

**Refugees and Primary Health Care
in the West Midlands**

Research Paper in Ethnic Relations No.25

by

Mark R.D. Johnson

and

Oladele Augustine Akinwolere

Centre for Research in Ethnic Relations
University of Warwick
Coventry CV4 7AL

August 1997

Midlands Refugee Council
The Argent Centre
60 Frederick Street
Birmingham B1 3HS.

Mark R.D. Johnson is Senior Research Fellow at the Centre for Research in Ethnic Relations, University of Warwick. He has developed a substantial body of research and publications relevant to health and welfare service delivery in multi-racial and multi-cultural settings, and regarding barriers to access in service delivery. He has also acted as a consultant with Health and Local Authority bodies and community voluntary organisations in the development of more appropriate models of service delivery, and the development of training for professional workers. Recent publications include 'Invisible Minorities: Community Needs in Dacorum', 'Dealing with Diversity', and book chapters on Culture, Race and Discrimination in Psychiatry, Equal Opportunities in Service Delivery and using 1991 Census data.

O. Augustine Akinwolere is a medically qualified doctor with masters degrees also in Immunology and has worked in the health services abroad and in England. He retired voluntarily from the University of Ibadan as a Senior Research Fellow with several publications in Child Health, Community Health and Infectious Diseases. He has also organised and presented at several national and international seminars, workshops and conferences, including the World Health Organisation. He is the Refugee Health Promotion Manager at the Midlands Refugee Council, a registered Charity in England, advising on the health of refugees from different parts of the world.

The term 'refugee' will be used, for brevity, to cover all who may have, or be seeking, asylum in Britain - when appropriate the specific legal status will be made clear in the text. In this, the report tends to follow the UN 1967 protocol defining a refugee as a 'person who is outside the country of his/her nationality or habitual residence and unable or unwilling to return to it because of actual or threatened persecution on account of race, religion, nationality, membership of a particular social group or political opinion'.

Contents

	page
Foreword	1
<i>A Review of Evidence from Literature and Professional Opinions</i>	2
Introduction	2
Health and the Refugee Experience	3
Levels of Registration	4
Other Health Services	5
The Role of Resettlement Camps and Centres	6
Language	6
Health Priorities	7
Other aspects of Prevention: Screening & Vaccination	7
Cultural Appropriateness of Services	8
Utilisation: Mental Health Services	9
Utilisation: Other Health Services	9
Staffing	10
Incidence of Ill Health	10
Ethnic or National Differences	11
Other Specific Health Issues	12
Other Problems	12
West Midlands Practitioners and Good Practice	13
Further Selected Examples of Good Practice and Projects	16
Recommendations	17

<i>The work of the Midlands Refugee Council Health Promotion ("MRC HELP") Project</i>	19
Introduction	19
Health Advice and Counselling	21
Health Support and Care	22
Health Promotion	23
Environmental Health	25
Interpreter Service	26
Outreach, Networking & Collaborative Services	26
Analysis and Evaluation of Client Workload	28
Conclusions	35
Recommendations	36
<i>References</i>	38

Foreword

Refugees suffer the most extreme losses any human being can - home, family, country, identity, status, belonging, value, reason for being. In addition they may have endured physical pain, torture, humiliation, depersonalisation. They may have witnessed these sufferings in others and in the people they love. Every value they hold dear may have been taken away. They are living a prolonged bereavement reaction and they are living in post-traumatic stress disorder. Basic human compassion demands that any society should do everything in its power to help refugees and asylum seekers. Indeed, a decent society should judge its standards of care by the way it responds to the need of such people. Health services and the caring professions are duty bound to do all they can to meet the care needs of refugees.

When the Midlands Refugee Council undertook its first health survey of refugees in the West Midlands, we were surprised at the number of refugees in the area - at least 7,000 - and surprised by the range of countries from which they were drawn. The different ethnic groups, different political and religious persuasions, and different cultures affected suggest that tolerance and understanding are not the preserve of any particular group of human beings. There is much to be done to prevent violence and conflict - it is a major public health problem. We need to develop our understanding and use of these methods of non-violent conflict resolution.

Health services are confronted with the health and social care problems of refugees. In Sandwell about 130 refugees were identified by the project, in Birmingham approximately 5,000. The number of refugees in Sandwell and Birmingham is not as huge as in Greater London, but their health problems are great and they are among those most in need of a health service. They are less likely to be registered with a GP and less likely to know their health rights in the United Kingdom. In addition to the problems of loss, pain and suffering, refugees face an often intransigent and uncaring bureaucracy, problems of adaptation, language and communication, economic hardship and the task of *keeping together* as individuals, as families and as social units. In addition, refugees are more likely to suffer from physical and mental illness and more likely to suffer from the consequences of not getting the health services they need to meet chronic illnesses they may have had since before becoming refugees.

For all these reasons Sandwell and Birmingham decided to pool their resources in partnership with the Midlands Refugee Council in order to develop a health needs assessment and a health advice and advocacy service. The partnership was funded jointly by Birmingham Joint Consultative Committee, Healthy Sandwell 2000 and NHS Ethnic Health Unit. We are pleased with the outcomes of this partnership so far. We hope it will be possible to support future initiatives by the Midlands Refugee Council to further improve the health of refugees in this area.

John Middleton
Director of Public Health
Sandwell Health Authority

Jacky Chambers
Director of Public Health
Birmingham Health Authority

A Review of Evidence from Literature and Professional Opinions

Introduction

While it is generally agreed that access to health care (and indeed, the enjoyment of good health) is one of the key human rights, it is clear that for significant proportions of the most disadvantaged groups in society, these rights are more observed in the breach. It is an issue of particular concern for those working with refugees and asylum seekers that there is so little apparently known about their specific health needs, the access they have to health services, and so little 'good practice' available to guide the development of services. This appears to be particularly the case for workers and refugees in Britain, since in at least some of the other countries of the European Union there is evidence of greater levels of development and expressed concern for these matters. This will be referred to at appropriate points in this review. The review will also draw upon what evidence has been made available regarding developments in Britain. In particular we shall seek to explore how far the 'good practice' developed in the setting of the London conurbation can be a guide for work elsewhere. The significance of this is that the best estimates available suggest that up to 15 per cent, perhaps one in seven, of the UK refugee population, do not live in London. One estimate places this at about 110,000 people. The majority of these are thought to live in the West Midlands, with significant numbers also in the North East and parts of the East Midlands. In these places, numbers are much smaller and dispersal makes it harder to provide services requiring specialist knowledge and facilities - including for example language interpretation, which is generally regarded as the prime barrier facing all refugees in Britain, less than one in three arriving with adequate spoken English to 'cope with most situations' (CareyWood 1995).

It is apparent that Britain has been in the past, and despite the explicit intentions of Government, continues to be, a place to which migrants from a variety of sources have come seeking asylum from their countries of origin, whether because of political, economic, social or natural upheavals in those lands - and that many of these remain in Britain with or without official sanction, until they feel able to return 'home'. In the vast majority of cases, it must be emphasised, that is the eventual outcome: few, other than some of the 'quota' refugees from Vietnam, seem likely to settle indefinitely in Britain (Duke & Marshall 1995). However, this is not the impression that may have been given in the recent debates about the 'Asylum Bill', which appeared to concentrate on the problems of an economy and society bearing an unfair burden by being expected to provide services for the refugees coming here. Mostly, therefore, public expressions even by officials of the health service, have tended to downplay the needs of these groups. It is unclear if this is because they genuinely do not perceive a need or whether the issue is too politically sensitive to debate publicly. Other commentators suggest that the prime concern is to protect the 'host' majority community from what migrants may 'bring with them' (Muecke 1992). The impression however remains that Government does not see mechanisms for the provision of health services to refugees as a priority. Various parliamentary questions, such as that asked by MP Corbyn (Hansard 27 July 1993 :834) about refugee access to GPs, receive dismissive replies that 'no such estimate has been made'. At the very least, as Joly (1996) has noted, the British tradition is one of ad hoc, short-term response to immediate problems raised by particular groups, rather than the more commonly adopted European (and American) models of setting up a continuing, long-term structure which can be adapted to the needs of particular groups as they arise.

Health and the Refugee Experience

Some form of justification for inaction or silence on the question of health service needs may be found in the only official British national study of refugee resettlement, which observed that 'the struggle to enter the job market tended to dominate interviewees concerns' (Carey Wood et al 1995 :ix). The same study noted that nearly all (98%) its informants - who were all 'officially recognised' refugees with Convention status or 'exceptional leave to remain' - were registered with a GP and that about three quarters were also registered with a dentist - levels comparable with the general population. Similarly, Grant's study in Brixton found that in the first six months after arrival, 'health' was a priority for only 13 per cent of informants, ranking fourth after benefits, immigration status and housing. The impression gained from this is clearly that there is no formal problem in accessing the health services. Two problems arise from this: firstly that those whose status is more problematic were not covered by the study and almost by definition cannot be established - and secondly that the same (CareyWood) study noted that 16 per cent - one in six, were suffering from a physical health problem that was severe enough to affect their way of life, and that two thirds had experienced anxiety and/or depression. One in ten had some form of disability affecting their everyday life, such as lameness, loss of vision or an amputation - yet virtually none had accessed health service support for any of these medical problems. A number of possible explanations for this can be put forward, in addition to that mentioned earlier (or 'prior concerns').

Firstly, it is clear that there are high levels of racial discrimination and harassment directed at refugees - to an even higher level than against most other ethnic minority groups. A study in Glasgow showed that 40 per cent of refugees had experienced some form of racial abuse (McFarland 1989). 'The chances of such harassment unfortunately grew, the more contacts they had with the British community' (Carey Wood 1995 :xii). It is natural to seek to avoid such stress, even if by so doing, one cuts oneself off from other things including health services, that might otherwise be seen as good.

Secondly, the same official study notes that negative attitudes in the 'host' society have serious effects on health. More forcefully, a conference on refugee needs was advised by David Forbes of Kairos Europe that 'Mental health and psycho-social services are a key area of need for asylum seekers who arrive traumatised by what they have experienced at home, by the process of getting to the country of refuge, and finally by the hostile and unbelieving attitudes of the representatives of the host country' (United 1996 :15). It must be expected that the anti-refugee sentiments expressed during the debates on the Asylum Bill will have effectively deterred many from seeking even those services to which there was no doubt of their entitlement - including health support.

Thirdly, the question of the suitability of the services on offer must be questioned: both in terms of resources and the training of the workers: 'The doctors serving refugee communities will usually be in very busy inner city practices and they are unlikely to have any special knowledge of the problems of refugees, especially where these are of a psychological or dietary nature. There appears to be a need to convey knowledge ...' (Carey Wood 1995 :104).

