



meeting the health needs

of refugee and asylum seekers in the uk

an information and resource pack for health workers

Angela Burnett & Yohannes Fassil



*"Understand that it is not simple or easy
Avoiding past memory
I can't remove from my mind
My traditional culture
My sentimental torture
The folktales of my childhood
Never old, never dead
Stamped in my mind
I have normal feelings
I suffer for dignity
Please do not kill my broken heart".*
Yilma Tafere, a refugee from Ethiopia

"I believe that future historians will call the twentieth century not only the century of the great wars, but also the century of the refugee. It has been an extraordinary period of movement and upheavals. There are so many scars that need mending and healing and it seems to me that it is imperative that we proclaim that asylum issues are an index of our spiritual and moral civilisation.

How you are with the one to whom you owe nothing, that is a grave test and not only as an index of our tragic past. I always think that the real offenders at the half way mark of the century were the bystanders, all those people who let things happen because it didn't affect them directly.

I believe that the line our society will take in this matter on how you are to people to whom you owe nothing is a signal. It is the critical signal that we give to our young and I hope and pray that it is a test we shall not fail."

Rabbi Hugo Gryn, a Holocaust survivor
(from a Moral and Spiritual Index, published by the Jewish Council for Racial Equality and the Refugee Council, 1996

"When you're a refugee your life is never complete. There is always part of your life that is missing, and that part is home"

Adil, a child refugee from Somalia
From Off Limits - Refugee Voices, Double Exposure for C4Learning

How would refugees like to be treated?

"Lots of smiles if possible, it could make a big difference to our health"

Asylum seeker, dispersed to the North West

Foreword

Every day healthworkers provide a wide range of care and support to refugees and asylum seekers. Frequently these people have left their homes in pursuit of safety and a better quality of life. Their circumstances are difficult and their needs are often highly complex.

We commend this comprehensive and clearly presented Information and Resource Pack. The authors have adopted a style which means the pack can be used as an education resource or as a reference point. Building on the skills and experience of health workers, the pack contains practical information, details of useful contacts and resources and includes examples of good practice from around the United Kingdom.

The prime aim of this Information and Resource Pack is to support and enhance individualised care for each refugee and asylum seeker. Its success in achieving this aim was expressed by a GP in Birmingham.

"This is an incredibly useful and well laid out document. It has made me realise that I need to adopt a new approach to caring for refugees and asylum seekers and this pack will be an invaluable resource for me."

Pippa Bagnall,
Head of Primary Care
London Directorate for Health and Social Care
Dr. David Colin-Thomé
National Clinical Director for Primary Care -
Department of Health



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1. Introduction and background

1.1) Using this resource pack and who it is for

This resource pack is for health workers in both the statutory and the voluntary sectors, particularly those with less experience of working with asylum seekers and refugees. It is for both clinicians and service planners.

We have not divided the pack into different sections for particular health workers as many health workers in this field, especially Health Visitors and nurses, are expanding their roles and taking on new responsibilities.

Many of the issues discussed are standard good practice for any person, whether or not a refugee. Health workers already possess many of the necessary skills for working with asylum seekers and refugees. However, some areas may be unfamiliar, such as torture.

While it raises issues and offers some practical suggestions, it should not be taken as a blueprint. The most important approach is to treat people as individuals, taking into account their views, cultural beliefs and practices, and not making assumptions. Although refugees and asylum seekers are often grouped together they, like all of us, have varying experiences, needs and aspirations and are not a homogenous group. The terms refugee and asylum seeker denote a situation rather than an identity. Issues facing those newly arrived are often very different from those more settled in the UK.

“There is no one best solution for all refugees”
Refugee health advocate, London

The pack was compiled following consultation with refugees, asylum seekers, health workers and others working in this field. Some of the present difficulties appear to arise from different expectations between users and providers of services. This pack aims to try to bridge the gap. Immigration policy is currently under revision (see

section 2.4). Changes in immigration policy affect both the health of refugees and the ways in which their health care is delivered. As a result, services need to be flexible. It is important that health workers connect with the full range of agencies charged with responsibilities in this field.

We have written the pack so that different sections can be used on their own, according to needs and interests. Each chapter is summarised as a box containing key points. The pack is available on the Internet on the following site: www.doh.gov.uk/london/index.htm. We strongly recommend that a nominated person in each area should be responsible for adding information about local services, organisations and resources.

We have tried to address the important issues which affect the health of asylum seekers and refugees, although not all are directly the responsibility of health workers. The information provided is the most accurate available at the time of writing and reflects the experiences of health workers who responded. If you feel there are inaccuracies in the text, do contact us so that we can update and amend future editions. In addition, if you have any comments or suggestions as to how this pack can be improved, we would welcome emails to a.c.burnett@qmul.ac.uk.

1.2) About the authors

Yohannes Fassil, a pharmacist and health planner by training, came to the UK as a refugee from Eritrea and now works for Kensington, Chelsea and Westminster Health Authority as head of Diversity and Community Development Strategy. He has been responsible for refugee health and community development programmes in Kensington, Chelsea and Westminster, and nationally, for over 15 years. Angela Burnett is the descendant of refugees. She was a GP in East London for 10 years and is currently developing the Sanctuary Practice, for asylum seekers and

refugees in Hackney, East London. She is also working at the Medical Foundation for the Care of Victims of Torture since 1995 and the Refugee Education and Training Advisory Service (RETAS). She runs training workshops in the care of refugees and torture survivors and has worked with Primary Care Trusts and Health Authorities on the development of health services for refugees. Both are involved in careers advice and support for refugee health professionals, in order to enable them to work in the UK.

1.3) Acknowledgments

We would like to acknowledge and thank all those asylum seekers, refugees and health workers who gave up their time and contributed their views and experiences for this study. We are unable to acknowledge everyone individually by name, but in particular we would like to thank:

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Asylum Seekers and Refugees, parts of which have formed the basis for this pack and Kensington, Chelsea and Westminster Health Authority for supporting Yohannes in this work.

1.4) Methodology

Initial interviews were held with 24 asylum seekers and refugees, in London and in three dispersal areas – Leeds, Manchester and Liverpool. These were open discussions, based on a loose framework, and enabled interviewees to raise issues they felt to be important. Some interviews were carried out individually in the person's own language. A group discussion was held in London, comprising refugee health workers and refugees working as advocates.

Based on these discussions, questionnaires were compiled for health workers working clinically with refugees and asylum seekers, and for administrative staff (receptionists and managers). These were sent to a number of health workers, with differing experiences of working with asylum seekers, using a snowballing technique. Fifty-five health workers responded from throughout England and Scotland, including refugee community workers, nurses, midwives, health visitors, GPs, consultants, psychologists, psychiatrists, receptionists, practice managers, researchers. Their background included primary care, mental health, child health, women's health, maternity care, infection control, sexual health, public health and service planning. Contact was made with services in Wales and Northern Ireland. A search was also conducted of both published and unpublished literature concerning the health of refugees.

A draft was circulated to all those who had originally given their views, in order to check that their views were fairly represented, as well as to further interested people. The pack reflects issues important to the respondents, and their quotes have been used to illustrate points.

2. Background to the situation of asylum seekers and refugees

- 2.1) The experiences of asylum seekers and refugees
- 2.2) Definitions of immigration status
- 2.3) The procedure for asylum application
- 2.4) Asylum and Immigration Legislation, dispersal and the National Asylum Support Service (NASS)

Key points

- *Britain, as a signatory to the 1951 Geneva Convention, is committed to offer asylum to people fleeing from persecution*
- *Most asylum seekers and refugees in Britain are from countries that are in conflict*
- *Most asylum seekers in the UK are young men, although worldwide the majority of refugees are women*
- *Asylum seekers and refugees have great courage, resourcefulness and resilience*
- *Asylum seekers are being dispersed throughout the UK, to areas that may have had little experience of working with refugees*
- *Planned changes to the asylum process and support arrangements include*
- *ID smart cards*
- *New systems of financial support to replace vouchers*
- *Use of induction and accommodation centres*
- *Improved consultation with local agencies*
- *A commitment to accepting UN- nominated refugees directly*

2.1) The experiences of asylum seekers and refugees

“When you’re a refugee your life is never complete. There is always part of your life that is missing, and that part is home”

Adil, a child refugee from Somalia

Nearly 22 million people throughout the world are estimated to be asylum seekers or refugees, with a further 21 million internally displaced within their own countries (www.unhcr.ch). Numbers of asylum seekers from each country fluctuate, principally according to the local human rights situation. The vast majority remain in neighbouring countries, most of which have scarce resources to provide for their needs. United Nations estimates suggest that Iran currently hosts 1.9 million refugees and Pakistan hosts 2 million, for example¹.

Only those with access to significant resources travel to industrialised countries. In 2000 the UK ranked 9th amongst EU countries and 78th in the world² in terms of asylum seekers per head of population, with 1.7 asylum seekers per 1,000 national population. This compares with the largest host countries, Armenia, Guinea and the Federal Republic of Yugoslavia, who host 80, 59 and 46 refugees per 1,000 national population respectively¹.

Some have been detained and tortured in their own countries, and exposure to violence is widespread. Some people have been persecuted because of their political or religious beliefs and activities, others because they belong to a minority ethnic group, or due to their gender or sexual orientation. Some have had to leave because of an environmental disaster or an engineering project. Many people migrate due to

¹ Home Office Secure Borders, Safe Haven, Integration with Diversity in Modern Britain White Paper on Immigration and Asylum 2002 (Figures from United Nations High Commissioner for Refugees (UNHCR)

² Refugee Council Website

<http://refugeecouncil.org.uk/news/myths/myth001.htm>

poverty as disparities between rich and poor, both between and within countries, continue to widen.

Those leaving their country to seek asylum experience many losses. As well as losing family members, through death or separation, they lose their home, family, friends, money, job and identity, and may lose dignity and hope. It is the multiple loss and, most importantly, the loss of their role, status and usual support network that may make it difficult for people to cope.

Most of those seeking asylum in the UK are single men under the age of 40, although worldwide most refugees are women. Many families in the UK are without one parent, who may be missing or dead, and there are a significant number of unaccompanied children.

Those making the often arduous and dangerous journey to exile are courageous, resourceful and resilient, and these qualities can assist them to rebuild their lives. After the initial relief of arriving frustration and disillusionment may ensue, as the reality of life becomes apparent. It is important to enable people to develop independence, acquire language, and have access to education and employment. Integration requires support from the local community. (see section 8.15 Linking with local communities and befriending)

Most refugees understandably hope that one day they will be able to return home, when the situation becomes safer. During 2000 almost 800,000 refugees throughout the world returned to their home country.

Further reading

Burnett A and Peel M

What brings asylum seekers to the United Kingdom?

BMJ 2001; 322:485-8

2.2) Definitions of immigration status

In order to be recognised as a refugee, an asylum seeker must fulfil the terms of the 1951 Geneva Convention and demonstrate that:

"...owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to

such fear, is unwilling to avail himself of the protection of that country..."

United Nations 1951 Convention relating to the Status of Refugees (Geneva Convention)

The various definitions of refugee status are explained below:

Asylum seeker

A person who has submitted an application for protection under the Geneva Convention and is waiting for the claim to be decided by the Home Office

Refugee status

Accepted as a refugee under the Geneva Convention and granted Indefinite Leave to Remain (ILR) – permanent residence in the UK. Eligible for family reunion (one spouse and any child of that marriage under the age of 18).

Exceptional Leave to Enter or Remain (ELE or ELR)

The Home Office accepts there are strong reasons why the person should not return to the country of origin. ELR grants the right to stay in the UK for 4 years. (S)he is expected to return if the home country situation improves. Ineligible for family reunion.

Refusal

The person's application for refugee status is rejected but (s)he has a right of appeal, within strict time limits

Family reunion

Spouse and children under the age of 18 of a person who is given refugee status. They are given Indefinite Leave to Remain (ILR) - permanent residence in the UK.

In order to fulfill the terms of the Geneva Convention an asylum seeker must demonstrate that (s)he is personally at risk of persecution were (s)he to be returned to his/her country of origin, This is not always easy to prove.

In this pack the term refugee may sometimes be used to include asylum seekers and people at all stages of the asylum process, as detailed in the table above.



2.3) The procedure for asylum application

An application for asylum may be made at the port of entry (port applicant) or after entry to the UK (in-country applicant). With a couple or family one application is made; the man is usually the main applicant. Unaccompanied children make their own application. An asylum seeker may be detained if an immigration officer believes (s)he may abscond, to establish identity or the basis of the claim, or prior to removal. (See section 8.11) Currently, asylum seekers complete a Statement of Evidence Form (SEF) in English, which must be returned within two weeks. If a claim is refused the applicant can appeal. It is essential that asylum seekers have access to a specialised immigration lawyer. (See section 8.9 - Legal support).

2.4) Asylum and Immigration Legislation dispersal and the National Asylum Support Service (NASS)

Before the Immigration and Asylum Act 1999 was implemented, the Benefits Agency and local authorities provided support to asylum seekers. From April 2000 this became the responsibility of the new National Asylum Support Service (NASS), administered by the Home Office.

NASS are responsible for providing support for all destitute asylum seekers until the Home Office determines their asylum application. Asylum seekers can be provided with both support and accommodation (on a no choice basis), or if they have accommodation already, support alone.

Provision of essential living needs is made in vouchers, which can be exchanged for goods at a variety of supermarkets, and a small amount of cash (£14 per adult from 2002) each week to cover expenses such as bus fares or phone calls. Pregnant women supported by NASS can receive a maternity grant worth £300. The application must be made between 36 weeks gestation and 2 weeks after the birth.

