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## **An evaluation of a family health programme for newly arrived asylum seekers living in an initial accommodation centre in northern England**

### **Abstract**

Asylum seekers in the UK often have complex health needs but face barriers when accessing health services. A family health programme was established in an initial accommodation centre (IAC) in northern England, by trained volunteers who are refugees and therefore peers. The main focus of the programme is peers educating asylum seekers about health services in the United Kingdom (UK), including maternity services, and evaluation research was undertaken to explore the effectiveness of this. Two sessions were observed and participants provided a short verbal evaluation. Data were thematically analysed. Around 30 people from 17 countries attended the sessions which were evaluated positively. Three themes emerged related to asylum seekers' perceptions of their learning: access to health care, living as a family, and the UK as a caring country. The findings suggest that peers educating asylum seekers within an IAC appears helpful in overcoming barriers to accessing health care in the UK and could facilitate pregnant women to attend for maternity care.

**Key words:** Asylum seeker, family health programme, mental and physical health, peer volunteers, maternity care

### **Introduction**

In 2013, around 2500 people per month, including pregnant women, applied for asylum in the UK (Gov.UK 2013). Asylum seekers are a particularly vulnerable group with complex health needs (Burnett & Fassil 2004). They may have fled their home country due to torture and violence, leaving behind or losing family members (Burnett & Fassil 2004). These factors can lead to mental health difficulties including post-traumatic stress disorder, depression and anxiety (Aspinall & Watters 2010). Physical health can be poor and compounded by infectious diseases including HIV (Aspinall & Watters 2010). Pregnant women are at an increased risk of miscarriage, stillbirth, neonatal and maternal mortality (NICE2010, Lewis 2011). It is essential, therefore, that once in the UK, asylum seekers receive good quality health care to meet their needs. Asylum seekers are entitled to register with a GP and receive free NHS care (O'Donnell *et al* 2007). However, they can experience barriers in accessing services. They may not understand UK health care systems (Crawley 2010), or receive insufficient information about services available and their entitlement (Norredam *et al* 2006). Health care in their home country may be organised differently, with direct access to hospitals rather than GP referrals (O'Donnell *et al* 2007). Consequently, they may attend services inappropriately such as presenting to the accident and emergency department for general concerns, or during labour. They may not understand the idea of preventative health care, and therefore not access screening including antenatal care (Szczepura 2005). Asylum seekers may also fear that personal information from health consultations will not be confidential and perhaps used within asylum claims (O'Donnell *et al* 2007)

To ensure asylum seekers access health care in the UK, it is vital that these barriers are overcome. To address this, the Refugee Council developed a family health programme whereby a group of trained multilingual volunteers and their coordinator provide a weekly two-hour educational session within an IAC, where most asylum seekers are housed on arrival in the UK. In northern England, the IAC houses 250 asylum seekers who remain there for around three weeks before they are dispersed. Whilst there, they receive medical screening and basic health care, including access to a midwife. The programme is designed to build on this basic provision by inviting asylum seekers to the two different sessions, each delivered fortnightly (Table 1). As well as access to health care, the social norms around living as a family in the UK are discussed. For example, asylum-seeking women are at an increased risk of domestic abuse (Burnett & Fassil 2004). Societal intolerance to this in the UK is also discussed. The volunteers are mainly refugees themselves, trained to work as health befrienders with other asylum seekers and refugees. Consequently, they are peers and can relate to the asylum seekers' beliefs and assumptions about services, whilst providing accurate information about UK health care.

## **Methods**

Research evaluating the programme was undertaken with the aim of exploring asylum seekers' perceptions of whether the sessions increased their understanding about how to access health services in the UK. The researcher attended two sessions. Permission was gained from the participants and confidentiality within the room assured in relation to personal issues that may be raised. Ethical approval was acquired from the researcher's employing university through the ethics committee. The sessions were observed and field notes taken. Recording equipment was not used as participants may have feared that the data could be used within their asylum claim. Field notes focused on identifying verbal and non-verbal interactions, actions and behaviour, relationships and events (Mason 2002) within the room which could suggest interest/ disinterest in the session being delivered. At the end, participants provided a short verbal evaluation of the session. The principles of thematic analysis (Mason 2002) were followed and the emerging themes verified by a colleague.

## **Findings**

Over the two sessions, the men, women (some pregnant) and children who attended were from 17 different countries including Africa and the Middle East. Apart from one woman from Albania, everyone had access to an interpreter through the volunteers. At the beginning of each session, there were around 30 people in the room. However, this number varied as people left, some of whom returned, and others arrived. In the second session there was a marked reduction in the number of men when maternity care was discussed, possibly due to cultural constructions around care during childbirth being a woman's responsibility.