A number of more general points should be noted: in particular, and beyond the very necessary observation that refugees are not the same as 'labour migrants', it is important to observe that most refugees will be perceived as 'ethnic minorities'. The majority tend to be young, but the small number of older people will have very little in the way of community

support networks, and are unlikely to find services for minority ethnic groups who have aged in the UK to be appropriate. Further, the majority of reports and studies have referred to refugees as if they were not differentiated by gender, beyond reference to obstetric and child-rearing issues: as Muecke comments, (this) 'defines women only in terms of reproductive capacity and ignores the impact of gender as an organising principle of life in asylum' (Muecke 1992 :518). Given that a common experience of refugees is for husbands and wives to be separated while seeking asylum, and for 'lone' women to suffer rape, this is short-sighted. When dealing with societies where gender is or has been a major role-defining characteristic ('men fight and herd; women dig and care'), such separation has implications for their ability to 'cope' in the country of asylum, including the likelihood of prior education. Wiggs notes that the effect of separation of women from their partners has very significant effects on their health and ability to 'cope'.

Refugees, however much they share certain key experiences and have common needs in terms of respect and provision for the trauma of becoming refugees and seeking asylum, are not homogenous, nor (as Karmi reminds us) is the refugee population constant. Few studies seem to adopt a comparative perspective - even those which more recently have studied the refugee populations of an area (e.g. Brent, Bernard-Jones (Haringey), Gammell (Newham), Hayes (Cardiff), Karmi (NE London), Grant (Brixton), McFarland (Strathclyde)), rarely are able to differentiate significantly between the needs of the various ethnic or national groups surveyed. Yet it is clear that, although we have attempted not to confine our study to 'official' refugees, there are significant differences in terms of status and many other critical dimensions. In a sense, the then Home Secretary (T Raison) was correct to argue that 'each refugee situation has its own characteristics' when arguing against setting up a permanent structure for reception - for example, (later) Chilean, Vietnamese and other 'programme' groups are often heavily pre-selected, and came with Government support which meant that 'resources were more readily obtained towards a reception programme and entitlements to social rights' (July 1996).

Levels of Registration

While Karmi suggests that there may be barriers to access with medical practitioners being likely to perceive asylum seekers as 'illegal immigrants' or to confuse their status and perhaps insist on ineligibility, under the 'payment by overseas visitor' regulations, this does not seem to be born out by the facts reported in most studies. The (British) Refugee Council had no evidence of any systematic refusal of service by GPs, although mobility and the lack of a fixed address could be problematic. Most studies, however, report that refugees were as likely to be registered with a GP as any other group in the community. CareyWood et al 1995 found high levels of registration across the country with GPs - 95 per cent of all refugees polled, and 78 per cent were also registered with a dentist. Interestingly, 3/4 were also aware that they could register as disabled and thereby get further benefits. The Brent study also reported high rates (94%) - sometimes being only 'temporary' registration because of problems associated with accommodation. The same study found that 76 per cent of its respondents were registered with a dentist - and many contacted dentists through school services. Similarly, Duke & Marshall (1995) found that the longer-standing Vietnamese community had very high levels of registration with dentists (86%) and GPs (95%) while Grant & Deane (1995) found that 89 per cent of refugees in their study were GP registered - 65 per cent within six months of arrival in Britain, while 6 per cent had been refused registration.

A study of Bosnian refugees in Ireland - a country without a strong tradition or mechanism for refugees, found that a very high proportion of those with medical needs had visited a GP soon after arrival (Murphy 1994). It is clear that so long as GPs are prepared and have an appropriate protocol, the majority of cases and needs should be identified through this 'opportunistic' screening process. Again, this would argue for a GP based approach - with certain key qualifications.

One of the most important concerns is that GPs may not be appropriately trained or briefed to receive either refugee or indeed other culturally distinctive patients. While this is an issue presently being debated by the Royal College of General Practice, the Department of Health and the NHS Executive, it is not clear that the agenda includes specific reference to refugee populations, as opposed to other minority ethnic groups. Studies from Scandinavia (Hetta 1992) indicate the need for specific training and advice in communication skills for dealing with refugee patients.

Under the present system, all new registrations with a GP (even on transfer) are supposed to incorporate a comprehensive health check. This should pick up any major health problems, but may not cover all tests and conditions particularly likely to be found in refugees - and does not generally deal with mental health or the effects of stress. Further, and more worrying, is the fact that temporary registration of the type offered to those without a permanent address in the practice area, does not necessitate such a full package of checks and advice. It is also true that all the studies reported concern 'approved' or 'registered' refugees, and there is no understanding of the situation of those who are not living in Britain with official recognition.

A different form of registration may be noted: Grant's study of 270 refugees in south London found that one in three had children aged under 18 living with them, many of whom were not necessarily known to the relevant authorities. Of those who had children born while living in Britain, 21 per cent had failed to register the births - in many cases due to a fear of bureaucracy, but inevitably meaning that they had not received all the services (including, for example, child benefit) to which they were entitled.

Other Health Services

Use of other health services is, in general, poorly recorded by most surveys - although a few do refer to problems in attending hospitals, and it seems quite common to enquire about levels of registration with dentists. On the other hand, there seems to be no attention paid to the contact refugees have with such services as the Health Visitor, community psychiatric nurses, occupational therapists or indeed, pharmacists. This may in part stem from the tendency for most studies of refugee health to arise from studies conducted through hospital services or in refugee 'settlement' camps.

Dental health is the most commonly reported need amongst refugees, after immediate treatment for traumas and longer-standing problems of mental health. Zimmerman (1995) found that very few refugees went early to see a dentist. Indeed, in Sweden the average lapse time between a refugee's arrival and seeing a dentist was four years - yet very serious dental health problems were recorded. Other studies of children have also pointed out high levels of caries. Dental health is a low priority amongst most refugees - reflecting UK studies of many ethnic minorities, who believe that they have 'strong teeth' and ignore other aspects of oral

health. Zimmerman (1993) notes that outreach and discussion in refugee community group settings brought rapid measurable benefits. Grant's study notes that a third of refugees had never visited a dentist but that most knew how to, if needed, and that 57 per cent knew where to go for an eye test.

The Role of Resettlement Camps and Centres

There is some research and reportage of the role played by reception centres and 'refugee camps' in Europe, which are generally seen as valuable. One of the most thorough systems is that of the Netherlands, where a network of some 14 sites exists with a careful protocol for health checks and information-giving. It may be that the (historic, if now changing) relatively welcoming attitude of the Dutch government towards refugees had encouraged asylum seekers to report to, and enter such facilities, while any concern that these might fulfil the role of some British 'holding centres' prior to refusal and refoulement would certainly work against their effectiveness as places for health promotion. On the other hand, it is not just the Dutch who maintain such a system with a degree of success: in France a national network (OFPRA: Office Francais de Protection pour les Refugies et Apatrides) incorporates free medical care, language classes and contact with over 25 NGOs - as well as catering not just for 'programme' refugees but also 'spontaneous asylum seekers'. British camps, however have mostly been closed down and were only used for Quota refugees (East African Asians, Vietnamese and Bosnians). They were, however, found to be very valuable. For example, 50 per cent of Vietnamese refugees were processed through Reception Centres and these were very effective in ensuring higher standards of housing, and providing some introduction to health services and E2L (English as a Second Language) classes (Duke & Marshall 1995)

Language

As the above implies, the main barrier to (any) services reported by most studies has been the lack of good spoken English. For example, of the Vietnamese, Duke & Marshall state that less than 1 in 10 had 'good' English on arrival in UK, and another 10 per cent had 'enough to get by - but while 1 in 3 had 'some' English, two thirds had none at all. Similarly, the study of Brent refugees found only 16 per cent spoke English well and over half hardly at all - the situation was worst among Somalis and Tamils, best for Iraqis. The researchers noted that that as children were learning English at school, health materials were asked for in bilingual format which could be shared with other family members and used as a learning tool. This is rapidly becoming the commonly held view in relation to health materials for other British ethnic minorities.

Language problems are clearly not the same for all groups. It is suggested by some authors (e.g. Wiggs) that language problems may be particularly great in female-only households, or those where the (male) head of household has not been able to join his family in exile. Other refugee groups may come from English-speaking countries - and the assumption that a refugee is ill-educated or does not speak English can be misleading, if not in itself a barrier. Many are, indeed, former civil servants or professionals - although the type of English, and technical language, may be another problem in understanding.

It should be noted that while English is the usual language of the consultation - but that this may be overcome by the use of an interpreter, all prescriptions are now written in English and few medicines carry multi-lingual instructions. Most pharmacists will advise clients about

their medicines, but very few have the language skill required to advise refugees appropriately.

In dealing with the need to acquire language skills, it is worth noting that many 'English as a Second Language' classes are not really suitable for the purposes of refugees. McFarland and Walsh comment that most classes they surveyed were of 'tourist' English, and did not cover such vital issues as how to deal with officials and forms. This is not necessarily the case where classes have been designed explicitly for refugees and many Midlands classes now provide essential health and other information as part of their course.

Health Priorities

Current British health authority practice, including the allocation of resources to most health promotion activity, is based upon the themes of the 'Health of the Nation' (HoTN) initiative. This may have led to an emphasis which is not necessarily to the advantage of refugees. In particular, while HIV/AIDS has been a priority, this is seen by many 'ethnic health' workers to have meant the stigmatisation of peoples from particular areas, including those in Africa from which many refugees have come. Secondly, much 'lifestyle' advice has been targeted towards a reduction in alcohol consumption - while relatively few refugees (many of whom are Muslim) appear to drink significant amounts (Brent 1995). It seems that substance use among stressed refugee communities is little understood, and this may be an area where further research would be useful (D'Avanzo 1994).

Tobacco smoking is also targeted in the HoTN priorities, and while levels are quite high among refugees, there is little evidence of resources or support being allocated to them - most smoking advice is general and confined to advice to stop: the (legal) drug of choice for many refugees is Qat (Khat) and while the Home Office Drug Prevention initiative has a leaflet in Somali regarding this, it is little known and few other than specialists would be aware of this issue. The other HoTN priority which might affect refugees is the prevention of suicide (Karmi et al 1993) but none of the practitioners interviewed for this study mentioned this as being an area of activity.

Other aspects of Prevention: Screening & Vaccination

A major concern of this study was that certain key elements of preventive health programmes may have been inaccessible to refugees. Meropol (1995) found that screening of refugee children in the USA showed up very poor levels of vaccination status, especially among non-Vietnamese children. This had implications for both their own, and public, health. In fact, the organisation of many of these programmes in the UK through schools seems to be helpful in ensuring that children do not remain outside the remit of the service. The Brent study found that 85 per cent of its families said children had been vaccinated. This data may be problematic: children may have been vaccinated for cholera or measles in refugee camps: other people may not have been familiar with the concept or the range of diseases for which vaccination is available in Britain. Some - but not very many - refugees may have the hand-held records from their country of origin (notably those from former Yugoslavia) but these may not be intelligible to British practitioners! Given that few databases can identify refugee patients, there is no way of checking the level of need here. However, some studies of British ethnic minority groups suggest that (partly because of insulation from debates about safety) their uptake of preventive immunisation when offered is higher than the national average. The

main problem will be ensuring that GPs check the vaccination status of refugee children on registering.