Asylum seekers are not dispersed from London if receiving care from the Medical Foundation for the Care of Victims of Torture. If an asylum seeker is receiving specialist health care and dispersal is considered inadvisable, NASS should be contacted via their lawyer or local One Stop Service (See Section 9.1 One Stop Services and National agencies working with refugees)

In February 2002 the Government announced proposed amendments to the asylum process and support arrangements in a new White Paper, Secure Borders, Safe Haven, including:

- *Issuing all new asylum seekers with a new ID smart card (the Application Registration Card, or ARC) that will include photographic and fingerprint details. This will be issued to all new asylum applicants from January 2002, with all asylum seekers registered in this way by the end of 2002. From July 2002, Post Offices will issue cash via the ARC.*
- *Vouchers will be superseded by early autumn 2002 by new systems of financial support, including the setting up of induction and accommodation centres, where asylum seekers will be housed. Those choosing to live with family or friends may no longer be entitled to any support.*
- *It is planned that all new arrivals will spend between 1-7 days in new induction centres, where they will receive information about the asylum process and their obligations. Accommodation centres are also planned to be piloted, where some asylum seekers will be housed while their claims are determined.*
- *The principle of dispersal from London and the South East will remain for most new arrivals, with NASS given a regional structure and promising improved consultation with local authorities and other agencies.*

- *A commitment to explore taking United Nations nominated refugees directly into the UK, ultimately as part of a Europe-wide agreed scheme.*
- *A requirement for most immigration applicants to demonstrate a knowledge of English and citizenship education, and the introduction of a citizenship ceremony and pledge as part of the naturalisation process.*
- *Measures to combat people trafficking, illegal entry and illegal working.*

National Asylum Support Service,
Voyager House, 30/32 Wellesley Road,
Croydon CR0 2AD

Helpline: 0845 602 1739 (local rates)

Voucher enquiries: 0845 600 0914

NASS policy bulletins are available on:
www.ind.homeoffice.gov.uk/default.asp?pageid=2056.

Further reading

Connelly J and Schweiger M
The health risks of the UK's New Asylum Act
BMJ 2000; 321: 5-6.

Audit Commission
Another Country. Implementing Dispersal under the Immigration and Asylum Act 1999 Abingdon: Audit Commission Publications 2000.

Wilson R
Dispersed: a study of services for asylum seekers in West Yorkshire Dec1999 – Mar 2001, The Joseph Rowntree Charitable Trust, 2001.
Available from the Joseph Rowntree Charitable Trust, The Garden House, Water End, York, YO30 6WQ Tel: 01904 627810 Price £10.

Home Office
Secure Borders, Safe Haven – Integration with Diversity in Modern Britain
Immigration and Asylum White Paper and Bill 2002



3. Culture, Language and Communication

3.1) Culture and health

3.2) Communication – working with interpreters and advocates

3.3) Speech and language difficulties

3.4) Information on access to health care and on health

Key Points

- Health is affected by cultural issues
- Asylum seekers and refugees are not a homogenous group
- Individuals may not follow assumed norms of culture or religion – check with the person
- If you can, offer a choice of gender of health worker and interpreter (may not be possible)
- People may be unfamiliar with the concept of 'mental illness' as we define it, which for them may be linked to spirit possession or divine punishment and carry great stigma
- Access to trained interpreters is crucial for all staff
- Advocates and linkworkers can provide health promotion and health needs assessments
- Using a family member or friend to interpret may have limitations
- Avoid using children to interpret
- Majority of respondents prefer face-to-face interpreting
- Telephone interpreting should supplement for emergencies, out-of-hours and languages not covered by face to face interpreters
- Allow double the time when working with an interpreter
- Try to spend a few minutes briefing and debriefing the interpreter (if time permits)
- Emphasise confidentiality

- The interpreter may be mistrusted
- Information on health and access to health should be available in relevant languages
- Not all asylum seekers and refugees are literate.
- Use different ways of communicating messages
- Provide a welcome pack for newly arrived asylum seekers
- Some translated materials are available

3.1) Culture and health

Health-related behaviour and health care are both affected by culture. How, when and what people present to health workers will be influenced by culture and beliefs. We need to be aware of our own assumptions, stereotyping and interpretations. Interpreters, health advocates and health workers from a displaced background can assist with details of cultural background.

"The interpreters provide most of my information" GP Gateshead

There are however both individual beliefs and values and those that are collective and shared with others from the same culture. Knowledge of their culture's beliefs and values needs to be balanced against the individual's perspective, which may differ, especially after spending some time in the UK. Individuals interpret differently values current in their culture and may not follow assumed norms of culture or religion. It is therefore important to discuss and understand a person's own values and wishes. Some people may observe certain rituals and customs associated with birth and death. In some cultures a post mortem is forbidden unless absolutely necessary (e.g. Islam). Cultural, religious and dietary needs of patients should be addressed. If possible, offer a choice of gender of the health worker and interpreter.

Every culture has its own frameworks for mental health and for seeking help in a crisis; individuals within the same culture may exhibit different degrees of resilience and vulnerability.

Mental illness carries marked stigma in many cultures, which may deter people from seeking help. Culture affects interpretation of behaviour and may influence diagnosis of mental illness.

When visiting someone's home, remove your shoes if other family members have done so. In many cultures great store is placed on providing hospitality to visitors, and people may feel upset if you refuse what is offered. It also provides an opportunity for those so often dependent to offer something in return.

3.2) Communication – working with interpreters and advocates

Access to high quality translation and interpreting services is a basic requirement for all agencies involved in providing services to refugees.

"We can't do any of this without interpreters"
GP London

The majority of health workers who responded prefer face-to-face interpreting, feeling it to be more personal and reassuring, and enabling verbal and non-verbal cues to be picked up.

"I feel I have a greater rapport with the refugee and with the interpreter with face-to-face interpreting. Refugees appear more at ease"
Health visitor, Bedford

Access to telephone interpreting is useful, particularly for emergencies and out-of-hours. A hands-free or 2-way phone will make this more practicable.

"At least the telephone is quick, efficient and always available" Community practitioner, London

However, telephone interpreting is more limited when working with psychological issues and for picking up non-verbal cues. Face-to-face interpreting allows more interaction. If possible, offer a choice of gender of interpreter, particularly if working with survivors of torture or sexual violence. Receptionists and managers should also have access to interpreting support for their work, if needed. Details will be required both of the language spoken by a refugee (e.g. Arabic spoken in Sudan differs from Arabic spoken in

Algeria) and also the language with which they feel comfortable (e.g. many Kosovars speak Serbo-Croat, but may feel uncomfortable doing so, given the history of persecution in Kosovo).

Advocates have further training in addition to interpreting skills, enabling them to deliver health promotion, carry out health assessments and improve access to health care.

"Advocacy services seem to be more appropriate than basic interpreting services"
Nurse team leader, London

For information on the Health Advocacy Network run by the Council for Ethnic Minority Voluntary Organisation (CEMVO), see Section 4.16 – Health Networks.

Minority Ethnic Health Inclusion Project (MEHIP)

Contact: Sana Sadollah,
Refugee Linkworker, MEHIP, Springwell House,
Ardmillan Terrace, Edinburgh, EH11 2JL
Tel: 0131 537 7561

MEHIP links minority ethnic individuals and communities with health services, to improve the accessibility and appropriateness of services across Lothian.

Linkworkers:

- *provide advocacy to increase patient participation in their own health care.*
- *support professionals to enable them to work more effectively with all minority ethnic individuals and groups*
- *Support people from minority ethnic communities to access primary care services and relevant community resources*
- *Bridge communication difficulties and assist in overcoming cultural barriers between professionals and individuals*
- *Promote the development of information resources for minority ethnic groups*

The linkworker can see a person before their appointment with a health worker, discuss their situation and assess where they can most appropriately find help, so that the time with the health worker can be spent more effectively. She can also provide follow-up.

If possible, offer a professional interpreter or advocate. People may bring a friend or family member to interpret, and this may be their preferred choice. Be aware, however, that inaccurate interpreting may result, and issues such as gynaecological problems, sexual health, psychological health, family relationships, domestic violence, child protection, sexual violation or torture may be difficult to discuss using a family member or friend. Asking children to interpret may place inappropriate responsibilities on them, disrupt family dynamics, and cause them to miss school. Although people may appear to choose to bring their own interpreter, this may not be the case. If a trained interpreter is not available, they fill the gap but may feel this is unsatisfactory¹. A recent survey in Barnet showed that the satisfaction of refugees with local health services was closely linked with the level of provision of interpreters at GP appointments, if they did not speak English themselves².

Continuity of interpreter can help both with development of trust for a refugee and also between interpreter and health worker.

“ My working relationship with the interpreters has improved enormously as we have got to know each other better”
GP Gateshead

However, communities in exile may continue to be divided along similar political lines as those determining the conflict in the country of origin. For this reason the interpreter may be viewed with suspicion if (s)he is seen as a member of another group, or as being politically opposed to the refugee patient.

When working with an interpreter:

- *allow more time for appointments (if possible double the time, although without extra resources, this will be hard to achieve)*
- *if possible, spend a few minutes explaining and discussing with the interpreter each of your ways of working. You should arrange how the interpreter should intervene if anything is done or said that is culturally unacceptable, or is misunderstood*

¹ Shackman J *The Right to be Understood 1984* (see resources)

² Cowen T *Unequal Treatment – Findings from a Refugee Health Survey in Barnet, Refugee Health Access Project, London, 2001*

- *arrange seating appropriately in a triangle, so that everyone can see each other*
- *both health worker and interpreter should introduce themselves*
- *emphasise confidentiality, covering yourself and the interpreter*
- *maintain eye contact with the client rather than the interpreter*
- *address the client directly as “you” rather than speaking to the interpreter and referring to the person as “she” or “he”*
- *speak slowly and clearly, using straightforward language and avoiding jargon, one or two sentences at a time*
- *ensure that everything you say to the interpreter in front of the client is interpreted – if you and the interpreter have a private conversation, this can alienate the person and can be uncomfortable for them*
- *when the client is talking, watch and listen. You may pick up important cues*
- *try to have a short de-briefing with the interpreter after the session. The interpreter may be able to offer additional feedback on cultural issues. Check how the interpreter feels – distressing events similar to the interpreter’s own experiences may have been discussed, and (s)he may need support*
- *the interpreter should be respected as a professional colleague*

Most asylum seekers are keen to learn English, which will increase independence and likelihood of gaining employment. As they gain language skills, they may require an interpreter only intermittently; but an interpreter may be needed if you know that you are going to address particularly difficult issues. (See section 8.6 - Learning English).

Provision should be made in each locality for the organisation and funding of interpreting services. Interpreters could be shared across different services e.g. health and social services, leading to better co-ordination and continuity. Initially there may be hesitancy in using interpreters, even if readily available, and work may be needed to ensure take-up of services. Training in working with interpreters will be needed for staff - most health workers have had none in this area, and

many would welcome this. Community interpreters covering a large geographical area need access to transport. In some areas, interpreting services are limited and are only able to cover a fraction of the need.

Considerations when recruiting interpreters

In addition to accurate interpreting, interpreters working in this situation should be able to:

Understand and be sensitive towards other people and their needs and difficulties

Have active listening and interpersonal skills

Deal with strong emotions

Appreciate the importance of boundaries

Match the tone of the health worker

Understand and cope with cultural and other conflicts that may arise in the work

Be self-confident and withstand pressures from either side

Work in a team

Based on The Right to Be Understood Shackman J et al, (see Resources)

Phrasebooks have been prepared in some languages (see below).

Further reading

Phelan M and Parkman S

How to do it – Work with an Interpreter.

BMJ 1995 311: 555-557

Tribe Rachel

Bridging the gap or damming the flow? Some observations on using interpreters/ bicultural workers when working with refugee clients, many of whom have been tortured.

British Journal of Medical Psychology (1999), 72. 567 – 576

Resources:

The Right to Be Understood – A handbook and training video on working with, employing and training community interpreters, Shackman J, Reynolds J, Greenwell S and Chin R 1984

ISBN: 0 86082 469 1

Available from Jane Shackman: 28 The Butts, Chippenham, Wilts, SN15 3JT
janeshackman@waitrose.com

As Good as Your Word. A guide to community interpreting and translation in public services, Sanders M

Available from the Maternity Alliance, 45 Beech St, London, EC2P 2LX

Tel: 0207 588 8583

Fax: 0207 588 8584

Email: info@maternityalliance.org.uk

Telephone interpreting

(both offer contracts throughout the UK)

Newham Language Shop

Tel: 0208 430 3040 or 0208 230 0800 (administration)

Language Line

Swallow House, 11-21 Northdown St, London N1 9BN

Tel: 0207 520 1400 or 0800 783 3503

Phrasebooks

Working with Kosovar/Albanian Patients A Medical Phrasebook and Resource.

Dr Philip Matthews and Dr Fahri Seljmani, South Essex Mental Health and Community Care NHS Trust 2000.

Available from Tel: 01268 366052 or fax: 01268 366076 and on the internet on <http://www.fam-english.demon.co.uk/albanian.pdf>

Working with Czech/Slovak Patients

Dr Peter Le Feuvre

Enquiries to Pippa Barber, East Kent Community NHS Trust, Queen Victoria Memorial Hospital, King Edward Ave, Herne Bay, Kent CT6 6EB or Dr P Le Feuvre, Mill Lane Surgery, Mill Lane House, Margate, CT9 1LB

Tel: 01843 220881

Fax: 01843 231713

Standard letters in various languages

Developed in Newcastle by Susan Donnelly, Specialist Health Visitor for Asylum Seekers, 2 Jesmond Road West, Newcastle NE2 4PQ, Tel: 0191 245 7319

Copies in other languages are planned on websites: www.medact.org and www.harpweb.org.uk

3.3) Speech and language difficulties

For both children and adults, speech, language (including both understanding and use of language) or communication difficulties in the mother tongue may be helped by referral to a Speech and Language Therapist. Interpreters or advocates may assist with assessment and therapy.

Turkish Phonology Screening Assessment (version 1)

By Francesca Buxton and Ed Hooke, London Speech and Language Therapy Special Interest Group (SIG) Bilingualism 1996

Price £16.00.