At the beginning of each session, it appeared that language barriers and unfamiliarity with each other influenced group dynamics. There was little group interaction and many people sat in silence. However, following the introductions and subgroup work, group interaction through the volunteers increased as people discussed health care differences between their home countries, though generally the men in the group appeared more vocal than the women. As the sessions progressed, through nodding and smiling, it appeared that individuals understood what was being discussed, but it

was also noted that many people had periods of disengagement where they appeared silent and lost eye contact with the group. At times, voices became raised and some women appeared to be crying. The volunteers suggested that this was because there was surprise and gratitude that asylum seekers could access health care in the UK without having to pay.

A total of 29 people provided a short verbal evaluation of the two sessions (15 and 14 respectively). Although all the evaluations were positive, it was noted that there may have been a sense of obligation to say something complementary. Three themes emerged from the findings as discussed below:

#### 1. Improved access to health care in the UK

Nine participants felt the first session in particular had prepared them to access health care should they need to, including understanding how to register with a GP. One participant suggested that this was his first opportunity since arriving in the UK to learn this:

*'I have been here one and a half years. I have learned more today than any time in the past.'*

#### 2. Living as a family in the UK

Six participants felt that through the second session they learnt about the UK family and expectations of the roles of men in the UK compared to other countries. In particular, there was an increased awareness around the need for husband and wife to communicate well. However, one man felt that the expectation for men to play an active role would make it difficult for him to have a baby in the UK. Two participants commented on their learning related to the unacceptability of domestic and child abuse. One woman felt that in her country, women suffer in order to protect her child from harm. Another male participant realised that his role as father within a family would be different in the UK:

*'My daughter is 6 years old. I learnt about children. I love to play with my daughter. I used to hit my woman because she hit my daughter.'*

#### 3. The UK as a caring country

Following the sessions, 19 participants perceived that the UK cared about its people. In particular, that the NHS provision of health care helps to meet basic human rights which did not happen at home. It was also perceived that the culture within the UK, including government provision, was supportive of women and children. One woman felt that she could not have a baby in her home country because of the cost implications. Consequently, there was a perception that England was a good place to live:

*'When I left my country I missed my loved one. Now I am feeling someone cares, it matters a lot to me.'*

### **Discussion**

The findings suggest that delivering a family health programme within an IAC appears to be helpful in preparing newly arrived asylum seekers, including pregnant women, to access health care in the UK and to address their mental and physical health needs. However, this is a small, time specific local study with people who may have felt obliged to be positive. Nevertheless, it provides an insight into the perceived benefits of the programme and the potential for further development. Evidence suggests that many asylum seekers are not aware which country they are

fleeing to and are unhappy when they realise that they have arrived in the UK due to a perception that they will not be welcomed (Crawley 2010). This could compound existing poor mental health and high suicide rates amongst asylum seekers (Aspinall & Watters 2010). Through the family health programme, asylum seekers can be made to feel welcomed, comfortable and safe living in the UK, which may contribute to improved mental health and clinical outcomes in pregnant women. However, it can be argued that the family health programme is limited and could be expanded to include broader issues such as access to mental health services in the UK. No other published literature could be found related to engaging trained refugees in educating newly arrived asylum seekers. However, peer education around health has been found to be effective in the context of college students and health behaviour (White *et al* 2009). This could be a powerful way to deliver essential public health messages with a common understanding of assumptions around health care having a greater impact on the uptake of services within this community. Peer involvement could be expanded to encompass other IACs in the UK and development of the current family programme, to encompass wider public health messages.

### **Table 1. Content of family training programme sessions**

#### **Week 1.**

##### **Access to health services**

Introductions and permission for researcher

Icebreaking. Each participant introduces themselves: name, where from and a way that they reduce their stress levels

Subgroups exploring health care in home countries, feedback and comparisons

Explanation of health care in UK, HC1 card and entitlements re enforced with DVD on access to health services

Summary and feedback from participants

Volunteers' evaluation and learning for next session

#### **Week 2.**

##### **Access to maternity services and family life in the UK**

Introductions and permission for researcher

Icebreaking. Each participant introduces themselves: name, where from and their feelings about being a parent

Subgroups exploring maternity care in home country, feedback and comparisons

Explanation of maternity care in UK, HC1 card and entitlements including the midwife's role

Discussion around families, the role of parents and the intolerance in the UK to child abuse, domestic violence and female genital mutilation (FGM)

Two volunteers role play a couple with a new baby and the role of both parents in the UK including intolerance to child abuse, domestic abuse and FGM

Summary and feedback from participants

Volunteers' evaluation and learning for next session

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