As far as research and policy are concerned, one of the main features has been a concentration on tuberculosis (TB), which is a public health hazard. While it is a disease of poverty which has been growing in prevalence in Britain recently, there are dangers in assuming that all refugees may be carriers, and thereby stigmatising them (Independent newspaper 7 May 1994). Equally, it is advisable that all should have the opportunity for an X-ray. However, while this is in theory offered to all 'immigrants' screened by the Port Health service, practitioners were certain that this was not universally done or that often only the head of household is checked. Refugees who do not declare their intention at arrival are also unlikely to be screened. Others may regard the procedure as frightening or another hurdle to their achieving asylum.

Cultural Appropriateness of Services

Refugees may be reluctant to utilise health services unless they are more understandable and culturally accessible (Duke & Marshall 1995 :44)

It is accepted quite widely that in measuring the quality of services, 'cultural appropriateness' is a norm that all health service users should be entitled to expect - and this is indeed one of the 'Maxwell Six' quality standards recommended by the Kings Fund and enshrined in the 'Patients Charter' (Johnson 1996). However, political pressure which may have been effective in some areas in ensuring that suitability for locally prominent minority ethnic groups is assured, rarely works in favour of refugee groups, and a monitoring role is necessary to ensure that services in areas where refugees are to be found, do not become inaccessible to potential clients.

There are two sides to this question - beyond the basic issue of language and cultural knowledge ('awareness') on the part of the service provider, which are the most obvious areas where organisations are lacking. The most common observation is that services are too formal and off-putting - a more relaxed and informal setting, even where this may appear to conflict with 'western' norms of confidentiality and professionalism, is generally preferred. Secondly, many mainstream services fail to project an inclusive, multi-cultural image - even to well-established ethnic minority groups - and thus appear to be part of the greater, cold and bureaucratic world of 'officialdom' which is associated with other problems of refugee status and welcome.

Utilisation: Mental Health Services

Across the board of refugee health studies, it is clear that the main problem seems to relate to utilisation of mental health services or support for people with mental distress. In one report, just over half of all the Vietnamese studied had stress or depression problems but only half having health problems had actually sought help (Duke & Marshall 1995). Another study noted that 'while 2/3 had high levels of stress - closely associated with feelings of rejection and poor spoken English, only 40 per cent of these who said they had problems, had actively sought help for them. Only one in three of these had approached health workers ...' (Carey Wood 1995). While many people in Brent had symptoms of, or reported that they suffered from, mental distress there was some reluctance to report this. As with British minority ethnic groups, the standard screening questions used by many practitioners appeared to be inappropriate - of those felt to be at high risk or need, less than one in five had received any care.

The Evelyn Oldfield Unit considers that the inclusion of reference to mental health in a service's title may itself reduce use of that service: similar observations have been made about services for ethnic minorities in Britain. They argue that Somali cultural norms recognise that a person can get relief from stress by talking with a friend - but inhibit people from exposing weakness to a stranger, preferring rather to 'put on a brave face' - thus formal counselling may be seen as culturally inappropriate. There is a consensus that this may be best resolved by the part played by voluntary (community-based) organisations: 'early contact with a refugee community group for support can reduce the severity and likelihood of mental illness (CareyWood 1995 :77)

Utilisation: Other Health Services

No problems (beyond language) seemed to be reported in obtaining 'emergency' treatment, and procedures for these seemed well known in those studies which have considered the question (notably Brent). Similarly, there seemed to be few reported barriers for such matters as admission for maternity services. However, Brent showed that very few had attended 'parentcraft' classes, and fewer than expected (63%) an ante-natal clinic. Significant numbers had, however, been to family planning services (GP or Clinic) and over half the Brent sample had used an optician.

There is no academic study of the use made by refugees of hospital services, but reports in British newspapers have pointed to the possibility that serious barriers may exist. In particular, one North London GP reported that 'at least' 25 refugees, identified primarily by the fact that they were non-English speakers, had been refused hospital treatment, and others needing an interpreter had first to produce evidence of entitlement (Guardian Newspaper 21 Feb. 1995). A subsequent enquiry by MP Bernie Grant received the reply that the Secretary of State for Health 'has no knowledge that any refugees are being refused incorrectly', their entitlement being properly assessed in accordance with the Department of Health Manual of Guidance on the NHS Treatment of Overseas Visitors (Parliamentary Question 8 March 1995). The Glasgow study of refugees observed that refugees with language problems were able to communicate with GPs while their problems were routine, but that 'attendance at out-patient clinics and admittance to hospital had proved a bewildering experience' (McFarland 1989 :105). Practitioners agree that there are problems, largely related to language and

knowledge of 'how the system works', requiring advocacy and accompanied visits to hospital clinics.

Staffing

The question of language and cultural competence is raised by many studies, and many refugees report a wish to be able to consult someone from their own background. There is no way of knowing what the possibility of this is, given the lack of detailed ethnic monitoring - but it is worth noting that the Brent survey of less than 600 people found 14 doctors, 5 nurses, a dentist, and three other health scientists - only three doctors and the dentist were 'currently working in that capacity'! It is very evident that the potential contribution of refugee communities' members is not being adequately used.

Incidence of Ill Health

It is well established that many, if not most, refugees do have health problems: over 40 per cent of those surveyed in McFarland & Walsh's study said that health was a problem, even if, as stated above, it was not their prime concern. Long-term limiting illnesses were reported by over half the Brent survey - rather more than the expected population average (and much more than the age-related prevalence) - five times the 'expected' level of problems (15%) of depression etc; twice the expected level of chest (asthma, bronchitis etc) symptoms, and also raised levels of skin and allergic conditions. Diabetes was reported by 7 per cent (compared to 1% expected). The problem is that for many diseases, prevalence rates can only be established by reference to those seeking treatment and being formally diagnosed - which returns to the question of those who do not register with or access health services. It is also problematic to estimate incidence rates without adequate data on the 'population at risk' and the total numbers of members of particular groups in a community, especially when numbers in an area are not constant over time.

Health and refugee status have a complex relationship. For many, it is clear that poor current health can be related to the experiences of becoming a refugee. On the other hand, especially where there have been 'convoy' refugees (as in former Yugoslavia), it can be that ill health may have been reason for being granted asylum - or at least enabled evacuation. Equally, the process of seeking asylum is well established as being stressful and creating mental health problems, particularly being associated with the growth of post-event neuroses (Post Traumatic Stress Disorders) - that is to say, settlement may be the beginning of problems and not the end.

Poor mental health, it is clear, stems largely from the experiences undergone in the country of origin, during flight, or associated with the process of becoming a refugee. Most refugees seem to be people of considerable mental and personal fortitude - and their expectation of an eventual return may give support against some disappointments in the 'host' country. Beiser (1993), for example, found that 'under-employment' (working in a lower status job than that for which they were qualified) had less effect on the self-esteem and mental health of refugees than other ethnic minority people - although loss of any income at all was equally damaging.

When discussing mental health, it is essential to consider the social and cultural context and construction of 'normal' health. Research in Britain has tended to concentrate on the over-diagnosis of certain minority ethnic groups (notably the African-Caribbean) as 'psychotic',

and the somatisation of complaints and symptoms amongst Asian people. Every cultural group may have its own ways of expressing symptoms, and even trained interpreters may not be able to detect or advise health professionals about these. Frye & Avanzo (1994) describe a condition known as 'Koucharang' (literally, 'thinking too much') amongst Cambodian refugees. This they regard as a culture-bound syndrome, or description of feelings, as a reaction to stress following the experience of violence in the Khmer Republic. It is evidently a way of describing a form of mental distress or depression, and could easily be missed in a consultation, unless the practitioner was aware that 'stressful and violent events were customarily managed by withdrawal' in this community. This, rather than any lack of contact with health services, may be a major barrier to the receipt of necessary services. Additional support for this suggestion is given by a Swedish study (Hauff & Vaglum) where it became clear that the experience of violence and physical trauma among Vietnamese refugees needed to be explicitly confronted and explored, if they were to receive appropriate treatment. Again, this seems to point towards the necessity of training and preparedness amongst health professionals meeting refugee clients.

Ethnic or National Differences

While the few comparative studies have noted some differences between refugee groups - for example, the lower skill and education levels of the Vietnamese 'quota' refugees, and higher levels of disability amongst Ugandans and Iranians (lower amongst Tamils and Sudanese), none show significant differences between them in terms of access and use of services, or of exposure to stress, beyond those attributable to education, language, skill and location of residence. In other words, the experiences of refugees are largely 'sui generis' and attributable as much to their refugee status as to their ethnic or cultural backgrounds.

It is also clear from the Home Office study (Carey Wood 1995) that official status - that is, the difference between 'Convention' and ELR refugees at least, was irrelevant to the experiences and feelings of the refugees in regard to their resettlement. It is unlikely that 'illegal' migrants would be unaffected by their status in terms of the stress it places on them, but those 'waiting' for adjudication, who (at least initially) were entitled to access welfare services may be expected to suffer in the same way as those whose applications have been approved - and certainly to be no better off!

The Evelyn Oldfield Unit makes the point that refugee community organisations are necessarily political and will reflect religious and political divisions within the societies from which refugees come. Further, they may be dominated by particular interests or individuals, and are often subject to a number of external pressures including the expectations of local authorities who fund them. These factors may affect their ability to provide (health-related) support across the entire community - but does not diminish their importance, particularly for the section of the community that they reflect.

Other Specific Health Issues

In addition to the raised levels of prevalence of 'common' health problems, including mental health, which are found to affect refugees but may be treated within existing frameworks of reference without requiring major retraining or resources, it is also the case that there are a number of issues which appear to be more peculiar to certain refugee groups. These, like 'ethnic specific diseases' such as the sickle-cell (SCD) condition, appear to cause problems for service providers and practitioners who have not been educated to recognise them - although indeed, some may already have been identified as being known amongst local minority communities and some services developed to meet this need. Sickle Cell and certain other haemoglobinopathies are such conditions, where a number of West Midlands authorities have set up screening or counselling services. It is important to ensure that those dealing with refugee health are made aware of this - and that those dealing with ethnic minority health are also alerted to any changes in the composition of the local refugee population that may affect demand for their services. There are also resource implications - especially as many of these 'ethnic' services are (like those for refugees) funded on the basis of short-term project monies.