Contact Francesca Buxton on 0208 210 3751

This assessment is intended for use by speech and language therapists to obtain a broad yet concise sample of Turkish-speaking children's pronunciation. It contains:

- explanatory notes including information on Turkish phonology
- 31 photocopied pictures for test items
- assessment form with target response in Turkish, phonemic transcription of target response and English equivalent; phonologically similar forced-alternatives are also provided.

3.4) Information on access to health care and on health

"From my experience, for new arrivals, information is important"
Female asylum seeker

"What is important is helping people, perhaps only recently arrived in the UK, how to find their way around the health care maze, how things work, and how to gain access to the various services"
Health visitor, London

Information on health and on health services needs to be available in relevant languages, although not all refugees, particularly women, are literate. Many cultures, e.g. Somali, communicate effectively by word of mouth, story-telling being an important way of disseminating information, and this has been used in health promotion, using video and audiotapes.

Health advocates and refugee community organisations can increase health awareness. Group outreach sessions in hostels can effectively disseminate information both on health and how to access health services. Information can also be made available in English language classes in local colleges, community settings such as cafes and restaurants (predominantly reaching men) and shops catering for particular cultural groups. Health information may need to be targeted for special groups e.g. by gender, age.

Translated Materials

The following materials can be obtained from Dr Sarah Montgomery, Guildhall St. Surgery, Folkestone, Kent. Tel: 01303 851411

- Health Screening Questionnaire: [Czech](#), [Albanian](#), [Farsi](#), [Sorani](#), [Arabic](#), [Romanian](#)
- About your doctor (information about being registered with a GP): [Czech](#), [Albanian](#), [Farsi](#), [Sorani](#), [Arabic](#), [Romanian](#)
- Advice and information for children (Vaccination programme and basic medical care that parents can do) [Czech](#), [Albanian](#), [Romanian](#)
- Immunisation Schedule: [Russian](#)
- Information and instructions for various contraceptive methods (Oral combined and progesterone, Depo-Provera): [Czech](#), [Albanian](#), [Romanian](#)
- How to stay healthy in England (information on diet, smoking etc): [Czech](#), [Slovak](#), [Farsi](#), [Arabic](#), [Sorani](#), [Russian](#)
- Standard Hospital Appointment Letters (fill in basic information from the hospital letter on translated sheet): [Czech](#), [Albanian](#), [Sorani](#)
- The role of the Health Visitor: [Czech](#)
- The role of the Midwife [Czech](#)
- Aspects of Antenatal Care: [Czech](#) and Aspects of Postnatal Care: [Czech](#)
- Stress symptoms: [Czech](#)
- Healthy Eating (British Hypertension Society Leaflet): [Czech](#)
- Preparing baby milk feeds: [Czech](#) and Sterilizing equipment for baby feeds [Czech](#)
- Sleep Problems in young children: [Czech](#)

Resources

Medact, 601 Holloway Road, London N19 4DJ
Tel: 0207 272 2020
Fax: 0207 281 5717

Email: info@medact.org

website: www.medact.org

The refugee section of the website has information about translated material and other resources.

Refugee Council: 3 Bondway, London SW8 1SJ
Tel: 0207 820 3000

Produces booklets covering legal, support and access to services including health and education. Separate booklets are available "Information for asylum seekers" available in English, Albanian, Arabic, Chinese, Czech, Farsi, French; Kurdish (Sorani), Romanian, Russian, Somali, Tamil and Turkish and "Information for refugees and people with ELR", available in English, Albanian, Farsi, French; Kurdish (Sorani), Somali, and Turkish. Available from the Information Team on 0207 820 3085.

The Terrence Higgins Trust publishes leaflets on HIV awareness, HIV prevention and safe sex and relationships in English and French, and also has tapes in Swahili.

African Health Team, Terrence Higgins Trust,
52-54 Grays Inn Road, London WC1X 8JU

Tel (Admin): 0207 831 0330

Email: info@ttht.org.uk

website: www.ttht.org.uk

It is planned to centralise translated information leaflets on the websites www.harpweb.org.uk and www.medact.org.

3.5) Welcome Packs:

Produced primarily for newly arrived asylum seekers, these contain information about local services:

Welcome Packs:

*Susan Donnelly, specialist health visitor for Asylum Seekers,
2 Jesmond Road West, Newcastle NE2 4PQ
Tel: 0191 245 7319*

In Newcastle, Welcome Packs have been developed for asylum seekers which explain how to access health services, information on prescriptions and information on local services. Pictures are used, e.g. a clock, in order to

indicate when medication should be taken. They are available in various languages. In addition, standard letters for appointments have been translated into various languages.

See Appendix 2 for information on welcome packs

Lambeth, Southwark and Lewisham

Refugee Health Team

Carmen Rojas, Team Leader,

Masters House, Dugard Way (off Renfrew Rd),
London SE11 4TH

Tel: 0207 414 1507 Fax: 0207 414 1513

E-mail:

Carmen.Rojas-Jaimes@chsltr.sthames.nhs.uk

Welcome pack with information about local services, available in French, Somali, Chinese, Farsi, Amharic, Spanish, Tamil, Arabic, Russian, Kurdish, Turkish and Albanian.

British Red Cross Information Pack for Newly Arrived Refugees.

Available in English, French, Spanish, Farsi, Kurdish, Somali and Russian and planned in Portuguese, Pashto, Czech, Arabic and Tigrinya. Aimed particularly at refugees in the London area, but may also be useful for other areas in the UK. Topics include sources of help and advice for refugees, rights to basic services like health and education and how to access these services.

Refugee Unit, British Red Cross London Branch,
54 Ebury St, London SW1W 0LU

Tel: 0207 730 7674 Fax: 0207 730 5089

The Red Cross Refugee Orientation volunteers carry out home visits and help with accessing services and provision of clothing, kitchen utensils, bedding, dictionaries etc.

Signposts - Information for asylum seekers and refugees

Available in English only. May in future be available in other languages. Covers how to get support, legal representation, health care, housing and education, the political system in the UK, UK laws, making phone calls, travel and shopping.

National Information Forum, BT Burne House,

Post Point 10/11, Bell St London NW1 5BZ

Tel: 0207 402 6681 Fax: 0207 402 1259

Email: info@nif.org.uk

Website: www.nif.org.uk

4. Health Services

- 4.1) Eligibility for health care
- 4.2) How to find a GP and dentist
- 4.3) Planning health services
- 4.4) Funding support for primary care services caring for asylum seekers and refugees
- 4.5) Asylum Seekers' expectations of health care
- 4.6) Information for receptionists and practice managers
- 4.7) Health screening, incl registration checks and needs assessment
- 4.8) Hand-held records
- 4.9) Community development and health
- 4.10) Linking with refugee communities and community organisations
- 4.11) Consultation with asylum seekers and refugees
- 4.12) Feedback, complaints and compliments
- 4.13) Multi-sectoral working and partnerships with other organisations
- 4.14) Training for health workers
- 4.15) Support for health workers
- 4.16) Health networks
- 4.17) Occupational health issues
- 4.18) Refugee health workers

Key Points

- All asylum seekers and refugees are entitled to full NHS care
- HC1 form needs to be completed for free prescriptions, dental treatment, optician services and travel costs to hospital
- Permanent rather than temporary registration is preferable
- NHS Direct can assist with finding and registering with a GP or dentist
- Information systems are needed in order to plan and monitor services
- Health services for refugees should be of similar range and quality to those of the local community
- A dedicated service may enable appropriate support to be provided
- Include refugees in strategic planning and policies
- Additional funding may be available
- People may have different expectations of health care
- The NHS and how it works needs to be explained
- A health assessment should be offered
- Uptake screening such as smears and mammography can be increased by the availability of female health workers and advocates
- Hand-held records can facilitate communication in a mobile population
- Link with refugee community organisations
- Multi-sectoral working and partnerships with other organisations are important
- Training should be made available for staff
- Health workers need support
- Avoid making people more helpless in exile by rescuing or creating dependence

- *Do not get isolated*
- *Networks for health workers can provide valuable support.*
- *Refugee health workers are a valuable resource for the NHS and need assistance to revalidate their qualifications.*

4.1) Eligibility for health care

"Health workers know the system, refugees are blinded to the system. They need help to access the system"

(male doctor with refugee status)

All asylum seekers, refugees and their dependents, at whatever stage of their asylum claim, are entitled to all NHS care without payment.

'Overseas visitors exempt from charges: No charge shall be made in respect of any services forming part of the health service provided for an overseas visitor, being a person, or the spouse or child of a person – who has been accepted as a refugee in the United Kingdom, or who has made a formal application for leave to stay as a refugee in the United Kingdom...'

Statutory Instrument no. 306: The National Health Service (Charges to Overseas Visitors) Regulations 1989.

The British Medical Association (BMA) recommends that doctors should not be obliged to check the immigration status of people before treating them. Where a hospital needs to verify that a patient is an asylum seeker or refugee, one of the following should suffice:

- an Application Registration Card (ARC), ID smart card (see section 2.4)
- a travel document issued in accordance with the Convention on the Status of Refugees
- a letter from the Home Office stating that the patient is a refugee or has been granted refuge in the UK
- a letter from the Home Office confirming an application for asylum

A passport should not be required.

(adapted from BMA guidance Access to Health Care for Asylum Seekers and the BMA's response to Secure Borders, Safe Haven: Integration with Diversity in Modern Britain 2002)

Anyone who has come to the UK under family reunion (see section 2.2) will not have made an asylum application but will have a passport stamp for Indefinite Leave to Remain. They also have full entitlement to health care.

People on low income without benefits should apply with an HC1 form for an HC2 or HC3 certificate, giving full or partial exemption respectively from charges for prescriptions, dental treatment, optician services and travel costs to hospital. The HC1 form is available from pharmacists, Primary Care Trusts or from the Department of Health, Sandyford House, Newcastle-upon-Tyne NE2 1DB Tel: 0191 203 5555. Travel to and from hospital for treatment is reimbursed by the hospital to HC2 certificate holders at the time of the visit. Certificates are valid for 6 months, after which a new application must be made.

Permanent rather than temporary registration with a GP is preferable, as it will facilitate a health check, screening, health promotion, immunisation, continuity of care and access to previous records, if in existence. Practices with large numbers of refugees and asylum seekers may have the possibility of applying for extra funding (see section 4.4 – Funding support for primary care services).

Asylum seekers and refugees are entitled to secondary and tertiary health care if indicated. Many people may come from countries where they have had direct access to hospitals. They may be unfamiliar with referral and waiting lists, and will need these explained. Waiting lists may also pose problems when asylum seekers have been moved or dispersed.

4.2) How to find a GP and dentist

Some people may be having difficulties registering with a GP or dentist. In many areas lists are closed due to recruitment problems, which are particularly acute in urban and deprived areas (where many asylum seekers are placed). Under the Race Relations Act, health services cannot discriminate on racial grounds. It would infringe the Act to deny registration to an asylum seeker or refugee living in the practice catchment area whilst registering other patients (for further information on the Race Relations Act see www.cre.gov.uk).

The process to follow for registration with a GP or dentist is detailed below:

- 1) Check the person's address
- 2) Ring NHS Direct on 0845 4647 (who access interpreters via Language Line), for information on local services. Primary Care Trusts (PCTs) have details of languages spoken by GPs and local access to interpreting.
- 3) If all local lists are closed, the registration department will arrange allocation to a practice for 3 months, most probably the nearest practice to where (s)he is living, with no choice. After 3 months (s)he may be taken off the list and have to reapply.
- 4) Some areas have Primary Care Walk-In Centres. Details can be obtained from PCTs. These are good for emergencies, but cannot offer continuity of care.
- 5) People can change practices, as long as they live within the catchment area of the new practice. They do not require permission from their GP to register with another practice.

4.3) Planning health services

We recommend that a named person leads and acts as co-ordinator within each area. High quality information systems are required in order to plan and monitor services. The population of asylum seekers is dynamic, with constant changes in circumstances. Information systems to include all asylum seekers, with comparable data in all regions, should be established as part of the initial infrastructure. At present the Home Office does not provide information on the number of asylum seekers resident in a particular area.

" We need notification systems from NASS and the council as to where people are placed."
Nurse, London

When planning services, ensure that refugees have access to a similar range and quality of health services as the local community. If services for asylum seekers are perceived to be better, resentment and hostility may ensue. Every effort should be made to improve resources for the whole community. Services should reflect the standards contained in National Service Frameworks (NSFs).

Outreach services may result in improved access, particularly initially for new arrivals. The issue of whether to provide a dedicated service for asylum seekers needs to be considered. There is a concern that separate services may marginalise refugees.

" Refugees should be dealt with by mainstream services – there should not be separate services, thus further stigmatising these people"
Psychiatrist, London

A dedicated service may, however, be able to provide more specialised support, including language support, more time available for appointments and a more comprehensive and specialist multi-disciplinary team, and may be the best solution for those in emergency accommodation. Ultimately, the aim should be to integrate people into mainstream services. In some areas (such as Newham in East London) asylum seekers register initially with a specialist practice and after a period of 12-18 months are expected to register with a local practice.

Newham Transitional Primary Care Team

Church Road Health Centre, 30 Church Road, London E12 6AQ

Tel: 0208 218 7625

email:ntpct@email.com

The team, comprising a GP, nurse practitioner, practice nurse, health visitor, clinical psychologist, reception staff and a practice manager, provides transitory quality primary care services to people currently unable to register with a GP in their local area. It assesses, treats and monitors health problems, referring to other specialist agencies as necessary. People are normally registered for between 6 - 18 months. At an appropriate time during this period the team will enable the client to register with a GP locally.

Asylum seekers and refugees should be included, as part of the local community, in district-wide planning, including strategic policies of Trusts and Primary Care Trusts (PCTs), Strategic Health Authorities, Health Improvement and Modernisation Plans (HIMPs) and voluntary organisations. For those areas where schemes are applicable, Health Action Zones (HAZ),

Education Action Zones (EAZ) Sure Start (children aged 0-4), the Children's Fund (children aged 5-12) and Connexions (young people aged 13 – 19) should address the needs of asylum seekers and refugees.

