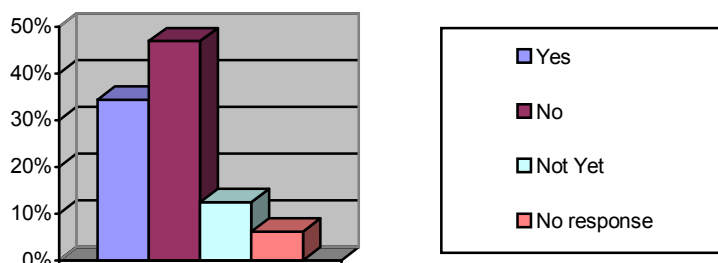
(Definition of secondary health care provided here: care that its provided by health specialists or hospital staff members, for a patient who has already been diagnosed or treated by a GP doctor and then referred on)

38. How did you access specialist medical treatment in your own country?



1. The graph demonstrates the potential for frustration or confusion amongst asylum seekers when trying to access secondary health care in the UK, considering that, overall, 47% said that direct access was possible, compared to only 9% who specified that access, as in the UK, had to be gained through a GP referral.
2. The direct approach was not uniformly a good thing; although a Turkish man pointed out that it meant a much shorter waiting time than in the UK, two respondents, one Tanzanian and one Iranian woman, added that this was coupled with a system of paying for appointments and treatment. Another Turkish respondent said that she had accessed specialist treatment via a GP referral, but that the waiting time was still much shorter than in the UK.
3. Another 16% answered that they had never accessed specialist treatment in their own country, whilst one Bosnian man said that he had been refused access in his own country.
4. One African man referred to traditional medication as a possible alternative or parallel route to a cure for conditions not treatable by a GP.
5. Two respondents, both African women, said only that access to specialist medical treatment was worse in their own country than in the UK.

39. Have you tried to access specialist medical treatment in the UK?



1. Only one respondent added any additional comment to this question, a Palestinian man who said no 'because of the referral system'.

40. If yes, what was your experience? (ie, waiting time, quality of service, etc.)

1. Of those who had tried to access specialist medical treatment in the UK, 73% said that the waiting time was too long.
 - One Afghan respondent said that this had prevented him from accessing treatment altogether.
 - Two respondents, an Albanian man and an Eritrean woman, said that although the waiting time was too long the quality of service had been good.
 - One of the respondents who had not tried to access specialist treatment also added that he had heard from friends that the waiting time was long in the UK.
2. Two respondents, a Congolese and an Eritrean male, said only that whatever treatment they had had was successful.
3. A Sri Lankan woman, who also commented on long waiting times, added: 'Lack of trained interpreter when appointments are made make it hard to keep them'.
4. A Bosnian respondent was happy with both waiting times and quality of the service he had received, saying 'The health service is in first place of all services in the UK (ie police, fire, etc.)'.

5. Acknowledgments

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*North of England Refugee Service
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