It should be noted that, as for ethnic minority health, a significant number of published medical articles relating the refugee health have been dedicated to alerting practitioners to such 'rarities' as ascariasis (Bratton 1993). These have their uses, and one function for a central refugee health project would be the maintenance (and dissemination) of a library of such information. Other issues, which might be described as 'social' as much as medical in their origins, could and should also be included, such as the facts about 'female circumcision' (Arbesman 1993), and habits such as the use of 'betel nut' (Areca, chewed with the leaf of the Betel pepper) (Pickwell 1994) which would certainly be of interest to dentists. A report from Cardiff notes that over half the refugee children seen suffered from scabies, an infestation in Britain usually associated with poverty and lack of cleanliness (Ruddy 1992). The danger with such information is that it can rapidly become mythologised and communities stigmatised or seen as pathogenic in their behaviour - yet for the proper best treatment of certain members of the community an understanding of these matters could be important. Further, as with infibulation, there are community-based groups seeking to improve practice and fight unhealthy lifestyles and it would be helpful for them to have access to the best possible supply of relevant scientific information.

Other Problems

A problem identified by practitioners is a worry about the degree to which refugee patients understand the treatment they are prescribed, and the likelihood that they will continue to take the medicines prescribed. One study of compliance (Lee 1993) did find that most refugees questioned knew the name of the medicines they had been prescribed, but few of them fully understood the value or function of them, or the proper dosage regimen. This had major effects on the efficacy of treatment.

Knowledge is a major constraint. One study (Grant 1995) found that nearly a quarter of refugees did not know how to use the emergency '999' system: recent research in multi-cultural areas of American cities has shown that simple training in 'how to call an ambulance' leads to a significant rise in survival rates from heart attacks, and saves the health service money.

The perspective of the practitioner must also be considered: refugees require fairly intensive counselling in many cases, and certainly place a strain on practice resources in terms of time, language provision and possibly investigation or referral costs. One public health worker expressed the view that 'Good (i.e. accessible) GPs get punished by getting more work'. Resource allocation should reflect the demands placed on those providing a service.

It should be noted that many studies and practitioners insist that health care is one of the least of the immediate concerns of most refugees. Karmi, for example, suggests that clothing is a more insistent need; others regard housing, income and 'safety' as having a higher priority, certainly compared to preventative health measures. It is evident that any health project seeking to assist refugees should be explicitly 'multi-agency' and have good links with social security and local authority housing and personal social service departments. Indeed, cross-referencing between such agencies is increasingly recognised as good practice in the primary health care field (Johnson 1996) and would multiply the value of any refugee health service offered.

Finally, it is still the case that because the majority of refugees are to be found in London, that is where most 'good practice' has been developed. This may lead to a belief that there is no local need, or that because ideas were 'not invented here', they are of no relevance to Midlands practice. The following sections explore this.

West Midlands Practitioners and Good Practice

As part of the study, a number of key practitioners in the West Midlands were interviewed for their views relating to the provision of services to refugees in the region. Many were well briefed and sympathetic regarding these issues, and made helpful suggestions for improvement. A significant number had themselves experience of being a refugee at some point in their life. However, some of those interviewed, including people in senior 'gate-keeping' roles, suggested that there was in fact no problem. Remarks included the following observations:

Most of them are very well catered for ... Carrier liability has very much reduced the number of people arriving by air ... The only refugees I have been aware of recently have been busloads of Bosnians, who have been whisked out of sight very quickly.

I have found that in general refugees in this City - those who come to be known to us - get a very good service. We have a lot of shelters for the homeless with good medical services - they may lack everything else, life's comforts, but not health services.

The danger is that such observations may lead to a failure to be aware of real problems and prevent an ability to react to the needs of newer groups who come to the region.

A number of pertinent points were made which require consideration.

The possibility was raised that 'political suspicion of the other side' amongst political refugees may prove to be a hindrance. This was seen primarily to be a problem 'within' communities, but it makes it important to ensure that where there is more than one organisation representing a particular 'national' community, the reasons for this are fully

understood, and a group not excluded from consultation or resources because 'they' have already got one 'on board'. More significant in many cases was the often justified fear of the British authorities. This has been shown elsewhere - Grant (1995) reports that 17 per cent of refugees were afraid that the doctor's consultation was not wholly confidential, and indeed 4 per cent thought that their GP worked for the Home Office.

A major concern was that the (ongoing) reorganisation of the health service had made life even more difficult for refugees and those seeking to develop services for them. New Trusts and areas cut across existing arrangements, or prevented flexible ways of working because of cash limited budgets. Many of the problems linked to the notification system for immigrants in the Port Health service arose from the re-organisation in 1974 which divided Health and Local authority responsibility and abolished the old 'Medical Officer of Health' posts. Refugees could hardly be expected to know who was responsible for every service they required.

The organisation of the Port Health system was referred to by nearly all those interviewed - and there was some confusion even amongst members of that system. While essentially funded out of the DoH budget, the priority is one of Public Health, and for at least part of the role, Port Health Officers are essentially employees of the Local Authority, reporting to its department of Environmental Health, rather than being part of the individual-oriented NHS ethos. "Our brief is essentially to check them under the Immigration Act (1971) and Public Health (Aircraft Regulations) 1969 as persons fit to come into this country". The same person may, however, also be asked to work in their role as a medical officer of the (air) port, to treat or screen an individual. There is no obligation (indeed, may be barriers) to cross-reference these activities. In their work they are often dependent on referrals from the Immigration Control officers, who are at present strongly advised to seek to reduce the numbers of immigrants and refugees, but whose duties also include identification of those who may be a public health hazard. This is not a service offered to encourage people to use the NHS, or to seek treatment for a current condition.

Similar to this point was the observation, made by refugees as well as providers, that the chain of the UK NHS system, based on referral from a GP to a Trust, did not resemble in any way the free access to specialists they knew in their homelands. With this was also a suspicion that the GP was not as good a practitioner, and that for every illness one should consult a different specialist. Some observers also pointed out that the expectation that specialists should be paid, might prove a barrier to accessing services, although this was not upheld by many informants.

Cultural values in health were suggested by some people as forming a barrier to access, although there is very little evidence to back this, beyond some research in the field of dentistry. It is true that some symptoms, or conditions, may be presented differently, but the fundamental understanding of 'good' and 'bad' health seems to be remarkably common. Healthy behaviour, on the other hand, especially as far as the use of tobacco (both smoked and chewed), may vary more between cultural groups.

Birmingham Health Authority has, over recent years (and during the various re-organisations affecting its structure) sought to take the issue of refugee health seriously, and produced a number of reviews and reports, having also a central point of contact (Dr Hawker). Its documents make several useful suggestions, supporting the recommendations of this study, but observe that they are handicapped by a lack of data and resources. They have however

been helped by the link to an explicit corporate strategy maintained by Birmingham City Council, and would be assisted if other West Midlands Health and Local authorities could adopt similar procedures or agreements.

A number of practical suggestions were made by those interviewed. The following list summarises some of the most important observations on:

Guidance or pressure from the Health Authority is needed

Pharmacists are an invisible source of care: Many people are used to the role of the Apothecary in their home country being more important than the GP.

Prescriptions should include referral to an interpreter to translate them!

We need an advice leaflet on eligibility of refugees

Training for GPs and receptionists in handling refugees

Wake up the Port Health Notification system - where do they go? And extend it beyond the basic public health function.

Why not use the traditional birth attendants system (they) are used to or other types of refugee health worker?

A salaried practitioner could work across the area and follow those who move from one practice area to another

There was a time when a school would not accept an immigrant child unless they had been to a health clinic but that had to be dropped as it was seen to be discriminatory

If they had 'patient held records' they could take them wherever they were, instead of waiting for the NHS bureaucracy - which they do not trust anyway

The Health Authority should 'buy in' sessions of welfare rights advice

The greatest problem is complacency

GPs should do all this at the registration medical - after all, they get paid for it

Social Workers and Voluntary Organisations do not always liaise - we need better referral system

There is the issue of the Asylum Bill - if as a refugee I feel my application is to be rejected, I'm not going to worry about my benefit but my life ...

There must be out-reach and drop-in clinics at places where refugees meet.

The Midlands Refugee Council health project, which incorporates already many of the factors identified as being necessary, provides a basis on which to build. It already offers 'surgeries'

at the MRC base, in community centres, and through visits to clients homes. At these, new refugees can obtain introductions to the working of the NHS, access to its services with interpreter back-up, 'guided appointments' for registration and screening visits to GPs - and subsequent hospital appointments if required. Counselling against PTSD, and health promotion work (notably in respect of smoking) is provided, and follow-up visits undertaken. Encouragement is also given to ensure a good vaccination status is maintained. A particularly useful feature of the service may be the support offered in 'cashing' prescriptions at chemists, where eligibility status can be explained to the pharmacist and the detail of the prescription to the client. In the longer term, similar support with Disabled Living Allowance or other social security benefits, and with the social work department of the council, are also necessary and offered. The MRC Health Project maintains liaison with other authorities and agencies, (including the environmental health department) raising their awareness of the needs of refugees through conferences and individual contacts. Interpreters are supported and trained, and a register of their availability kept - although this service seems to be less used, perhaps because of reluctance by other agencies, than might have been expected.

The service, however, is under-resourced and requires additional support (such as a Health Visitor or other female medical practitioner) and would benefit from the production of a 'welcome/outreach pack' in suitable languages, and perhaps also with better links to health promotion units and their resources in the areas it serves. The second part of this study contains a progress report for the MRC project, demonstrating its potential.

Further Selected Examples of Good Practice and Projects

In the course of preparing this review, a large number of health projects around the country have also been contacted, and evidence compiled from a variety of sources, including reports of practical ideas which appear to have relevance for the Midlands project. Key details of the most valuable or innovative are presented in this section.

Brent Health Authority is seeking to ensure that the Port of Entry Notification system is properly used to convey information.

A General Practice in Newham has obtained funding support for a nurse practitioner to offer a (longer-appointment) clinic at a fixed time, at which an interpreter (Somali) is present to provide not only immediate health care but also TB and other forms of screening, help in filling out forms, and health advocacy on hospital visits. 'Word spread quickly among the community'.

Another General Practice, in Cardiff, was given funding for a salaried partner and nurse link-worker to offer special services. This includes reversal (or repair) of infibulation damage caused by female circumcision, vaccination, and treatment of refugee children's problems. Collaboration with the social service department has ensured even better child support services, including a toy library.

South Derbyshire Health Authority is employing a health link worker to assist the estimated 2-300 Bosnian refugees in its area, and training some of these as interpreters to an appropriate level to assist health care delivery work.