Facing up to Difference - meeting the health needs of a diverse community

Kensington and Chelsea and Westminster Health Authority's Health Improvement Programme for commissioning services for Black and Minority Ethnic Communities - "Facing Up to Difference" - is based on equity of access and provision of care. Focussing on the impact of ethnicity and cultural diversity, it aims to develop partnerships between the NHS and Black and Minority Ethnic Communities locally. It aims to improve health and reduce adverse impacts linked to ethnicity on people's access to and experience of health services.

- *A Social Mapping project draws together information mapping, needs assessments and provides audits to agree priority areas for implementation. Voluntary organisations and community groups have contributed to a database.*
- *The Black and Minority Ethnic (BME) Communities Health Forum, an independent health partnership forum, is facilitating communication between the PCT, NHS Trusts, BME groups and individuals.*
- *Ethnic recording of all NHS in-patient service users is aiming to meet a 95% performance target.*
- *Trusts and PCTs are improving access to written/audio-visual materials, interpreting services, staff training on anti-discrimination practices and tackling racial harassment in the NHS.*
- *Community groups will be supported to effectively participate in service planning and monitoring.*
- *Improve advocacy services for refugees and asylum seekers with mental health problems.*
- *A recruitment and selection strategy aims to increase the local health service staffing profile, to reflect the ethnic and cultural*

diversity of the local population.

- *Race equality and diversity work will be integrated in the Trusts' and PCTs' Clinical Governance work.*
- *A Local Development Scheme facilitates permanent GP registration for refugees and asylum seekers.*
- *Commissioning refugee support services, interpreting and advocacy, training and family support*
- *A refugee health workers' support scheme is being developed.*
- *Members of the community are encouraged to actively participate in the health improvement initiatives, programmes and partnership forum.*

Further reading

Levenson R and Coker N
The Health of Refugees – A Guide for GPs
London: King's Fund, 1999

Trafford P and Winkler F
Refugees and Primary Care
London: Royal College of General Practitioners 2000



4.4) Funding support for primary care services caring for asylum seekers and refugees

Many health workers have emphasised the importance of proper resourcing for this important work, which can be very demanding in time and energy, both physical and emotional.

Support for primary health care services caring for large numbers of asylum seekers and refugees can be structured and resourced in a variety of ways:

Local Development Schemes (LDS) can provide extra funding for practices registering refugees.

Hammersmith PCT, Brook Green Medical Centre, Bute Gardens, London W6 7EG

Tel: 0208 237 2805

Fax: 0208 237 2804

Website: www.hammerpcg.org.uk

Hammersmith Primary Care Trust Local Development Scheme (LDS)

Tel: 0208 237 2805

Practices taking part receive a joining payment per 1000 patients on their list and an additional one-off payment for each refugee or asylum seeker given permanent registration. They are expected to undertake the following key tasks:

- Full, rather than temporary, registration of all asylum seekers and refugees*
- Each newly registered patient receives an extended health check*
- Use of formal, rather than informal, interpreting services*
- Practice staff (GPs, nurses, managers and receptionists) attend training, the aim of which is to raise awareness about the experiences and needs of refugees and asylum seekers*
- Data collection (e.g. ethnic mix, language needs) so that the PCT can build up a profile of the refugee population of Hammersmith, in order to plan and develop services in the future*

Personal Medical Services (PMS)

Practices can bid for extra resources to support their work in looking after asylum seekers and refugees

Three PMS pilots in Westminster include asylum seekers and refugees, and specific quality standards are built into the contract. These include offering full registration, identifying and addressing health needs, engaging in learning opportunities, and referring to mother tongue and/ or specialist counselling services if appropriate. For further details contact:

Anna Barnes, Westminster PCT,

The Medical Centre, 7e Woodfield Road, W9 3XZ

Tel: 020 8451 8169

Fax: 020 8451 8162

Dedicated primary care services provided under Personal Medical Services Schemes (PMS).

Examples of these include:

PMS Service for newly-arrived asylum seekers

Dr Peter Le Feuvre, Mill Lane Surgery, Mill Lane House, Margate, CT9 1LB

Tel: 01843 220881

Fax: 01843 231713

A one-stop service run by a GP, a full-time nurse, attached health visitor, receptionist and manager, offering all new arrivals a health assessment and preventative health screen, including immunisation and cervical smears. People are subsequently allocated to local general practices, where their details are faxed and the patient receives a hand - held record.

The Sanctuary Practice for asylum seekers and refugees in Hackney

Valerie John-Charles/Dr Angela Burnett, John Scott Health Centre, Green Lanes, N4 2NU

Tel: 0208 210 3766

Fax: 0208 210 3769

email: a.c.burnett@qmul.ac.uk

Newly established, the practice will provide health care to asylum seekers living in emergency accommodation, prior to dispersal. Working closely with interpreters and advocates, it will assess their health needs, provide appropriate screening and ensure this

information is passed on to practices in dispersal areas where they subsequently register. It will provide support to other practices throughout the district in developing best practice working with refugees, enhanced by a Local Development Scheme, to facilitate the registration of refugees who are settled within the district. The practice will develop strong partnerships with local voluntary sector organisations, which play an important role in the health and social care of refugees. A linkworker will provide outreach to hostels.

Refugee health teams, primarily nurse-led, working across GP practices.

Lambeth, Southwark and Lewisham Refugee Clinical Team, provides nurse-led primary care services, working with local GP practices

Jane Cook, Team Leader, Moffat Clinic, 65

Sancroft St, London SE11 5NG

Tel: 0207 411 5689

Fax: 0207 411 5667

Email: Jane.Cook@chsltr.sthames.nhs.uk

Lambeth, Southwark and Lewisham Refugee Health Team identifies and addresses difficulties preventing refugees from accessing health services and aims to improve their access.

Carmen Rojas, Team Leader, Masters House, Dugard Way, Renfrew Road, London SE11 4TH

Tel: 0207 414 1507

Fax: 0207 414 1513

E-mail:

Carmen.Rojas-Jaimes@chsltr.sthames.nhs.uk

The Three Boroughs Team, Lambeth, Southwark and Lewisham

Tel: 0207 411 5689 (Clinical Team)

0207 414 1507 (Health Team)

The Refugee Clinical, the Refugee Health and the Homeless Teams have developed a model of working which fills many of the gaps in the provision of information and awareness-raising to refugees and asylum seekers, agencies which work with them and health practitioners.

Through the provision of clinical services, the production of written materials and health promotion and awareness raising sessions, the teams support front line services to better meet the health needs of this population. They also

feed the experiences of agencies in meeting these needs into service development and policy networks, and have piloted a model of support which enables GP practices to effectively work with this population in a culturally sensitive way.

(from Hinton T. Working with Refugees and Asylum Seekers in Lambeth Southwark and Lewisham, Health Action for Homeless People, 2001).

The Asylum Seekers' Health Support Team (ASHST) - Glasgow

Brian Moss, Staff Nurse, Asylum Seekers' Health Support Team,

Cowglen Hospital, 10 Boydstone Road, Glasgow G53 6XJ

Tel: 0141 211 9222

Fax: 0141 211 9305

Email: Brian.Moss@glascomen.scot.nhs.uk

Greater Glasgow Primary Care Trust employs the Asylum Seekers' Health Support Team (ASHST) in the greater Pollok and greater Govan areas of Glasgow. Two team members visit a newly arrived asylum seeker at home, to assess immediate health problems and accommodation, and identify any interpreting needs. The team undertakes an initial health assessment and then, in conjunction with local GPs, identifies a suitable practice with which to register.

Specialist health visitors work in some areas with refugees and asylum seekers and support GP practices. For information on the UK Health Visitor network, contact:

Susan Donnelly,

Specialist health visitor for Asylum Seekers,

2 Jesmond Road West, Newcastle NE2 4PQ

Tel: 0191 245 7319

Other Possible Sources of Funding for Developing Services

Health Action Zone (HAZ)

Health Action Zone funding to improve psychological well-being of families

Irene Sclare

tel: 020 7919 2683

email: Irene.Sclare@slam-tr.nhs.uk

In Lambeth, Southwark and Lewisham, the Health Action Zone is developing a service for troubled refugee children and their parents, teachers and carers. It aims to help to resolve emotional and behavioural difficulties, increase child and parent support, and improve capacity to access mental health services. Child mental health specialists, clinical psychologists and a family therapist will work jointly, offering services in schools, clinics, and community organisations. Training and group work will be carried out in partnership with health workers, teachers and social workers

Sure Start

Sure Start aims to improve the health and well-being of families and children before and from birth to 4 years old. Sure Start programmes are concentrated in neighbourhoods where a high proportion of children are living in poverty and where new ways of working can improve services. Local programmes will work with parents and parents-to-be to improve children's life chances through better access to:

- Family support
- Advice on nurturing
- Health services
- Early learning

Further information from:

<http://www.surestart.gov.uk/text/info.cfm>

Children's Fund

The Children's Fund addresses the needs of children aged from 5-12 years

The Children's Fund in Newham

Contact details:

bill.bolloten@newham.gov.uk

Tel: 0208548 5023/5094

In Newham a range of projects has been grouped together for networking and co-ordination purposes in a Refugee and Homeless Delivery Team. Projects include an access to schooling outreach worker, art therapy, play and focussed work with the Roma community. They are underpinned by developing preventative work, accessing mainstream provision and supporting well being through creative activities. Projects ensure that children are actively involved in developing and implementing services.

Further information on the Children's Fund at:

<http://www.cypu.gov.uk/corporate/childrensfund/index.cfm>

http://www.go-london.gov.uk/educationskill/childrens_fund_in_london.asp

Connexions

Connexions in Lewisham

Lewisham is piloting the new Connexions service, offering a range of guidance and support for 13–19 year olds, scheduled to go 'live' across the London East area from April 2002. Locally, the service has seen work with young asylum seekers and refugees as an integral part of the programme. It has formed close links with the Lewisham Asylum team and the Lewisham Refugee Network, as well as having Personal Advisors in Schools, Lewisham College and in the local community. Examples of areas of work with Refugees and Asylum Seekers have been: support in finding school, college, or training places, group work, personal development & volunteering opportunities, advice and support in gaining accommodation, access to benefits, and access to education for those who have recently obtained ELR/Refugee Status. Connexions has a firm commitment to all young people, including

asylum seekers and refugees. There may, in the future, be the possibility of some funding to voluntary organisations offering specific services to targeted groups of young people within the Connexions framework. Connexions is committed to involving young people in the design and running of the service.

For further information:

www.connexions.gov.uk
main Connexions website

Lewisham Connexions Pilot website:
<http://communities.msn.co.uk/Connexions>
Lewishampilotsite/_whatsnew.msnw?f=0

The European Refugee Fund and the Challenge Fund

Projects relating to the integration of people with refugee status or Exceptional Leave to Remain, and for voluntary repatriation are eligible for funding. Projects can cover areas such as learning English as a second language, mentoring/befriending, health, housing, education and employment, addressing specific social needs amongst refugee communities, e.g. women, children and vulnerable groups. Guidelines are available on the website, <http://www.ind.homeoffice.gov.uk> or by post or e-mail from the address shown below, marked 'ERF project guidelines'.

Refugee Integration Unit, Asylum and Appeals Policy Directorate, Home Office, 5th Floor Voyager House, 30 Wellesley Road, Croydon CR0 2AD
Tel: 020 8633 0065

E-mail: stephen.mccracken@homeoffice.gsi.gov.uk or ian.barton@homeoffice.gsi.gov.uk

Other sources of funding for individuals

The Family Welfare Association helps families with grants for household items and for holidays for children with a disability. Applications must be made by a professional on behalf of a family. Family Welfare Association
501 - 505 Kingsland Road, London, E8 4AU
Tel: 0207 254 6251

The Buttle Trust, Audley House, 13 Palace Road, London, SW1E 5HX. 0207 828 7311 administers Child Support Grants for clothes, bedding, essential furniture and household equipment. Children must have refugee status or Exceptional Leave to Remain, or have lived in the UK for 2 years or more, and not be subject to a removal/deportation order.

4.5) Asylum seekers' expectations of healthcare

Asylum seekers from countries where primary care is not well developed may expect hospital referral for conditions which, in the UK, are treated in primary care. This may result in disappointment for them, irritation for health workers and frustration for both. Careful and repeated explanation of how the NHS functions may be needed. In some areas (e.g. Newcastle) information packs have been developed in different languages for newly arrived asylum seekers. In others, (e.g. Lambeth, Southwark and Lewisham) outreach workers conduct health sessions in hostels, providing information about how local health services can be accessed (See Section 3.4 Information on access to health care and on health). However, clinicians may need to explain again when referring to hospital.

Some people may come from countries with technologically developed health care systems. They may expect investigations for conditions that in the UK are managed more conservatively. In many countries injections are a preferred method of drug administration.

Some may not have had access to health care services in their own country, due to disruption by conflict, gender (e.g. Afghanistan where women could not be seen by male health workers, nor themselves work), or ethnic group (e.g. Kosovars of Albanian heritage). Health workers and others in authority may be viewed with mistrust, as they may have been part of the system of oppression in the person's home country. Confidentiality needs to be emphasised, and trust may take a while to develop. People may have fears about interpreters maintaining confidentiality, particularly in small communities.

4.6) Information for receptionists and practice managers

The role of receptionists, as the first point of contact, is very important.

- Receptionists and managers should have access to telephone interpreting services, as needed. Receptionists in a Glasgow practice are piloting videophones. For information, contact:
Margaret Hanlon, Practice Manager,
Fernbank Medical Centre, 194 Fernbank St,
Glasgow, G22 6BD.
Tel: 0141 589 8000 Fax: 0141 589 8004
- Many people will be unfamiliar with appointment systems, which will need explaining. This can be done through outreach sessions in hostels or written information (see section 3.4 - Information on health), but some flexibility is likely to be required. Check that appointments do not fall on religious days of worship. If possible, try and enable people to make use of cheap travel arrangements when booking appointments. People with sleep problems may find early morning appointments difficult to keep.
- There may be a need to liaise with people about hospital appointments, in order to explain the content of letters written from the hospital. This is particularly important for patients who do not have any relative or contact in the local community to translate for them, and it can reduce anxiety and misunderstandings.
- Check how a person would like to be addressed and how they wish to be registered. Do not assume the name order is the same as in Western European usage.
- In the UK, date of birth is frequently used as a form of identification. This is not the case in many countries and some people may not know their date of birth, or there may be differences in how people describe their date of birth and age¹. Some people² may express their age as one year older than European convention. So a child born in January 1990 would in November 2001 be considered in the UK to be aged 11; but her family would measure her age as being her 12th year and

would describe her as 12 years old. Some³ may record only the year when they were born.

- Time may be expressed differently in some cultures⁴

4.7) Health assessment, including registration checks and screening

The new patient check provides an important opportunity to establish health needs, language needs, and social circumstances.

“Carrying out a thorough initial health assessment is critical”
Nurse team leader, London

In addition to the usual health check, consider adding the following. It is unlikely to be feasible, nor appropriate, to carry out everything at the initial visit:

Ethnic origin

Language needs – whether an interpreter is required and, if so, which language/dialect

Social history – accommodation/family/whether separated, how travelled to the UK

Experiences of torture/violence

Disability/special needs

Diet/Nutrition

Immunisation as appropriate

Screening as appropriate – breast, cervical, testicular

Sexual health advice and screening /family planning – as appropriate

TB screening (see Appendix 3)

HIV and Hep B/C screening as appropriate

Sickle cell/thalassaemia

If bowel symptoms are present, check stool for ova, cysts and parasites

Assessment of psychological well-being (See section 5.3)

Oral health

Recently arrived asylum seekers may have run out of essential medication for a chronic illness and need urgent assessment and resupply. Check if an HC1 form is needed (see section 4.1)

¹ In Ethiopia the Julian calendar is used, which is roughly 7.5 years “behind” the Western Gregorian calendar. The year 1994 in the Ethiopian calendar began during September 2001 in the European calendar.

² e.g. including people from Turkey, Iran and Afghanistan

³ including Tibetans

⁴ In Ethiopia, time is measured with a 12-hour day starting at daybreak (12 o'clock in the morning or 6am European time), and ends at 12 o'clock in the afternoon, or 6pm European time. 10 am European time is 4 o'clock in the morning Ethiopian time. 5pm European time is 11 o'clock in the evening Ethiopian time.

Screening, such as smears and mammography, has tended to have low uptake amongst refugee women. Access can be significantly increased through the availability of female health workers and advocates. Translated leaflets have also been found to be useful, but not all women are literate. Women who have experienced sexual abuse, sexual violence or female genital mutilation (FGM) may have particular difficulties with cervical screening.

Health Assessment for asylum seekers in Belfast

At a local church-based drop-in clinic, health visitors offer basic health assessments and information on how to access health services. Free condoms are available. It is planned to expand the service to offer blood pressure checks, urinalysis, Heaf testing, BCG vaccinations and health promotion sessions. Information will be passed on to GPs, highlighting the findings of the health assessment, with onward referral to other services if required. A health link worker is planned, to act as an advocate for asylum seekers and a resource for health workers, raising awareness of the health needs of asylum seekers and improving their access to services.

4.8) Hand-held records

Hand-held records may be useful for asylum seekers, who are often moved around frequently. Our experience is that asylum seekers are very reliable with carrying papers, but cramped living conditions and lack of privacy may make it difficult to maintain information as confidential. People should be given a summary of what is written in the record. Offering people a copy of their health record can be a way of enhancing their autonomy and building trust.

Hand Held records

*Health Support Team, The Medical Centre,
7E Woodfield Road, London W9 3XZ
Tel: 0208 451 8175*

The Health Support Team in Parkside developed hand held records for those who are homeless, asylum seekers and refugees, due to the mobility of these groups of people. The records are based on the child development record,

“The Red Book”, used in England. The pages are in triplicate – one copy remains with the client in the hand held record, another is kept with the Health Support Team and the third is for the GP and primary care team.

The advantages of the system are that it improves continuity of care and reduces duplication. Information from the initial health assessment carried out by the Health Support Team can be useful for the GP’s registration check. The client can choose whether to share information with other agencies such as housing or benefits offices. The record gives an in-depth analysis of health needs and makes it clear who is working with the client, the health needs that have been identified and the future care plan.

Information about local services, how health services work and breast and cervical screening programmes is available at the back of the record. This has been translated into Arabic and Albanian.

Hand held records have also been developed in many other areas, including Lambeth, Southwark and Lewisham, Luton and Sheffield (contact names and details below).

Jane Cook, Nurse Practitioner and Team Leader,
The Refugee Clinical Team
Moffat Clinic, 65 Sancroft St, London SE11 5NG
Tel: 0207 411 5689
Fax: 0207 411 5667

Linda Penny, Nurse Practitioner,
Health Care for the Homeless, Asylum Seekers
and Travellers (HHAT),
The Lodge, 4 George St West, Luton, LU1 2BJ
Tel: 01582 511000
Fax: 01582 511001

Joan MacFarlane, Primary Care Nurse Consultant,
Asylum Seeker Health,
Park Health Centre, Duke St, Sheffield S2 5QQ
Tel 0114 2261739
Fax 0114 2261742
Email: joan.macfarlane@sheffieldse-pct.nhs.uk

We hope to develop a standard hand-held record, to be used nationally.



4.9) Community development and health

Community development approaches to improve health have been widely used since the 1960s, particularly in areas of deprivation and poverty. They offer a framework for health workers and other agencies to involve local communities in the promotion and development of good health.

The King's Fund Primary Care Group has produced a series of publications to support health care teams. For more information refer to:

Community Development in Primary Care – a guide to involving the community in Community Orientated Primary Care (COPC) by Richard Freeman and Stephen Gillam. King's Fund 1997.

www.health-activist.net contains details about training in community development.

4.10) Linking with refugee communities and community organisations

Refugee community organisations (RCOs) provide advice and support to asylum seekers and refugees. Some work with specific communities (by country or ethnic group) or groups, e.g. women or people with a disability; others work with all groups. They may provide immigration, housing and benefits advice, interpreting and translating. They can act as advocates, reducing isolation, providing orientation, social support networks, information in people's own language and a connection with their own culture.

Depression amongst refugees is closely linked with poor social support. Some organise education - English and computer classes, mother-tongue classes and homework clubs for children.

They may assist people to register with GPs and accompany them to outpatient appointments, or visit them in hospital. Some employ health workers, many of whom have health qualifications from their own country (See section 4.18 - Refugee health workers) whose skills and experience can contribute greatly to the health of their community. They may be involved with health promotion activities and may organise sessions to raise awareness about particular health issues. Although many provide services on a voluntary basis, this cannot be assumed and health workers should wherever possible try to seek funding to pay workers for the time they offer as interpreters, translators or advocates, unless they are being funded specifically to do this work.

However, political divisions may exist within refugee communities and this may deter some people from contact with such organisations

Continued funding remains a problem for many of these organisations, and part-time staff or volunteers carry out much of their work. There is a need to support the creation and development of refugee groups and organisations in dispersal areas.

4.11) Consultation with asylum seekers and refugees

Involving users in planning, developing and implementing services is likely to contribute towards their appropriateness and acceptability. We have already highlighted the fact that asylum seekers and refugees are not a homogenous group and have varying needs and expectations. It is therefore important that consultation is wide, and that care is taken to include those whose views may not ordinarily be heard, such as women, older people, young people, people with disabilities, those with mental health problems. Evaluation of services should also include the views of users.

4.12) Feedback, complaints and compliments

Asylum seekers and refugees should have access to feedback and complaints procedures. Information needs to be available in relevant languages, and assistance given to enable people to participate, e.g. through making an interpreter available.

4.13) Multi-sectoral working and partnerships with other organisations

Communication is crucial between the range of different agencies involved in providing services for asylum seekers and refugees. These include refugee community organisations, groups and individual displaced people, local and national voluntary organisations, social services, health workers and health organisations, education departments, housing departments, accommodation providers, National Asylum Support Service (NASS), lawyers, advice agencies, the police, interpreting services, religious groups, local residents' groups and anti-racist groups. Systems need to be established to ensure that information is exchanged efficiently and appropriately. Many areas have developed a multi-agency Refugee Forum, which facilitates meetings and contact between agencies.

A list of agencies working nationally with asylum seekers and refugees is included (Section 9.1 One Stop Services and national agencies working with refugees). Information on local agencies can be obtained from your nearest One Stop Service (Section 9.1 as above).

“Working with other agencies prevents fragmentation, makes it easier to meet the breadth of needs and provides an opportunity for consultation and supervision.”

Psychologist, London

Resources such as interpreters, translation, advice, advocacy and training can be shared across agencies within a district. Supporting services with longer-term funding, if shown to be successful, is preferable to the insecurity of short-term funding.

Partnerships between Health and Education in Westminster

*Health Support Team, 7E Woodfield Road,
London W9 3XZ*

Tel: 0208 451 8175

*Joy Stanton, Refugee Support Co-ordinator
to Schools,*

Tel: 020 7641 6391 Fax: 020 7641 6330

email: jstanton@westminster.gov.uk

The Health Support Team based in Kensington Chelsea and Westminster works closely with the Education Department in Westminster. The Health Support Team does outreach work to refugees in Bed & Breakfast hotels, carrying out an in-depth assessment and helping people to access mainstream services. The Refugee Liaison Worker in the Education Action Zone arranges school places, interpreters, admissions interviews and induction in school. Education services refer children with health care needs to the Health Support Team. Both contribute to educational sessions. TB screening sessions form part of a one-stop Community Health initiative at the Bayswater Family Centre, also incorporating Education, Housing, Environmental Health and Benefits advice.

Refugee and Asylum Seeker Participatory Action Research (RAPAR)

*c/o Faith and Justice Commission,
Cathedral House, 250 Chapel St, Salford,
M3 5LL*

Cath Maffia: 0161 212 4452

Rhetta Moran: 0161 295 5277

RAPAR is bringing together health, social services, education, youth and leisure series, housing, community safety, community development workers, advocacy agencies, church groups, the police, local residents' groups and the Red Cross. Current work is focussing on issues of communication, mental well-being, community gynaecology, group health promotion, community safety, and employment opportunities.

4.14) Training for health workers

Clinical and reception staff in all agencies require training, to include awareness of issues facing asylum seekers and refugees and of the available services.

Many health workers who responded to the questionnaire requested training. Postgraduate tutors and others responsible for training can arrange courses and study days. Training should be multi-disciplinary, bringing together the voluntary and statutory sectors, in order to share information and to develop skills and networks.

Organisations offering training on working with asylum seekers and refugees:

Medical Foundation for the Care of Victims of Torture, 96-8 Grafton Road, London, NW5 3EJ
Tel: 0207 813 7777

(Training on working with survivors of torture and organised violence against adults and children)

Refugee Council, Breathing Space, Refugee Council: 3 Bondway, London SW8 1SJ
Tel: 0208 210 3766

(Training on access to health care and on psychological health)

Dr Angela Burnett
email: a.c.burnett@qmul.ac.uk
Tel: 07960 860 266

(Training on access to health care, physical and psychological health for adults and children)

4.15) Support for health workers

"As with all new ventures, staff pressure and stress have been big issues."

Practice Manager, Glasgow

Working with refugees is both rewarding and challenging. It is important not to set up unrealistic expectations, nor to make promises that cannot be fulfilled. Encourage independence, although refugees may need more help to access services. Health workers may be exposed to a high degree of distress whilst listening to people's accounts of their experiences and may need support themselves. Administrative staff may also be affected. It is important not to become isolated and to recognise limitations and vulnerabilities.

It is easy to feel impotent when faced with so many problems. You may feel a huge pressure to meet all needs yourself, while feeling that you do not have the information, skills or time to do so. If possible, build networks with others involved in this work, both within and outside your own discipline and within the statutory and voluntary sectors, so that you are not working in isolation. Some problems may have no solution, but it may help to listen.

"I realise it's not just me who doesn't always know what to do"

Health visitor, London

Managers need to be aware of the time demands placed on workers by interpreting, multiple and complex difficulties and multi-agency liaison.

4.16) Health networks

Medact, 601 Holloway Road, London N19 4DJ
Tel: 0207 272 2020
Fax: 0207 281 5717

Email: info@medact.org
website: www.medact.org

The Refugee Health Network comprises a multi-disciplinary group of health workers from throughout the UK, whose aims are to share information and lobbying for improved conditions for asylum seekers and refugees.



Network of Health Visitors working with asylum seekers and refugees.

Susan Donnelly, Specialist Health Visitor for Asylum Seekers,

2 Jesmond Road West, Newcastle NE2 4PQ
Tel: 0191 245 7319

Council for Ethnic Minority Voluntary Organisations (CEMVO) Health Advocacy Network

Tel: 020 8432 0409,

E-mail: bhan@emf-cemvo.co.uk

Website: www.emf-cemvo.co.uk

Provides health advocates with access to information, support and resources.

4.17) Occupational health issues

The usual precautions should apply. It is recommended that clinical healthworkers should check their immunity for TB and Hepatitis B.

4.18) Refugee health workers

It is estimated that there are 1-2 000 doctors and a similar number of nurses amongst refugees and asylum seekers, as well as dentists and professionals allied to medicine. Schemes exist in many cities, offering careers advice and support to assist them to be able to work within the NHS. They must pass English language exams and a revalidation process, specific to their discipline.