The Greater Manchester Immigrant Aid Unit has employed a 'Health & Immigration Control' project worker to increase liaison (and proper treatment) for those subject to immigration control procedures.

One (London) Consultant in Public Health received weekly lists of notified refugee/immigrant arrivals from the Department of Health and Environmental Health department and was able to follow these up with a visit from a Health Visitor, to ensure that the new arrivals had been seen, screened, registered and linked into the system with appropriate support.

At least two London Health Authorities (Ealing Hammersmith & Hounslow 1992; Kensington Chelsea & Westminster 1994) have circulated their GPs with local guidance based on the Department of Health guidance on treatment of overseas visitors, stressing the rights of refugees and that reception staff should not insist on passports or make other barriers to access. "GPs and Dentists are expected to treat as NHS patients, refugees and asylum seekers known to the Home Office".

Tower Hamlets Health Authority produced an 'emergency multi-lingual phrase book', with the British Red Cross, containing 43 useful phrases in 28 languages.

The Evelyn Oldfield Unit, launched in London in 1994 to provide support to refugee community organisations, has recognised the essential role that these [play and their needs for training, information and practical assistance. It runs conferences (e.g. on mental health issues - November 1994) at which practitioners and refugees running such community organisations can meet and exchange views.

Recommendations:

All relevant services should identify a lead manager or responsible officer - who should participate in, or establish a link with, key organisations such as the MRC, Forum etc.

Training courses and information packs - or periodic briefings to take account of new population movements, should be provided for those GPs and other 'inner city' health professionals most likely to have refugees in their catchment areas.

Better relationships with the 'Port Health' system (both that based at the International Airport, and nationally) are required. This should include some mechanism to ensure that references from the system to local health and welfare agencies are made and followed up.

GPs should be circulated with a reminder of the Health Authority's regulations and interpretation of the 'Overseas Visitors Fees' regulations.

A library of 'refugee health' materials, including articles relating to relatively rare events, should be maintained centrally and briefings prepared for community and health workers or circulated to interested parties in a newsletter.

There are specific needs of women: a female worker may be needed, and links should be made with women's support groups.

Training in the use of English as a Second Language (E2L or ESL) is needed and popular among refugee groups - these classes provide a prime opportunity to introduce health promotion and 'civic' (access and entitlement) education materials.

Health related materials (some of which are already available through the Refugee Council, HEA and other agencies) should be made more accessible, where possible in bi-lingual versions - and distributed through ESL classes.

More positive efforts should be made by statutory and 'mainstream' agencies to establish links with (and outreach through) refugee community organisations.

The work of the Midlands Refugee Council Health Promotion ("MRC HELP") Project

Introduction

The Midlands Refugee Council (MRC) was founded in 1987 at Birmingham by refugees as a response to the needs of refugees living in the West Midlands. The majority of refugees in the UK (about 85%) settle in inner and outer London while the remaining 15 per cent settle in other parts of the UK (Carey-Wood et al 1995). The West Midlands accommodates an estimated 6000 to 7000 refugees, the second largest in the UK. Birmingham City alone accommodates some 5000 (Birmingham City Council 1993). Between 300 and 500 refugees each live in Coventry City and Sandwell Metropolitan Borough Council areas (MBC) while the rest are distributed in the remaining MBC areas - Dudley, Solihull, Wolverhampton and Walsall (Birmingham City Council 1993). The refugee population in the West Midlands is bound to increase as internal migration and referrals from ports of entry to the Midlands are on the increase due to the congestion in London.

In 1994/95, a total of 2150 refugees were seen by the MRC when six funded projects were operative (housing; women's support; women's employment; community development; training and employment; immigration advice). The projects were reduced to three in 1995/96, due to diminished funding, but the health project was also started during this year.

Out of the 2150 clients seen in 1994/95, 1206 came from Birmingham, 374 from Sandwell, 224 from Coventry, 133 from Wolverhampton, 67 from Walsall, 52 from Dudley, 31 from Solihull and 63 others (unspecified) were also attended to. 50 per cent of these refugees were African, 30 per cent were Asian, 10 per cent Eastern Europeans, 5 per cent Latin Americans.

Refugees' Health

The physical and mental health of refugees have been found to be significantly worse, showing greater morbidity than in the general population (Brent and Harrow Health 1995). The health needs of refugees in the UK have been documented for the Vietnamese community (Duke and Marshall 1995) (the first "programme" refugee experience in Britain between the late 70s and early 90s) and for other communities (Carey-Wood et al 1995; Brent and Harrow Health 1995; British Red Cross 1993; Mcfarlane and Walsh 1988).

These include both physical and psychological needs. However, little is known, in particular, about the access barriers to using the mainstream health services by refugees except that language barrier seems to be the biggest single obstacle (Brent and Harrow Health 1995).

It is known that although the majority of refugees were registered with doctors (Carey-Wood et al 1995; Brent and Harrow Health 1995) and dentists (94-99% for doctors and 78-86% with dentists), only 40-52 per cent of those with medical and psychological problems actually sought help from any source (Carey-Wood et al 1995; Duke and Marshall 1995). The proportion of those seeking help from the mainstream health services were even lower (15%-25%) (Carey-Wood et al 1995; Duke and Marshall 1995). Health needs also varied widely for the different nationalities e.g. 54 per cent of Ugandan refugees required help compared to 23 per cent of Iranians or 8 per cent of either Tamils or Sudanese refugees (Carey-Wood et al 1995).

Greater health problems occurred with breathing/chest, the digestive system, the urinary system, diabetes, sickle cell and thalassaemia (Brent and Harrow Health 1995). Physical disabilities include lameness, partial loss of vision, paralysis, amputated limbs, severe back pain, lung removal, hearing difficulties. More men were disabled than women (11% and 6% respectively) and the disabled were more likely to be older i.e. 40 years or over (16% of this group had disabilities compared to 8% below that age) (Carey-Wood et al 1995).

Psychological problems included high levels of stress, anxiety, depression and nervous breakdown. Two thirds had experienced such feelings since arriving in Britain with variations across nationalities but without gender differences (100% of Ugandans and of Sudanese, 82% of Kurds, 72% of Somalis, 65% of Iranians, 22% of Tamils and 82% of others) (Carey-Wood et al 1995). The period of limited rights and uncertainty for the individual taking refuge, in addition to other causes, could be detrimental to the psychological well-being and eventual resettlement of those allowed to stay (Carey-Wood et al 1995). They were even more frightened and destabilised by frequent changes to the asylum/immigration laws in this country.

The MRC Health Promotion ("MRC HELP") Project/Service

In response to the health needs of refugees living in West Midlands, a health project was started in autumn 1995, essentially:

- * to develop, organise and promote specific health programmes (for refugees) in Birmingham and Sandwell areas,

- * to work closely with primary health care teams in Birmingham and Sandwell health authorities who were committed to eradicating inequalities in health, promoting partnerships and evolving community development principles and methods.

Funding was provided to the MRC for a Refugee Health Promotion Worker (RHPW) and an Administrative Worker by the Birmingham Health Authority while Sandwell Health Authority also provided funds for a refugee health research project.

A total of 1650 cases/clients were reported at the MRC during the 95/96 year, including 65 clients for health matters. A good number of the reported 329 women given support were also seeking advice on health matters which were not included in the health project report.

The activities of the RHPW are reported below under the following headings

- * Health advice and counselling
- * Health support, care and advocacy
- * Health promotion
- * Environmental health
- * Interpreter service
- * Outreach, networking and collaborative services
- * Analysis and evaluation
- * Conclusions and recommendations

Health Advice and Counselling

The role of the RHPW was always advisory to refugees on health matters, especially in accessing the mainstream health services. This service was given in response to phone enquiries or at 'surgeries' held either at the MRC premises or at the community centres or at the homes of clients. Immediate service to new arrivals include an introduction to the NHS and entitlements within the NHS, accessing the health services, interpreter services, guided appointments to the General Practitioner (GP) for registration and health screening. A pre-screening chat with new clients was carried out to establish rapport, trust with confidence and to discover areas of immediate support, care advice and counselling.

Topics for counselling included talking through traumatic experiences (e.g Post-traumatic Stress Disorder, PTSD) before, during and after arrival in the UK. This was intended to let them come to terms with their present situation. Habits which were picked up as part of the process of surviving, e.g. smoking or substance misuse, were also elaborated upon.

On the medium term, these areas were further explored and plans for action were outlined and followed up by visits. Further use of the health services were encouraged, particularly vaccinations and any outcome of the health screening was discussed, explained and advice given on any treatment measures.

Long term advice focused on settlement in the UK with the client taking the initiative of identifying health needs and contacting MRC for any necessary support and care.

Health Support and Care

The most important health service needs of refugees were support and care, especially the elderly and women. A total of 104 persons and 155 surgery clients were supported and cared for during the first six months of the project (August/September 1995 - February 1996). These consisted of 50 men, 29 women and 25 children (11 boys and 14 girls). Since then (as shown in the tables) demand has continued to increase.

Three groups of refugees were supported. These were: a) the new arrivals in the UK (primary migrants), b) secondary migrants from other regions within the UK and c) those who were still settling in the West Midlands.

Health support and care included visits and liaison with GPs, dentists, opticians, other primary health providers and specialists on specific health concerns of clients. Registrations with GPs were actively supported as well as referrals to specialists. Advice was given to GPs for clients' NHS rights and health benefits. Clients were reminded of their appointments and consultations at GP clinics, at dental clinics, in hospitals and at specialised clinics. Interpretation in the refugees' native languages were also provided where necessary. Clients were supported at the chemists' shops in order to verify status, to translate and explain dispensed medicines. The diagnosis and the treatment of choice were also explained to the clients.

Short-term support

Immediate health care needs included a welcome introductory package consisting of service at the port of entry, an interpreter service, counselling and support to allay their anxieties, fears and insecurities. A convenient visit was made within the first week of arrival for a preparatory chat for registration and health screening at the GP surgery.

The interview included personal details, medical and mental history before, during and after arrival in the UK. Physical examinations, investigations and prescriptions were carried out by the GP on appointment. Prescriptions, when given by the GP, were dispensed by the chemists. This was followed by interpretation and explanation to the clients about the outcome of the exercise. Transport support to and from the GP surgery was highly essential to new clients and this was provided as well.

Medium-term support

Home visits, further counselling and general advice about the effect of housing on health; language courses as a way of accelerating settlement into the new environment; immigration matters for legal security and prevention of anxiety; welfare of women and children including support services were given. Further follow up appointments were made with GPs for necessary immunisations, further investigations, illnesses, prescriptions, special clinics and referrals to specialists in secondary health care. Support was similarly given in other primary health care services (dentists, physiotherapists, alternative medical practices, ophthalmic services etc.).