Doctors

Regional Postgraduate Deans are local points of contact. A refugee doctors' database is being co-ordinated by the British Medical Association (BMA) and the Refugee Council. Doctors on the database are notified about any events or new developments and receive a newsletter with information about local groups offering support in preparing for the exams and in gaining clinical attachments and work. Information is available on www.refugeecouncil.org.uk and www.bma.org.uk or telephone Deng Yai on 0207 820 3138. The BMA (tel: 0207 383 6680) offers a free benefits package to refugee and asylum seeking doctors.

An updated " Guide for Refugee Doctors" , outlining the procedures to gain registration and the sources of help and support that are available will shortly be available from:

Jewish Council for Racial Equality (JCORE), 33 Seymour Place, London W1H 6AT

Tel: 0208 455 0896

Fax: 0208 458 4700

Email: jcore@btinternet.com

The Postgraduate Centre for Refugee Doctors runs courses for refugee doctors preparing for the PLAB exam, both by attendance and through distance learning.

Dr Nayeem Azim, Postgraduate Centre for Refugee Doctors, 67 Elliot Road, London NW4 3EB

Tel: 0208 203 4466

Fax: 0208 203 1682

Mobile: 07950 644956

Email: Nayeemdoc@aol.com

Website: www.plabisgood4u.com

RETAS

(Contact details see Section 8.7) offers careers advice and support for monitoring for refugee doctors.

Nurses

Helen Watts, Praxis, Pott St, London E2 0EF

Tel: 0207 749 7601

Email: helen@praxis.org.uk

Website: www.praxis.org

Offers career advice and support with the revalidation process for nurses

The Royal College of Nursing,
20 Cavendish Square, London W1M 0AB
Tel: 0207 409 3333

Offers support for nurses including career advice, workplace representation, educational opportunities, immigration and visa advice

Professions Allied to Medicine

Helen Watts, Praxis, Pott St, London E2 0EF

Tel: 0207 749 7601

Email: helen@praxis.org.uk

Website www.praxis.org

Offers career advice and support with the revalidation process for professions allied to medicine

5. Key Clinical Areas

- 5.1) General health status
- 5.2) Prescribing and dispensing
- 5.3) Psychological well-being (see also section 6.2 - psychological health following torture and violence)
- 5.4) Psychological therapies and counselling
- 5.5) Discussing distressing events (see also section 4.15 – Support for health workers)
- 5.6) Physical expressions of distress/somatisation
- 5.7) Sleep problems
- 5.8) Physical health (see also Section 6.3 - Physical health following torture and violence)
 - 5.8.1) Gastro-intestinal symptoms
 - 5.8.2) Chronic diseases: diabetes, hypertension, coronary heart disease, strokes
 - 5.8.3) Rheumatic heart disease
 - 5.8.4) Haemoglobinopathies
 - 5.8.5) Dermatology
 - 5.8.6) Respiratory illnesses
 - 5.8.7) Musculo-skeletal
- 5.9) Immunisations
- 5.10) Tuberculosis (TB)
- 5.11) Other communicable and tropical diseases
- 5.12) HIV/AIDS
- 5.13) Sexual health and family planning
- 5.14) Health promotion
- 5.15) Oral health
- 5.16) Nutrition
- 5.17) Drugs and alcohol
- 5.18) Physiotherapy
- 5.19) Role of complementary therapies
- 5.20) Traditional healthcare
- 5.21) Arts therapies and creative arts

Key Points

- Take a holistic approach to health
- Practical issues may need to be addressed
- Social isolation and poverty have a negative effect on physical and psychological health
- Many people's health deteriorates after arrival
- Immunisations may be incomplete
- Consider alternatives to drugs, such as massage, if available, for chronic pain
- Consider cultural factors when assessing health, particularly for psychological health
- Symptoms of psychological distress are common
- Carefully consider before pathologising what may be natural responses to highly abnormal situations

- Physical presentations of distress are common
- Drugs and alcohol may be used as a coping strategy
- Offer voluntary counselling and testing for HIV if appropriate
- People living with HIV/AIDS need specialist legal advice
- Offer information on sexual health and family planning
- Oral health may be poor
- People may be undernourished
- Complementary therapy, art therapy, music therapy, and creative support may be helpful

5.1) General health status

The health of asylum seekers and refugees, as with anyone, is affected by physical, psychological and environmental factors. In order to make the pack easier to follow, health issues are classified into different sections. However, in practice physical and psychological health issues are interwoven requiring a holistic approach. Attention is drawn to the special circumstances of this group of people, but their health is more likely to be affected by commonly occurring medical problems.

The physical health status of asylum seekers on arrival is not perceived to be a major problem. The majority of people seeking asylum are relatively young. However, previous surveys and our own research have found that many people perceive that their health deteriorates after arrival.

“The health of asylum seekers often deteriorates after their arrival in the UK. Mental health also deteriorates.”

Health visitor, Salford

People with serious illnesses who would not have access to treatment in their home country may seek to stay in the UK on compassionate grounds. They should seek specialist legal advice.

Further reading

Aldous J et al

Refugee health in London - Key Issues for Public Health

London: the Health of Londoners Project, East London and the City Health Authority 1999

Fassil Y

Looking after the health of refugees
BMJ 2000; 321: 59

Burnett A and Peel M

The health needs of asylum seekers and refugees
BMJ 2001; 322: 544-7

5.2) Prescribing and dispensing

“When I tell my GP my worries with my broken English, he tells me everybody has worries and gives me tablets”
Male asylum seeker, dispersed

Although some health conditions are amenable to medication, prescribing may not help many of the problems which refugees experience. Consider alternatives to drugs such as massage for pain, if this can be made available. One refugee is quoted:

“We are probably going to develop an anti-paracetamol antibody because we have been taking it so much”

Taylor G. Amnesty conference proceedings
Sept 2001

Muslims observing Ramadan may fast between sunrise and sunset and may not wish to take medication orally between these times. Fasting is not recommended for patients who have significant renal disease, heart failure, during pregnancy and for diabetics, who are insulin-dependent or poorly controlled. Diabetics well-controlled on short-acting oral hypoglycaemics (e.g. gliclazide, glipizide, and metformin) can fast if they split their total daily calorific intake into two meals and take their tablets with the meals. Short-acting meglitinides such as repaglinide should be taken immediately prior to food. Blood glucose should be regularly monitored, and treatment should not be omitted.

Information developed in Newcastle for asylum seekers includes a clock, on which the times for medication may be drawn. (note that Ethiopians use a different time system) (see Welcome Packs in section 3.4 and Appendix 2). Some pharmacists have access to telephone interpreting.

For identification of differently named medicines from abroad the pharmacy department at your

local hospital may be able to help. Some people may receive medication from abroad, but may be having only intermittent supplies.

Asylum seekers not on social security benefits need to complete an HC1 form in order to access free prescriptions. (See section 4.1) People who do not yet have an exemption certificate should complete form FP57, so that they can claim back prescription charges when they have obtained a certificate.

5.3) Psychological well being

(see also section 6.2 - psychological health following torture and violence, Section 7.6 - health needs of families, section 7.7 – children and adolescents, section 7.8 – unaccompanied minors/separated children, section 8.2 - spiritual support)

“Because of my worries my doctor gives me tablets, but my worries are due to my immigration status and my loneliness”
Female asylum seeker, dispersed

Presentation

Psychological distress is common amongst asylum seekers and refugees. People commonly experience:

- extreme sadness
- anxiety, depression and panic attacks
- problems with memory, concentration and disorientation
- poor sleep patterns (almost universal)

These may result from:

- the atrocities and multiple losses that people have experienced
- displacement and their current situation in the UK
- social isolation, poverty, hostility, loss of status and racism, which have a compounding negative effect on psychological health.
- the uncertainty of a life in limbo and the fear of being sent home
- loss of their friends, family and community, as well as their home, job, culture and country
- mental illness, which may be long-standing, or which may be linked with their experiences.

¹ Minnis et al *Racial Stereotyping: Survey of Psychiatrists in the United Kingdom* *BMJ* 2001 323: 905-6

Assessment

Expressions of distress and the ways in which people cope differ both between and within cultures, which makes assessment and treatment of psychological health problems of refugees complex. It is important to maintain an open mind over a longer period of assessment. Check how the client makes sense of psychological distress from within their culture; and also what culturally appropriate responses to distress may be. When making a psychological assessment, include an assessment of risk of suicide and issues of child protection (see section 7.10) if indicated. There may be cultural and religious taboos regarding talking about self-harm.

Cultural differences and difficulties with language and communication may increase the possibility of a misdiagnosis of mental illness. The questions used to diagnose mental illness may not be reliable when used in translation or cross-culturally. Black and minority ethnic people in the UK have been shown to be disproportionately diagnosed with schizophrenia, sectioned under the Mental Health Act¹ and given high doses of anti-psychotic drugs rather than talking therapy.

“I worked with an asylum seeker who had been labelled as having mental health problems, but the client herself had not been involved (in the assessment) nor was she aware of many of the discussions that had taken place. It illustrated to me some of the difficulties when an assessment is made in a way that does not match the client’s needs. She was not listened to.”
Health visitor, London

Language

Bilingual health workers or interpreters are essential. Interpreters and advocates may need additional training in mental health issues and may find therapy sessions confusing and upsetting. If possible, try to spend some time with the interpreter at the beginning and end of a session, discussing ways of working. (See section 3.2 - Working with interpreters and advocates). Some mental health workers have expressed concerns about working with interpreters, and may require training. Our experience is that psychological work is effective through interpreters (and would be impossible without them, where language is not shared).

Addressing psychological distress

For many people, restoration of their normal life as far as possible can be the most effective promoter of mental health and can do much to relieve feelings of sadness and anxiety. On the part of health workers, supportive listening is very valuable in order to acknowledge injustice, both past and present and to help people to cope both with their memories and with their current situation. Many people find that talking helps, a bearing of testimony. However, some people may be suspicious of health workers, as they may have been identified with the ruling state in their home country, and even been involved in oppression. Trust needs to be earned and may take some time to develop. In addition, many people may experience guilt or shame regarding their experiences.

“Refugees are looking for safety – after some time, if we feel safe, we will open up”
Male Doctor with refugee status

“The catharsis of being listened to for long enough and patiently enough can be all that is needed to restore health to a nearly normal level”
GP Glasgow

Working with asylum seekers and refugees has particular challenges, because people are dislocated, have lost their usual support systems and, especially in the case of asylum seekers, have an uncertain future. Build on a person's strengths, giving them as much control over the pace and content of your meeting as possible – overall they are in control of very little and this can be very debilitating. A psychologist in London described the importance of *“being a witness”* and of *“politicising rather than pathologising anger”*. He had arranged for one of his clients to record his experiences for an Oral History Project at the Museum of London, which had strengthened his sense of identity and had been very therapeutic¹.

For many people, psychosocial support, reducing their isolation and accessing help with practical and social issues may help to improve mood. The factors outlined below have been shown to protect against mental illness for people in exile², and interventions should aim to enhance these.

- contact with family/family reunion (See section 8.3 - Tracing missing family members)
- social support – links to integrated community groups (see section 4.10 - Linking with refugee communities and organisations)
- strong religious or political ideology (see section 8.2 - Spiritual support)
- having a proactive problem solving approach

Waltham Forest Refugee Mental Health Project

*Kate Thompson, Refugee Support Psychologist,
Larkwood Centre, Thorpe Coombe Hospital,
Forest Road, London E17 3HP
Tel: 0208 520 8971
Fax: 0208 535 6850*

Prior to setting up the service, a thorough needs assessment was conducted with local refugee community groups, individuals and support organisations. The main difficulties and concerns described were:

- Isolation/cultural bereavement
- Boredom/confounding of expectations of life in the UK – anxiety about immigration status, financial worries and a feeling of not being wanted in the UK,
- Changing roles in the family/clash of values
- Residual effects of traumatic events (although less mention of this than might be expected)
- Physical illness
- Risk of substance abuse, connected with worry, sleeping difficulties or boredom
- Suicide

Community suggestions for intervention were:

- Counselling
- Awareness raising
- Activities/keeping busy
- Traditional healers/traditional community or religious leaders

¹ Webster A Personal Communication

² Watters C Refugees and Asylum Seekers- needs and service development issues. Presentation to a conference on 'Developing effective Mental Health Services for a multi-ethnic society' London 1997 Cited in Harris K and Maxwell C A Needs Assessment in a Refugee Mental Health Project in North-East London: Extending the Counselling Model to Community Support, *Medicine, Conflict and Survival* 2000, 16, 201-215

The psychologist has placed great importance on supporting those people and organisations helping refugees to rebuild social and community links. Her work comprises

- *community mobilisation, with existing groups or finding a link person, if none exists, giving assistance to obtain funding for community initiatives*
- *raising awareness of mental health issues with both refugee groups and with health workers.*
- *Networking and liaison*
- *individual clinical work, working flexibly and with a wide holistic perspective, with referral to a counsellor from a particular background, an elder or healer if indicated.*

A Turkish speaking counsellor has joined the project, working with individuals and groups.

However, those whose ability to function remains impaired may need additional intervention.

Treatment and support

Psychological therapies and counselling are discussed in section 5.4. If prescribing ensure that information about the drug and anticipated side effects is clearly understood.

Mental health services

“Why are mainstream mental health services unable to deal with refugee mental health as part of their services?”

Nurse practitioner, London

Mental health services, for those who need them, should aim to be accessible, flexible and appropriate, reflecting the standards in the Mental Health National Service Framework, The Journey to Recovery 2001. Services have a statutory responsibility to provide care. In many societies mental illness carries significant stigma, which may deter people from accessing services. Offering services within the community may be more acceptable and close links should be established with community mental health teams and the voluntary sector, including refugee community organisations.

Resources

The Breathing Space Project

This initiative between the Refugee Council and the Medical Foundation aims to address the

mental well-being needs of refugees and asylum seekers across the UK. Its main working areas are case work, capacity building for Refugee Community Organisations, advocacy and training

For further details, contact:

The Refugee Council, 3 Bondway,

London SW8 1SJ

Tel: 0207 820 3000

Fax: 0207 582 9929

Emma Williams, The Medical Foundation for the

Care of Victims of Torture, Star House,

104-8 Grafton Road, London NW5 3EJ

Tel: 0207 813 9999

Fax: 0207 813 0033

Further reading

Burnett A and Peel M

The health needs of asylum seekers and refugees

BMJ 2001; 322: 544-7

CVS Consultants and Migrant and Refugee Communities Forum.

A Shattered World - The Mental Health Needs of refugees and newly arrived communities

London, Lavenham Press, 1999.

Available from CVS Consultants,

27-9 Vauxhall Grove, London SW8 1SY

Fernando S.

Mental Health in a Multi-Ethnic Society

London: Routledge 1995.

Watters C

The Mental Health Needs of Refugees and

Asylum Seekers: Key Issues in Research and

Service Development in Nicholson F Current

Issues of Asylum Law and Policy Avebury 1998

Webster A and Rojas Jaimes C

The Mental Health Needs of Refugees in Lambeth

London, 2000

Available from Refugee Health Team,

Master House, Dugard Way, off Renfrew Rd,

London SE11 4TH

Tel: 0207 582 5247

5.4) Psychological therapies and counselling

Counselling may be an unfamiliar concept for some people, who may be more accustomed to discussing problems with family and community, rather than with a stranger, and may be concerned about confidentiality. Some members of refugee communities are trained in counselling skills, which can be used in culturally appropriate ways. Story-telling and narrative may be helpful.

Group work can offer support and reduce isolation. Groups may be primarily therapeutic, or may be more social and practical in nature. Adult and child psychotherapy, family therapy and cognitive behavioural therapy may also be considered.

Somali Counselling Service, Tower Hamlets

Amina Hassan, Somali Counsellor, Steels Lane Health Centre, 384 Commercial Road, London E1

Tel: 0207 790 7171

Email: amina.hassan@thpct.nhs.uk

The bilingual counsellor is trained in several techniques, including Cognitive Behavioural Therapy, psychodynamic and systemic family therapy techniques, using these in ways appropriate for the Somali community with whom she works. The community in East London is long established, with merchant seamen first arriving from Somalia towards the beginning of the 20th century, some of whom chose to settle in London and other parts of the UK. Subsequently the civil war in Somalia resulted in many people fleeing to the UK as refugees.

The counsellor has written leaflets in Somali on psychological health issues. She carries out training for health workers and gives information and education on health issues relevant to Somali people. The service is part of the Primary Care Psychology team. The Counsellor works with the Somali Advisory Group in Tower Hamlets, composed of health workers in both the voluntary and statutory sectors, whose focus is to address health issues faced by Somali people

In many cultures, problems are talked over with an older member of the family, an elder or religious leader. There may be people who fulfill these roles within communities in the UK.

Further reading

Guidelines for providers of counselling training to refugees and Guidelines for refugee community organisations providing counselling services.

Available from:

The Evelyn Oldfield Unit, 356 Holloway Road, London N7 6PA

Tel: 020 7700 0100

Fax: 020 7700 8136

Email: EvelynOldfieldUnit@compuserve.com

5.5) Discussing distressing events

(see also section 4.15 – Support for health workers)

Many people wish to talk about their experiences and find the process of testimony itself to be therapeutic. However not everyone needs nor wants to do this and some find telling their stories extremely distressing. If psychological or physical difficulties persist, acknowledging possible causes may be important through establishing trust and gentle questioning.

It may be possible to ask about experiences of torture and violence, but if direct questioning appears to be too uncomfortable, the subject may be introduced indirectly:

"I know that some people in your situation have experienced torture and violence. This is something that I may be able to help with. Has this ever happened to you?"

This sort of work is best done when the client's social situation is relatively stable and they are feeling 'safe'. If this is not the case, it may be better to focus on improving their social situation and strengthening their coping skills to help with the distressing memories. If you do address such memories it is important that the client feels in control of the process. Keep checking whether the pace and content feels comfortable.

Sometimes a person who has previously disclosed a painful past event becomes unwilling to talk about it. It may be more helpful in such cases to talk about current concerns rather than pressing them.

With a child, additional considerations need to be taken into account, including age, level of understanding and the context in which (s) he is living.

It is also important that the health worker feels safe and confident about being able to manage the disclosures that might be made.

The client may be searching for the meaning of an apparently meaningless event. It may be helpful to locate this within their political or religious belief systems, if present. There is some evidence that survivors of torture who have a political understanding of what happened to them are less troubled than those who have no such understanding.

5.6) Physical expressions of distress/somatisation

“ Sometimes refugees express emotional distress or depression as physical symptoms, such as back pain, and this can be very difficult to address.”

Community practitioner, London

Stressful circumstances may manifest as weakness, headaches, abdominal, neck or back pain, with no apparent physical basis. People may experience their distress physically or they may only describe physical symptoms, believing that health workers are more interested in physical problems. They may be experiencing psychological symptoms but may not describe them, perhaps due to lack of appropriate language or due to the stigma of mental health problems. Although people may expect investigations and treatment, they are often aware of the interrelations between physical and psychological symptoms.

Symptoms commonly last for some time. It may be useful to chart the variability of such symptoms alongside mood states. If symptoms persist, consider ways of support, perhaps through counselling or complementary therapies such as massage, if available.

5.7) Sleep Problems

“ They just give me tablets to help me sleep”
male asylum seeker dispersed to Leeds

- Sleep problems are very common amongst refugees (in fact 20% of the overall adult

population admit to a “serious” sleep problem, and 35% of over-65’s)

- May be associated with depression, stress, fear, grief and nightmares
- Keep prescribing to a minimum, and only for a limited period. Because of tolerance and dependence, most hypnotics should not be taken for more than 4 weeks. Give information about the medication and expected side effects.
- The following advice may be helpful:
Usual advice about exercise, alcohol, smoking, caffeine etc.
Avoid napping during the day
Try to go to bed and wake up at the same time every day
Allocate a limited time each day to focus specifically on worries/concerns
Practice relaxation, meditation or prayer

Insomnia is a symptom not a condition, and treatment should address the underlying problem. Many people do not feel safe where they live. In hostels, some people may feel uncomfortable sharing a room with someone whom they do not know well, and this may affect their sleep. This may be particularly an issue for survivors of torture. Bedwetting may be a problem, particularly for children.

5.8) Physical health

(see also Section 6.3 - Physical health following torture and violence)

The list below is not exhaustive, but highlights some of the more important issues, drawing attention to the special circumstances of this group of people.

5.8.1) Gastro-intestinal symptoms

These are commonly experienced, particularly by young men, and may result from gastritis, peptic ulceration, unfamiliar food or stress. H. Pylori is commoner in people from poorer countries. People may have consumed contaminated water or food en route to the UK and parasitic diseases, gastroenteritis and more rarely, cholera, bacillary dysentery and typhoid, may occur, although gastro-intestinal infections are usually due to common pathogens and pose little risk to public health. The usual principles of infection control and hygiene apply.

Routine stool screening in the absence of symptoms is not indicated, unless it is known that asylum seekers are arriving from an area where there is a known outbreak of, e.g. cholera.

5.8.2) Chronic diseases

Eastern Europeans experience high rates of diabetes, hypertension and coronary heart disease. High rates of diabetes, coronary heart disease and stroke are found amongst people of South Asian and E African origin.

5.8.3) Rheumatic heart disease

This is more common in poorer countries and may not have been detected previously.

5.8.4) Haemoglobinopathies

Sickle cell disease and A and B thalassaemia are more common in people of Black African, Indian, Pakistani, Roma, Middle Eastern or Eastern Mediterranean heritage. Some practices opportunistically screen for haemoglobinopathy in people in affected groups. Pregnant women from affected groups should be offered screening and, if positive, offered genetic counselling.



5.8.5) Dermatology

Fungal infections and scabies are common, often related to poor conditions of hygiene during travel or whilst in temporary accommodation.

5.8.6) Respiratory illnesses

There may be an increase in both upper and lower respiratory illnesses, which may be associated with poor living conditions, poor nutrition and smoking.

5.8.7) Musculo-skeletal

Pain in muscles and joints and backache are common. As well as analgesia, consider physiotherapy or massage or other complementary therapies, if available. (See section 5.6 - Physical expressions of distress/somatisation)

5.8.8) Eyes

People of African and Afro-Caribbean heritage may have a higher incidence of glaucoma. Eastern Europeans, South Asians and E Africans have a higher incidence of diabetes.

People exposed to nerve gas (e.g. in Halabja in Iraq) may have visual problems. (See section 6.3 – Physical effects of torture and violence).

Asylum seekers need to complete an HC1 form in order to access a free eye check (see section 4.1 Eligibility for Health Care for details).

Those with visual impairment are entitled to a Community Care Assessment and to be registered blind or partially sighted (see section 7.11 Disability and special needs).

Further reading

Burnett A and Peel M

The health needs of asylum seekers and refugees
BMJ 2001; 322: 544-7

5.9) Immunisations

Country immunisation schedules are available on <http://www-nt.who.int/vaccines/GlobalSummary/immunization/CountryProfileSelect.cfm>. Conflict may have disrupted immunisation programmes, or the family may have left before completion. Refer to standard immunisation protocols. More detailed advice can be obtained from your local Consultant in Communicable Disease Control (CDC).

Offer HiB and Meningitis C vaccines to those in the appropriate age groups.

Offer rubella screening for women of childbearing age

It may be worth screening for hepatitis B/C (discuss with CDC as above)

Consider offering neonatal BCG vaccination (see section 5.10 - TB)

Immunisations

Hammersmith Primary Care Trust includes a list of immunisations in the following languages in their resource pack, compiled by Rachel Manolson: Albanian, Amharic, Arabic, Armenian, French, Farsi, Polish, Romanian, Russian Somali, Spanish, Turkish.

*Parsons Green Centre,
5-7 Parsons Green,
London
SW6 4UL*

5.10) Tuberculosis (TB)

Although asylum seekers and refugees should not be stigmatised as vectors of infection, those coming from areas where TB is prevalent carry a heightened risk of infection. Living conditions in the UK may be over-crowded, promoting transmission of TB. Maintain an increased index of clinical suspicion. If you are planning screening, see Appendix 3 for TB screening protocol.

Community TB outreach services may increase screening uptake, such as the outreach service based at West Beckton Health Centre, 90 Lawson Close, West Beckton, London E16 3LU Tel: 0207 445 7088. Only a small proportion of new arrivals is screened for TB at the port of entry.

Concurrent HIV infection increases the false negative rate of the tuberculin test. If there is reason to suspect HIV, check status before

screening for TB and discuss with a Communicable Diseases Consultant (see section 5.12 HIV/AIDS).

Information sheets produced by the British Lung Foundation are available in English, Somali, Turkish, Urdu, Punjabi, Bengali and Gujarati on <http://www.phls.co.uk/facts/TB/Index.htm>

Consider neonatal BCG vaccination for babies at risk of TB (discuss with your local Communicable Diseases Consultant).

5.11) Other communicable and tropical diseases

Malaria, meningitis, hepatitis A, B and C, and measles may be more common, depending on the country of origin. Chronic hepatitis B infection increases the risk of liver cancer. Filariasis and leprosy and other tropical diseases, although rare, may occur. HIV/AIDS is discussed in more detail in section 5.12

Further information can be obtained from:
Hospital for Tropical Diseases Grafton Way
London WC1E 6AU
Tel: 0207 387 4411

Liverpool School of Tropical Medicine,
Pembroke Place, L3 5QA
0151 705 3205

5.12) HIV/AIDS

HIV/AIDS is a significant issue for many refugees and asylum seekers, but is often hidden and difficult to address. Situations of risk include unprotected sex in a situation of high prevalence, paid sex, (which refugee women in particular may have been forced to use during their flight in order to survive), through a blood transfusion, contaminated needle, intra-venous drug use, or mother-to-child transmission. Some may have been placed at risk of HIV as a result of sexual violation, particularly as in many countries the incidence of HIV is higher among the military, who are often the perpetrators of sexual violence.

People may be concerned about the possibility of HIV infection, but may not raise it due to fear, and to concerns about confidentiality and stigma, and mistrust of interpreters. Those at risk should be offered information, confidential voluntary counselling and testing for HIV and other sexually

transmitted infections (STI's) and the availability of treatment explained. It can be difficult to raise the issue of HIV/AIDS when it is not clear whether a person feels that they have been at risk. The following questions may be helpful in initiating discussion:

“What do you know about HIV/AIDS? Do you think that you have been at risk?”

People may feel very concerned about being recognised as being HIV positive. Services which can be provided in a setting that does not identify people by their diagnosis may be preferred. Some may prefer to travel to a clinic further from their home. The specialised confidentiality of genito-urinary clinics, where no information is disclosed without the patient's express permission, may enable people to feel more secure, but this may be problematic if GPs do not have full information about a person's condition or medication.

Asylum seekers and refugees are eligible for all available treatments, although people may not be aware of this, as treatment is often unavailable in their home countries. Asylum seeking women are not however currently eligible for milk tokens. Some women who are HIV positive may continue to breastfeed, in order to conceal their HIV status within the community.

People may be at risk of transmission in the UK and information should be given on prevention. Health outreach teams (e.g. Lambeth Southwark and Lewisham) have carried out education sessions (See section 3.4 – information on health and healthcare for contact details). People who are HIV positive are at increased risk of TB (See section 5.10 – TB).