Long-term support

Counselling and advice in primary and secondary health care services; processing of health and social benefits and allowances e.g. disability living allowance (DLA) forms; health education, advice, notification and referrals to the housing or environmental services; general advice and referrals on educational, vocational or professional training.

Health Promotion

The standard model of three overlapping health promotion activities (Tannahill 1985) was adopted. Emphasis was placed on prevention and health education (including health protection). In prevention, the aim was to reduce the risk of illness, disease and disability as well as prolong life by avoiding premature death. The main objective of health education was to improve health and prevent ill-health by enabling refugees to follow and sustain particular habits or methods of treatment or care as well as taking advantage of available preventive health programmes.

Prevention

Primary prevention was carried out by applying the strategies of health education, immunisation and environmental measures among healthy refugees. Parents were encouraged to take their children for routine primary vaccinations (e.g. BCG, DTP, Polio, Hib, MMR) as well as the necessary booster doses when due, while adults were persuaded to be vaccinated with tetanus toxoid and polio boosters at GP surgeries. Homes were visited, essentially to inspect the condition of living ; the environmental services and the housing departments were informed accordingly regarding any necessary attention.

Secondary prevention was carried out at both asymptomatic and symptomatic stages, first with a presymptomatic questionnaire which was administered during a 30-minute discussion session with all new clients. This was intended to obtain past and present medical and family histories of prevalent diseases (contracted in home countries and since arrival in the UK). The discussion was followed with a screening exercise at a GP surgery by physical examination, blood pressure measurements, urinalysis and blood analysis by the GP. Chest radiography and further investigations were also requested, when necessary, by the GP. Dental examinations and optical tests were encouraged for individual clients if there was immediate need for them. Early diagnosis and prompt effective treatment were given by the GPs and dentists at the symptomatic stages of diseases. Health education was also provided for existing screening programmes in common use in the UK, e.g. anaemia in pregnancy, pre-eclampsia, hypertension, cervical and breast cancers.

Tertiary prevention was done by supporting visits to physiotherapists and applications for Disability Living Allowance (DLA) in cases of physical disabilities of mobility , eyes, ears and debilitating medical conditions (e.g. diabetes, epilepsy etc.)

Health education

Three methods were applied, i.e. the educational model, the health improvement model and the preventive medical model (Whitehead and Tones 1991). Health education of refugees began from the first contact during the administration of the screening questionnaire. Specific areas for giving information to the clients were identified and they were equipped with practical skills in order that they could exercise choice and resist social pressures. They were encouraged to pursue healthy lifestyles.

Particular areas emphasised were substance misuse (tobacco smoking; alcohol; "Khat", or "Qaat" presently a legal drug), nutrition, sexual health (restrained and, protected sex),

women's health (gynaecological), pregnancies, family planning issues, child health (immunisation, pre-school and school health programmes), mental health (counselling).

Health protection

Measures, strategies, policies and legislations for prevention of the spread of disease or for reduction of risks were accepted and explained to clients, e.g. the Patient's Charter in health services or restriction of smoking at offices (MRC office was declared a smoke-free environment to staff and clients).

Corporate strategies on the health of refugees in the West Midlands were actively being sought from local authorities in order to address inequalities in health services. Examples of existing strategies existed within the framework of Healthy Birmingham 2000 and Healthy Sandwell 2000. The Birmingham City Council also published strategies and plan of action for promoting the health of the refugee population in Birmingham.

A regional refugee conference (including a workshop on Health and Social Services), was organised by MRC, at Coventry on the 12th of March 1996. A panel of discussants addressed the implications of the changes to the Asylum/Immigration Bill on access to welfare benefits by asylum seekers, including the effects on health care. A local Health Project Steering Group was planned throughout the region (like the Joint Steering Group for Birmingham and Sandwell), consisting of health purchasers, health providers, health contractors and voluntary agencies in order to make recommendations for a programme of action and strategy for the health of refugees throughout the West Midlands region as well as implement these policies.

Environmental Health

Activities were focused on the effect which housing of refugees, in Birmingham and Sandwell areas, had on the health of individuals and families. Refugees' houses were inspected during home visits and any concerns about damp dwellings (e.g. the growth of moulds), poor heating and ventilation, inadequate water supplies and drainage, poor cooking and toilet facilities were pointed out promptly.

Pests (insects and mammals e.g. cockroaches, rats and mice) were also observed in some homes. Indoor air quality as in severe cigarette smoking or carbon monoxide poisoning from gas and solid fuel installations at homes were also looked for.

The effect of such environments on refugees, including the transmission of communicable diseases, was highlighted. Subsequently, the appropriate liaison with GPs, the Environmental Services and the Housing Services were made.

Interpreter Service

The Brent and Harrow study (Brent and Harrow Health 1995) identified language as the biggest obstacle to access as a major issue for providing health care to refugees. Nothing could be more frustrating for a client whose complaints were not understood because of a language barrier; perhaps one experience was enough to put him or her off and lose confidence and faith completely in the health service.

It took a lot of patience, time and good will to be a good listener but quite often the usual ten minutes or so offered at the GP surgery appointment or at the hospital clinic was not adequate for this and the client was left worse off with little solution to his/her health needs.

An interpreter service, based at the MRC, was set up for use by health providers at short notice (24-48 hours) to provide interpretation in the appropriate refugee community language at hospitals, GP surgeries, Dental surgeries and with Opticians and Chemists as well. An appropriate interpreter was always available in any of the refugee community language, including Serbo-Croat, Bosnian, Dinka, Zende, Arabic, Somalian, Spanish, French, German, Albanian, Russian, Amharic etc. The RHPW arranged with the client, GP or hospital and the interpreter that would be acceptable to both the client and health service provider. The interpreters were trained on the job for special interpretation skills required and were expected to attend formal certified training courses as a part of personal development.

Outreach, Networking & Collaborative Services

Refugees were supported and cared for at regular 'surgeries' held in Birmingham at the MRC premises, at the Bosnian Hezergovina Community Association (BHCA) premises, at the Refugee Housing Association Ltd hostel and during home visits to individual refugees and families living in Birmingham and Sandwell areas. A regular weekly 'surgery' was also planned to start at a convenient GP surgery premises in Sandwell (Smethwick/West Bromwich). Counselling and screening discussions were also carried out at these 'surgeries'.

Referrals were received from the Bosnia Project, from Hospital Trusts in Birmingham as well as from other agencies (e.g. Refugee Housing Association, Refugee Arrival Project) on health matters.

Personal advocacy meetings were held at hospital appointments with specialists on several occasions. These departments included the A & E General and Selly Oak Hospitals; Neurophysiology; Selly Oak Hospital; ENT Queen Elizabeth Hospital; Out-patients and Wards; City Hospital; Out-patients; Children's Hospital.

Special meetings were held with Birmingham and Sandwell Health Authorities, Sandwell FHSA & Translation Unit, Sandwell Health Promotion Services. Networking included the following with:

Birmingham and Sandwell Joint Refugee Health Project Steering Group
Birmingham City Council Social Services
Birmingham Health Promotion Services
Birmingham Refugee Forum
Bosnia Network Coventry
Bosnia Project
British Red Cross Solihull
British Refugee Council London
Coventry City Council Race and Equality
Coventry Health Primary Health Care
Coventry Health Promotion Services
Equal Access Brent & Harrow, London
Healthy Birmingham 2000
Healthy Islington 2000 London
Nigerian Refugee Welfare Association London
North Birmingham Mental Hospital NHS Trust
Solihull Council of Voluntary Services
Solihull Council Social Services
Solihull Health Authority
Warwick University Centre for Research in Ethnic Relations Refugee Health Team
West Midlands Regional Health Authority.

These meetings explored areas for co-operation, sharing of experiences, collaborations and advice for the benefit of refugees.

Two conferences were organised: 'Refugee Women and Health' at Oldbury, November 1995 and 'Regional Refugee Community Development Conference', including a Workshop on Health Services at Coventry, 12 March 1996.

Analysis and Evaluation of Client Workload

Since the start of the service, the numbers of people attending clinics or requesting medical help have grown steadily. In the first six months, one hundred consultations were expected but 155 client sessions were delivered. By the end of nine months, the workload had exceeded the expectation for the full year, and two-thirds of workload was taken up by revisits from 'old clients'. This suggests a high level of confidence in the service. The rapidly increasing level of demand is partly due to implementation of better documentation of services available, but also is due to the effectiveness of refugees themselves in familiarising themselves with the initiative.

The majority of those attending the service are men, and the sex-ratio has remained fairly constant during the service. Numbers of female users also continue to increase, however.

There is indeed an increasing demand for family healthcare needs. If an experienced female assistant were employed, this would probably lead to a further development of activity and is likely to encourage more refugee women to access the services. Work with young people, especially on sexual health education, has been a priority and this too could be developed further.

Analysis of the cumulative data on age, sex, country of origin and service provision, for registered refugees in the MRC HELP, between September 1995 and May 1996 are reported below.

Sex distribution

Table 1: Sex Distribution of Refugees seen by MRC-HELP (Aug/Sept. '95 - May '96)

SEX	NUMBER (& PROPORTION %)	
Male	79 (58%)	
Men	63 (46%)	
Boys	16 (12%)	
Female	57 (42%)	
Women	39 (29%)	
Girls	18 (13%)	
TOTAL	136	(100%)

Age distribution

Young adults between 17/18 years and 44 years of age predominated (59%) accounting for 96 per cent of female adult clients and 81 per cent of male adult clients. Children up to 16 years of age constituted 26 per cent with the under five's and the older children making up 11 per cent and 15 per cent respectively. The older adults constituted 16 per cent with the middle aged and the elderly making up 7 per cent and 9 per cent respectively.

Table 2: Age Distribution of Refugees in "MRC HELP" (Sept. 1995 - May 1996)

AGE RANGE (YEARS)	Per cent
0 - 5	11%
6-10	7%
11-16	8%
17-24	23%
25-44	36%
45-59	7%
60 & over	9%
TOTAL	100%

Country of origin

Refugees were seen from 21 different countries of origin in the health promotion project so far (Table 3). Three communities predominated (75%). These were from the former Yugoslavia, Sudan and Somalia. So far, refugees from South Asian origins have made little use of the MRC services. It is likely that these nationalities are able to rely on established community networks for advice and support.

Table 3: Countries of Origin of "MRC HELP" (September 1995 - May 1996)

COUNTRY OF ORIGIN	NUMBER
Former Yugoslavia (Bosnia, Serbia, Croatia)	59 [400]*
Sudan (North, East & South)	23 [300]*
Somalia	20 [280]*
Kenya	5
Zaire	5
Libya	3
Nigeria	3
Iraq	3
Eritrea	2
Ecuador	2
Chile	1
Columbia	1
Yemen	1 [30]*
Uganda	1
Algeria	1
Iraq (Kurdish)	1
Liberia	1
Cyprus (Turkish)	1
Greece (Albanian)	1
Romania	1
Pakistani	1
TOTAL	136 (100%)

* The numbers shown in brackets [] for the predominant communities were the updated population estimates obtained through community representatives at the MRC Management.

Type of service and strategy

The type of service provided depended on the needs of individual refugees, which were assessed at the initial discussion or interview. The prominent needs were: GP registration and health screening; support at GP surgeries; advice and support with NHS/Social benefits; health education; child health; family health support and care; women's health; advice on family planning methods; psychological counselling; counselling on smoking and substance misuse; and other needs (Table 4).

Most clients (89%) had multiple needs at first presentation and these could change with subsequent visits. The needs were prioritised and appropriate services were provided accordingly. Strategically, these services translated into five main functions as follows:

- Primary Health Care Advice, Advocacy and Support (46%) [including GP list and screening, GP support, dental health support, ophthalmic health support, pharmacy support, alternative medicine support, NHS/Social benefit advice, medical interpretation, disability support, medical specialist support].
- Family Health Care (20%) [including women's health support, ante-natal care advice and support, family planning advice, child health advice and support, men's health, home visits and care].
- Counselling (17%) [including psychological trauma and stress, smoking, substance misuse].
- Disease Prevention and Health Promotion (15%) [including vaccination, health education]
- Environmental Health and Housing Support (2%).

Table 4: MRC HELP SERVICES (Aug./Sept. 1995 - May 1996)

SERVICE	NUMBER OF CLIENTS * (& PROPORTION %)
Health Education	49 (13%)
Health/Social Benefits Advice and Support	45 (12%)
GP List and Screening	38 (10%)
Counselling (Psychological)	34 (9%)
GP Support	31 (9%)
Child Health	25 (7%)
Family Health Support (home visits and care)	20 (6%)
Women's Health Support	14 (4%)
Family Planning Advice	11 (3%)
Pharmacy Support	11 (3%)
Counselling (smoking)	10 (3%)
Medical Disability Support	10 (3%)
Medical Specialist Support	9 (2%)
Counselling (substance misuse)	9 (2%)
Medical Interpretation	8 (2%)
Physical Disability/Physiotherapy Support	7 (2%)
Disease Prevention (vaccination)	6 (2%)
Environmental Health Support	6 (2%)
Dental Health Support	5 (1%)
Ophthalmic Health Support	5 (1%)
Ante-natal Care Advice and Support	4 (1%)
Alternative Medicine Support	3 (1%)
Others (Material Assistance etc.)	3 (1%)
Housing Support	2 (1%)
TOTAL	369 (100%)

* Number of new registrations who needed the particular service, a new registration/attendance could have a single or multiple service provision.

Health care advice, advocacy and support

These constituted 46 per cent of all the services offered in the first 10 months of the refugee health promotion project and the following skills were involved:

- a) NHS/Social benefits advice and support (12%) was necessary for obtaining prescriptions from GPs, dentists, opticians as well as chemist shops. They included a certificate for help with NHS charges where a client was not entitled to income support.
- b) GP list and screening (10%) were actively encouraged for refugees and GPs were approached to include refugees on their lists, priority being given to those within the proximity of client's residence. The option of the gender of the practitioner was also allowed for the client in order to establish trust and confidence in the practice. GP registration and screening were done for both primary and secondary migrants as soon as possible within the first week of arrival in the Birmingham area.
- c) GP support (9%) was necessary in most of those registered and screened but particularly so afterwards whenever medical problems arose. Medical interpretation as well as explanation of the nature of illness to the client beyond short appointment/visit to the GP's surgery were often supported. The presence of the RHPW or a prior discussion with the GP had a positive effect in understanding the refugee's situation and, where necessary, options of management for the clients were suggested to the practitioners.
- d) Pharmacy support (3%) was important especially for clients who did not understand English and were assisted with filling the reverse side of the prescription form. Explanation of the doses of prescribed medicines was emphasised to the clients.
- e) Medical specialist support (2%) was necessary, either through options of management discussed with the GP (in order to emphasise the need for the client) or by accompanying the client to specialist clinic appointments for encouragement and better understanding of a client's needs.
- f) Disability support was either as medical disabilities (3%) like diabetes (juvenile and adult), malignancies, Coronary heart disease (CHD), epilepsy, blindness, deafness, asthma, Downs Syndrome, etc. or as physical disability/physiotherapy (2%). The adult clients were also advised on and assisted in filling the DLA1 application forms.
- g) Dental health support (1%) was usually demanded by the client or suggested to the client after the GP screening. The RHPW assisted the client to register with and receive treatment from dentists who operated the NHS dental list.
- h) Ophthalmic health support (1%) was necessary for refugees who needed sight tests and wanted to wear glasses. NHS vouchers were advised to the client appropriately.

i) Medical interpretation (2%) was done for those who needed translation in the French language by the RHPW. An interpreter service run by the MRC was also available as described above.

j) Alternative medicine support (1%) was given to cases who had more confidence in homeopathic practice. Prescriptions were also given to the GPs to be transferred on to the NHS prescription form (Form FP10).

Family health care (21%)

This was, probably, the single most important service encouraged because most refugees got comfort and strength from family and community lives. The family was where their lost cultures, traditions, habits were either reactivated or rediscovered or where trust with confidence developed.

The RHPW made home visits to families as well as to hostels and community associations as part of the outreach service. The family atmosphere was more relaxed, caring and supportive for establishing the much needed trust for service providers. Members of the family expressed their pleasure at such a gesture from someone who could relate to them and their environment; more importantly sharing in their living, concerns and worries.

Areas of health covered included child health support [7%, e.g. routine immunisations, child development, pre-school (under five) and school health]; men's health and visits (6% e.g. sexual health); women's health support (4%, e.g. preventive screening for breast and cervical cancer; sexual health) family planning advice (3%); ante-natal care, advice and support (1%).

Counselling (14%)

Counselling was at the individual level, apart from group "therapy" which was obtained from family/community support. This service was usually in three forms, namely, psychological counselling, (9%) for traumas and stress resulting from the circumstances of a refugee at the home country and in the host country (Britain) as well; smoking counselling (3%) which was very common among the Bosnians resulting from habits picked up early in life (there were worrying teenage smokers in this groups); substance misuse counselling (2%), for example alcohol and "Qaat" which were legal drugs but were turned into habits leading to abuse in many cases, specially with "Qaat" among the Somali young men. Young smokers or substance users were particularly counselled with success. Some of them had picked up the

habit (especially smoking) in response to the stress of the "refugee experience" during the period of settlement in Britain, rather than from a peer pressure.

Disease prevention and health promotion (15%)

The service was effective with teenagers and adults alike at the point of first interview in order to educate, seek to prevent illness and encourage healthy living among refugees. Young men did not particularly realise the benefits of prevention (because they were usually healthy at the first visit) until an emergency situation occurred to them. The elderly were initially resentful of any vaccination against infectious diseases as they claimed, they had already survived in life long enough to have been naturally immune to most diseases.

Environmental health and housing support (1%)

Two clients wanted a change of accommodation because of poor housing with problems arising from ineffective heating, dampness and subsequent toll on the health of individual members of the family (e.g. asthma, respiratory tract infections, rodent or insect-borne infections). The houses were inspected and their GPs were advised to write letters for the Environmental Health departments in support of either an improvement or relocation of housing, particularly where this could lead to an improvement in the health of the family.

Conclusions

The refugee health project is expected to continue for 24 months more and additional grounds should be covered as the project become more familiar to refugees and the mainstream services in the Birmingham area. So far the response has been overwhelming from the refugees themselves and the health care providers are also finding it beneficial to their practices. Some access barriers to the health services have been identified and one of the solutions include, the advice, advocacy, support and care by the RHPW.

The following conclusions are drawn from the refugee project so far:

- Access barriers do exist for refugees in Birmingham and Sandwell areas. These include, a) alienation from the NHS by the lack of information to refugees and knowledge of what needs to be done, b) negative and unwelcoming attitude of some health practitioners towards refugees, c) lack of understanding of health problems of refugees d) cultural and religious barriers e) communication difficulties between refugees and practitioners.

- Refugees in Birmingham areas are multi-nationals with various backgrounds and each community has unique areas of cultural and historical sensitivities. They are not only members of minority ethnic groups but are also marginalised people who have suffered loss (human and material) and are in need of help; they also suffer lack of understanding from the perception and attitude of neighbours. Their needs go beyond those of ethnic minorities in the UK. This background needs to be understood by service providers to give better services to these communities.
- Most of the health needs are in the areas of Primary Health Care, Family Health, Psychological Counselling, Health Education and Disease Prevention.
- Genuinely friendly and trusting advice, support and care are essential to satisfy the needs of refugees.
- Health Practitioners serving refugees need to acquire skills in all areas of living in order to serve refugees better and make them feel accepted. The Health Practitioner could be the obvious source of comfort and relief.
- More time is needed to attend to a refugee than the usual 5-10 minute or so surgery appointment time, otherwise, both the client and practice would have wasted their times.
- The health service mostly needed by refugees is outreach in nature and home visits are effective in prevention, cure and rehabilitation of diseases in refugees.
- New arrivals need frequent health visits and more resource should be made available for outreach work.
- Medical interpretation is better done verbally. Although written information in various languages can help literate and settled refugees needs for additional information, their immediate communication and educational needs are not met by this method.

Recommendations

- Health practitioners need information and training on access barriers to the NHS by refugees. This could be done in the form of seminars, workshops and conferences in addition to the support being provided for refugees by the RHPW. Copies of the MRC

Health Project reports could be made available to the health and general practitioners through the Health Authorities.

- Refugees need a welcome package, including information pack about the health services in the UK. This pack should be translated in various languages of refugee communities (e.g. Serbo-Croat, Somali, French, etc.) in collaboration with Interpretation units in Sandwell and Birmingham.
- All providers and purchasers of statutory health service (Primary Health Care, Contractors including Hospitals and Trusts, Community Health Councils, Health Authorities) need to provide a regular budget for the interpretation needs of some refugees. Interpreters should be professionally trained and sought from the refugee communities.
- The outreach work of the refugee health project should be emphasised. This should include more health visits.
- A Health Assistant, with special interest in refugees, needs to be appointed for areas where the refugee population is high (e.g. Birmingham/Sandwell, Coventry) to assist the RHPW because of the increase in workload.
- A statutory recognition for the health promotion services at the Midlands Refugee Council is necessary to attract experienced professional and ensure continuity in health services. The possibility of secondments from the mainstream health providers and purchasers could be explored.
- The MRC needs a regular budget to provide car allowance for the health promotion project worker(s). This should help towards vehicle maintenance costs for the worker(s) and ensure that the outreach work continues unhindered by transport.

References

- Arbesman, M., Kahler L., Buck G.M. (1993) 'Assessment of the impact of female circumcision on the gynecological, genitourinary and obstetrical health problems of women from Somalia' *Women & Health* 20(3):27-42
- Bala, J. (1995) 'The interactive context of stress, adjustment and support of refugee families and children' *ESSOP* 1995 :80-85
- Ball, C.S., Welch J.M., Ward T.J., Himid K.A., Lynch M.A. (1995) 'HIV in the Family: The Ultimate Disadvantage for Refugees' *ESSOP* :124-125
- Bang, S. (1993) *We came as a friend: towards a Vietnamese model of social work* Leeds: Refugee Action
- Beiser, M., Johnson, P.J., Turner, R.J. (1993) 'Unemployment, underemployment and depressive affect among South East Asian refugees' *Psychological Medicine* 23(3) :731-743
- Bernard-Jones, S. (1993) *Haringey Refugee Development Project* London: New River Health Authority
- Birmingham City Council Corporate Strategy for Refugees (1993)
- Bollini, P. (1993) 'Health for Immigrants and Refugees in the 1990s. A comparative study in seven receiving countries' *Innovation* 6,1 :101-110
- Bratton, R.L., Nesse, R.E. (1993) 'Ascariasis: an infection to watch for in immigrants' *Postgraduate Medicine* 93 :171-173, 177-178
- Brent & Harrow Refugee Survey (1995) Brent & Harrow Health Agency & others
- British Red Cross (1993) *Health Situation of Refugees and Asylum Seekers in the United Kingdom*
- Bucher, H., Weinbacher, M., Gyr, K. (1994) [Compliance of asylum seekers with an expanded border health screening program in the Basel-Stadt canton 1992-1993]. [German Original Title] *Schweizerische Medizinische Wochenschrift. Journal Suisse de Medecine.* 124(38):1660-5
- Budak, N. (1993) *Health Needs of Kurdish refugees in Haringey* London: New River Health Authority
- Carey Wood, J., Duke, K., Karn, V., Marshall, T. (1995) *The settlement of refugees in Britain* Home Office Research Study 141 London: HMSO
- Castley, J. (1991) 'The plight of refugee women and children in the UK: profile of the Somali refugee community' *African Woman* 5 :18-20

- Clabots, R.B., Dolphin, D. (1992) 'The multilingual videotape project: community involvement in a unique health education program' *Public Health Reports* 107(1):75-80
- Clinton-Davis, L., Fassil, Y. (1992) 'Health and social problems of refugees' *Social Science & Medicine* 35(4):507-13
- Cohen, P. (1995) 'Safe Havens' *Community Care* 16-22 Nov. :21
- D'Avanzo, C.E., Frye, B., Froman, R. (1994) 'Culture, stress and substance use in Cambodian refugee women' *Journal of Studies on Alcohol* 55(4):420-6
- Duke, K., Marshall, T. (1995) *Vietnamese Refugees since 1982* Home Office Research Study 142 London:HMSO
- ESSOP: European Society for Social Paediatrics (1995) *Child Health Care for Migrants & Refugees* Conference Report (3-6 October) Rotterdam (NL): ESSOP
- Forrest D. (1995) 'Patterns of abuse in Sikh asylum-seekers' *Lancet* 345(8944):225-6, Jan 28
- Forsberg, E., Svensson, P., Starrin, B. (1993) 'Ill-health and social conditions amongst migrants and refugees - the case of Sweden' *Innovation* 6,1 :75-83
- Frye, B.A., D'Avanzo, C. (1994) 'Themes in managing culturally defined illness in the Cambodian refugee family' *Journal of Community Health Nursing* 11(2):89-98
- Frye, B.A., D'Avanzo, C.D. (1994) 'Cultural themes in family stress and violence among Cambodian refugee women in the inner city' *Advances in Nursing Science* 16(3):64-77
- Gammell, H., Ndahiro, A., Nicholas, N., Windsor, J. (1993) *Refugees (political asylum seekers): service provision and access to the NHS* London: College of Health
- Gilman, S.C., Justice, J., Saepharn, K., Charles, G. (1992) 'Use of traditional and modern health services by Laotian refugees' *Western Journal of Medicine* 157(3):310-5, Sep.
- Gorst-Unsworth, C. (1992) 'Adaptation after torture: some thoughts on the long-term effects of surviving a repressive regime' *Medicine & War* 8(3):164-8
- Grant, C., Deane, J. (1995) *Stating the obvious - factors which influence uptake and provision of primary health care services for refugees* Brixton Refugee Health Project, Brixton Challenge & Lambeth Southwark & Lewisham Health Authority
- Guardian* Newspaper - 21 Feb 1995 L Donegan: 'Doctor accuses hospital of racism for rejecting Kurds'
- Hauffe, E., Vaglum, P. (1993) 'Vietnamese Boat Refugees: the influence of war and flight traumatisation on mental health' *Acta Psychiatrica Scandinavica* 88(3) :162-8

- Hauffe, E., Vaglum, P. (1995) 'Organised violence and the stress of exile' *British Journal of Psychiatry* 166 :360-367
- Hayes, S.L., Mott, A., Braude, D., Webb, E. (1995) 'Somali Child Health Clinics in Cardiff' in *ESSOP* :125
- Hetta, O.M. (1992) 'Thank you, doctor' Knowledge of intercultural communication is necessary in health care for refugees (Norwegian Original Title) *Tidsskrift for Den Norske Laegeforening* 112(8):1043-6, Mar 20
- Hoar, S. (1991) 'Refugee Action in Kingston' *Voluntary Voice* 56 :12-13
- Independent* newspaper - 7 May 1994 C Brown 'Immigrants targeted in moves to fight TB'
- Karmi, G., Abdulrahim, D., Pierpoint, T. (1993) *Suicide amongst ethnic minorities and refugees in the UK* London: NETRHA/NWTRHA Health & Ethnicity Programme
- Karmi, G., Awiah, J. (1992) *Refugees in North West and North East Thames Regional Health Authorities* London: NETRHA/NWTRHA Health & Ethnicity Programme
- Kemp, C. (1993) 'Health services for refugees in countries of second asylum' *International Nursing Review* 40(1):21-4, Jan-Feb.
- Lee, A., Buchwald, D., Hooton, T.M. (1993) 'Knowledge and compliance with medications in South East Asian refugees' *Journal of Clinical Pharmacy & Therapeutics* 18(3):199-204
- Marett, V. (1993) 'Resettlement of Ugandan Asians' *Journal of Refugee Studies* 6,3 :248-259
- McFarland, E., Walsh, D. (1989) 'Refugees in Strathclyde: The challenge of Resettlement' *Critical Social Policy* 26 :101-106
- McFarlane E and Walsh D (1988) *Refugees in Strathclyde* Scottish Ethnic Minority Research Unit: Glasgow College
- Meropol, S.B. (1995) 'Health status of pediatric refugees in Buffalo, NY' *Archives of Pediatrics & Adolescent Medicine* 149(8):887-92
- Mohamed, L.A. (1993) Final report by the Somali Health worker, London: New River Health Authority
- MRC Proceedings of the 1996 Regional Refugee Community Development Conference and Workshops, Coventry, 12 March 1996. (in press)
- Muecke, M.A. (1992) 'New paradigms for refugee health problems' *Social Science & Medicine* 35(4):515-23
- Murphy, A.W., Lynch, M., Bury, G. (1994) 'Cead Mile Failte' - an assessment of the screening of 178 Bosnian refugees to Ireland *Irish Medical Journal* 87(6):174-5

- Paiva, R.G. (1995) 'International Migration and its Social Impact on Europe' in *ESSOP* :15-24
- Pearson, R. (1980) 'Health Visiting with a Difference' *Health Visitor* 53,7 :257-258
- Pernice, R., Brook, J. (1994) 'Relationship of migrant status (refugee or immigrant) to mental health' *International Journal of Social Psychiatry* 40(3) :177-188
- Pickwell, S.M., Schimelpfening, S., Palinkas, L.A. (1994) "'Betelmania", Betel quid chewing by Cambodian women in the United States and its potential health effects' *Western Journal of Medicine* 160(4):326-30
- Poot, A.J. (1995) 'Single Underage Refugees coming to the Netherlands' in *ESSOP* :114-6
- Refugee Council (1994) *The Health of Refugees: A National Conference London (17 March)*
- Ruddy, B. (1992) 'Any port in a storm' *Health Service Journal* 102 (5330) :29
- Sandstedt, A.C., Carlsson, V.A., Hornquist, J.O., Thyberg, M. (1992) 'War-wounded refugees. Quality of life after 2-3 years in Sweden' *Scandinavian Journal of Social Medicine* 20(3):173-8
- Stubbs, P. (1995) 'Working with Refugee and Displaced Children: from Trauma to Safety?' in *ESSOP* :63-68
- Sundquist, J. (1994) 'Refugees, labour migrants and psychological distress' *Social Psychiatry & Psychiatric Epidemiology* 29(1) :20-4
- Swerdlow, A.J. (1991) 'Mortality and cancer incidence in Vietnamese refugees in England and Wales' *International Journal of Epidemiology* 20(1) :13-19
- Tang, M., Cunninghame, C. (1994) 'Ways of saying' *Health Service Journal* 104(5420) :28-30
- Tannahill, A. (1985). 'What is health promotion?' *Health Education Journal* 44 : 167-8
- Todd, R., Gelbier, S. (1988) 'Eat more food, get more health - attitudes and food habits of ... Vietnamese refugees' *Health Education Journal* 47,4 :149-153
- UNHCR (1979) *UN Convention Relating to the Status of Refugees* Geneva, 28 July 1951 as in "Collection of International Instruments Concerning Refugees" UNHCR Geneva
- United 1996 Conference Report - Speak Out for Refugees Rights Brussels June 13-14 Amsterdam: United for Intercultural Action
- Van der Veer, G. (1992) *Counselling and therapy with refugees* Chichester: Wiley
- van Willigen, L.H.M.(1995) 'Refugees in the Netherlands' in *ESSOP* :47

Whitehead, M., Tones, K. (1991) *Avoiding the Pitfalls* London: Health Education Authority

Wiggs, L. (1994) 'Meeting the needs of refugees' *Nursing Standard* 8,14 :18-20

Zimmerman, M., Bornstein, R., Martinsson, T. (1993) 'Attitudes and knowledge about preventive dental care in Chilean refugees in Sweden' *Community Dental Health* 10(4):343-51

Zimmerman, M., Bornstein, R., Martinsson, T. (1995) 'Utilization of dental services in refugees in Sweden 1975-1985' *Community Dentistry & Oral Epidemiology*. 23(2):95-9