Access to specialist legal advice is important. Those who, if deported, would lose access to treatment may seek compassionate grounds to remain. A list of specialist solicitors is available from Terrence Higgins Trust's Specialist Advice Centre (SAC):

SAC consultancy line for professionals
(Fridays 2:00 - 5:00 pm):
0207 816 46 05

THT Direct - Service users
(service also available in French):
0845 12 21 200

Information on HIV/AIDS can be obtained from:

The African Health Team,
Terrence Higgins Trust,
52-54 Grays Inn Road,
London WC1X 8JU
Tel (Admin): 0207 831 0330
Tel Helpline: 0207 242 1010
(Noon – 10pm daily)

Regional offices:

Coventry	02476 229292
Birmingham	0121 694 6440
Oxford	01865 243389
Brighton	01273 764200
Bristol	0117 955 1000
Bath	01225 444 347
Leeds	0113 295 1921

Email: info@tht.org.uk

Website: www.tht.org.uk

Terrence Higgins Trust offers support and information through a telephone helpline, for people affected by HIV/AIDS. Offices nationwide and an African Team based in London, publish leaflets in English and French and also have tapes available in Swahili. They have published a good practice guide for health professionals.

Refugee Council Information Team

Tel: 0207 820 3085

Produces leaflet “Advice on HIV/AIDS”, giving basic advice, information and useful organisations in the following languages: English, French, Somali, Arabic and Albanian.

African Aids Helpline

Tel: 0800 0967 500

(Freephone Tues - Sat 2 – 10pm.)

Offers telephone support, advice and information in English, French, Luganda, Swahili and Shona. Check time availability for different languages.

National AIDS helpline

For free telephone advice and information about HIV/AIDS in different languages:

English	0800 521 261
(24hours)	
Arabic	0800 917 2227
(Wed 6 - 10pm)	
Bengali	0800 917 2227
(Mon 6 - 10pm)	
Cantonese	0800 917 2227
(Sun 6 - 10pm)	
Gujerati	0800 917 2227
(Thur 6 - 10pm)	
Hindi	0800 917 2227
(Fri 6 - 10pm)	
Punjabi	0800 917 2227
(Sat 6-10pm)	
Urdu	0800 917 2227
(Tue 6- 10pm)	

Positively Women,
347-349 City Road, London EC1V 1LR
Tel helpline: 0207 713 0222
(Mon – Fri 10am - 5pm)

National organisation offering counselling and support for women with HIV/AIDS. Runs support groups, including one for African women.

5.13) Sexual health and family planning

This is an area where refugees, and in particular young people, would like more information. People may not use family planning due to religious or cultural reasons, but this should not be assumed. Offering choice of gender of health worker and interpreter may enable discussion to take place. Children should not be used to interpret. Domiciliary family planning services may be appropriate for those who cannot access clinics or GP surgeries. Information on contraception should be made available in appropriate languages.

The Refugee Outreach Team in Lambeth, Southwark and Lewisham distributes condoms amongst refugee communities (See Section 3.4 for contact details).

Be aware that many women and some men are survivors of sexual violence, including rape (see section 6.5 - Sexual violence). Infection screening should be offered, although many people may be

hesitant to attend. Advocates and outreach health workers can explain the importance of this and may be able to increase uptake.

There has been a recent increase in syphilis in countries of the former Soviet Union, attributed to the rapid growth of the sex industry, increasing homelessness, poor diagnostic facilities and limited access to treatment. People may be at risk of chlamydia, trichomonas, and gonorrhoea. The incidence of hepatitis B and C is higher amongst people from Africa, Asia and Eastern Europe.

Sex education and effective outreach work are important. Teenage refugees are asking for information about sexual health. They often feel caught between two cultures – that of their parents and that of their peers. Relevant information should be made available, including where to obtain contraception.

As in any other situation, the news of pregnancy may be welcomed or dreaded. Although in many cultures abortion is unacceptable, do not make assumptions about what the woman or couple might wish to do.

Asylum seekers and refugees are entitled to access fertility services.

In many cultures homosexuality is a taboo issue and it is often denied that it exists, making it difficult for gay men and women to discuss sexual health, and increasing their isolation.

Reading:

Layzell S and England R What do Turkish-speaking women want to know about sexual health? A study to inform the production of Turkish language information leaflets. Health Education Journal 1999 58 (2), 130-8

Organisations:

Women's Health,
52 Featherstone St London EC1Y 8RT
Tel (office): 0207 251 6333
Fax: 0207 608 0928
Tel (helpline): 0207 251 6580
(Mon – Fri 9.30am – 1.30pm)
Email: health@womenshealthlondon.org.uk
Website: www.womenshealthlondon.org.uk

Help and information on a wide range of issues concerning women's health.

Blackliners, Unit 46,
Eurolink Business Centre, 49 Effra Road,
London SW2 1BZ
Tel (Admin): 0207 738 7468
Tel (Helpline): 0207 738 5274
Website: www.blackliners.org

Offers sexual health and HIV support to people of Asian, African and Caribbean origin and a support service for men who are gay or who are questioning their sexuality.

5.14) Health promotion

Translated written information on health can be useful, but other methods will be more effective for those who are not literate. Oral traditions are strong among many refugee communities and story-telling is an important way of disseminating information, which has been used in health promotion. Community organisations can raise issues in group and individual settings. Video and audio-cassettes have also been used successfully. Peer educators can offer information and advice about health services and about health promotion. Word of mouth plays an important role in disseminating information and publicising services. Health services in many countries have a curative rather than a preventative focus, so many people may not understand the relevance of health promotion and this may need to be explained. Sexual health promotion (see Section 5.13 Sexual health and family planning) and mental health promotion (see Section 5.3 Psychological well-being) should be included.

Group health promotion activities provide opportunities to:

- break down social isolation and in the process improve mental health and wellbeing
- share information about health needs and how to address them
- efficiently use the time of health workers and interpreters.

Smoking is high amongst some groups of refugees (e.g. men from Eastern Europe). This may be a reflection of their culture, but may also reflect the stress under which many refugees live.

Examples of translated leaflets for health promotion are on the Medact website www.medact.org

Lambeth, Southwark and Lewisham Refugee Health Team

Carmen Rojas, Team Leader,
Masters House, Dugard Way,
Renfrew Road, London SE11 4TH

Tel: 0207 414 1507

E-mail:

Carmen.Rojas-Jaimes@chsltr.sthames.nhs.uk

Health Promotion for Asylum Seekers

Lambeth, Southwark and Lewisham Refugee Health Team (contact details above)

The team organises health promotion sessions at colleges, Refugee Community Organisations, hostels and the Refugee Council One Stop Shop. They work closely with the health promotion unit of the community dental services, reproductive health and the Community Drug Education Project to organise sessions covering family planning, dental awareness, drug awareness, sexual health and access to services. They have also worked with the African Well Women's Clinic to facilitate sessions addressing female circumcision. This work entails either working with specialists to develop training sessions, delivered by the team, or specialists facilitate the sessions, with the team providing language support. There has been much use of role play and visual techniques. For many health promotion agencies this represents their only work with this population.

Further reading

Clark C et al

Promoting the Health of Refugees

London: Health Education Authority 1998

5.15) Oral Health

Several studies have indicated that refugees and asylum seekers are at risk of poor oral health, reflecting the conditions and time span of migration, and oral health and access to dentists in countries of origin. The availability of refined sugar in the form of soft drinks and sweets may be high in refugee camps. Oral health may have low priority compared to the more immediate problems of resettlement.

- Access to interpreters is crucial for clinical care, information and health promotion.
- Lack of awareness of cultural factors and health beliefs can lead to difficulties with compliance and misunderstanding. In some cultures, e.g. Vietnamese, deciduous teeth are not normally conserved if they are diseased, so there may be barriers to children accessing dental care. It may be difficult for a man to treat an orthodox Muslim woman.
- Written oral health information is obviously not useful where illiteracy is a factor.
- Recruiting and training health personnel from the same country as asylum seekers and refugees may address cultural barriers, but other barriers may exist, e.g. class.
- Dental and facial trauma could be a result of violence, torture or even carried out by health personnel
- Conditions such as soft tissue malignancies and oral manifestations of HIV/AIDS can be detected early through screening procedures. (See section 5.12 - HIV/AIDS)
- Oral cancer is on the rise in many continents due to an increased use of tobacco.
- Culturally relevant oral health promotion should be developed.

When treating or giving advice on oral health, the following should be taken into account:

- Expressions of pain
- Differences in the interpretations of symptoms
- Expectations of dental care due to different or no previous health care experiences

Asylum seekers must complete an HC1 form to access free dental treatment (section 4.1 – Eligibility for Health Care). For information on how to find an NHS dentist, see Section 4.2.

5.16) Nutrition

“Because of my language problem, I don’t know what to order. I always say bread and spaghetti. That is the few things I know. So my diet is not so good” female asylum seeker, dispersed

Limited finances, language difficulties and a lack of choice mean that diet may be restricted. Culturally familiar and acceptable food (e.g. Halal meat eaten by Muslims) may not be locally attainable.

Some, including pregnant and breast-feeding women, have been found to be under-nourished. Those living in hostels, where all meals are provided, may have difficulties with unfamiliar food.

Children may suffer from chronic under-nutrition, with stunting of growth. Rickets, scurvy and thiamine deficiency are more commonly seen. UK centiles charts are not standardised for all ethnic groups, but children should be referred for further assessment where there is more than a two-centile discrepancy between height and weight, or where serial measurements of growth fail to show adequate weight or height gain.

5.17) Drugs and alcohol

There is little information currently about the prevalence of drugs and alcohol use amongst refugee communities. However, it is known that people under stress may use alcohol and drugs as a coping mechanism; the risk factors for drug use, such as poor housing, poverty, less access to education and unemployment are prevalent amongst refugee communities.

Drugs and alcohol services need to have an understanding of the issues facing refugees, both past and present, and they need to have access to interpreters. There is significant stigma around drug use amongst refugee communities and, in addition, families feel a great responsibility if a family member is using drugs. There is a need to involve and support families and to stress confidentiality.

Khat/kat/chat

These leaves are chewed predominantly by people of East African, Middle Eastern and Arab heritage. Taken socially to dispel hunger and fatigue and for relaxation, users may become euphoric initially and then depressed as the effects wear off. Use can cause dizziness, lassitude, tachycardia, epigastric pain and psychiatric manifestations similar to the effects of other stimulants. It can lead to psychological addiction, but no physical dependence has been reported. It is a common social activity amongst men of Somali, Ethiopian and Yemeni heritage, and taken in small amounts is unlikely to be harmful. However there is concern amongst the Somali community about young men frequently

chewing khat in large amounts. There is also concern that there is a potential for khat to be replaced by other drugs and alcohol.

Drugs awareness

The Refugee Health Team in Lambeth, Southwark and Lewisham has carried out outreach work in hostels on drugs awareness, in conjunction with the community drugs education service. They have also translated information and worked to increase drugs awareness in community organisations working with refugees (See section 3.4 on Information on health and health care for contact details).

Orexis, an organisation in Deptford, South London, offers support to users of khat and has carried out a study of khat in the Somali community.

Tel: 0208 691 1233

Telephone helplines

Drinkline

Tel helpline: 0800 917 8282 (Freephone)
Mon – Fri 9am – 11pm, weekends 6-11pm

Offers advice, information and support to anyone concerned about their own or somebody else's drinking. Uses Language Line

National Drugs Helpline

Gives information and advice for drugs users and their families in the following languages

English	0800 776600 (24hours)
Bengali	0800 917 6650 (Mon 6 - 10pm)
Cantonese	0800 917 6650 (Sun 6 - 10pm)
Hindi	0800 917 6650 (Fri 6 - 10pm)
Punjabi	0800 917 6650 (Sat 6 - 10pm)
Urdu	0800 917 6650 (Tues 6 -10pm)

5.18) Physiotherapy

Many people may be unfamiliar with physiotherapy and it is helpful to establish the person's beliefs concerning the problem, what they feel may help them and realistic goals and outcome measures. Pain patterns may not conform to the familiar, particularly for a survivor of torture.

The problems which people present will be broadly similar to the host population, but some conditions may be more prevalent. Many come from war zones and may have had amputations or may be paraplegic; requiring referral to limb-

fitting centres and wheelchair services, or may have experienced torture. Some of those with long-standing polio may be coping well functionally and may not need intervention. Many refugees have poor housing and little money and exercise on prescription may be more accessible than joining a gym or doing exercises at home (although some may feel uncomfortable with prescribed exercise). Groups teaching relaxation techniques may be useful. Many people feel uncomfortable taking their clothes off, especially if they had had them forcibly removed. In a hospital gym people may feel acutely embarrassed stripped down to their underwear in front of others.

Physiotherapy for survivors of torture

Torture survivors may be sensitive about being touched. Be aware of the position that the person is placed in, which may be reminiscent of the torture situation and of your own and the interpreter's positioning. Some may feel uncomfortable about mixed sex hydrotherapy sessions and some torture methods may have involved the use of water. If tortured using electric shock, some may be sensitive to electrotherapy.

Further reading:

Franklin C (2001)

Physiotherapy with torture survivors Physiotherapy 87, 7, 374-377

Contact:

Elizabeth Carrington,
International Development Adviser,
Chartered Society of Physiotherapists.
Tel: 0207 306 6694

5.19) Role of complementary therapies

Therapies such as massage, physiotherapy, osteopathy, relaxation and herbal medicine may lessen chronic pain, anxiety, insomnia, stress and some of the physical and psychological effects of torture.

"I would like to see the introduction of a massage therapy service, to alleviate musculo-skeletal pain, reduce stress, improve self-esteem and reverse issues associated with negative touch such as torture."

Nurse, London

5.20) Traditional healthcare

Refugees may use traditional health care remedies or consult traditional healers within their own communities. Traditional practices include scarification (cuts made in the skin by African traditional healers, usually in a regular pattern, into which herbs may be inserted). Some herbal remedies may interact with prescribed medication, so it is worth checking if people are using these.

5.21) Arts therapies and creative arts

The arts therapies (art, dance movement, drama and music) offer a variety of different channels of communication in which to engage with psychological issues. Therapists, who have a professional training, may combine one or more psychological framework (e.g. psychodynamic, systemic) with the creative dimension of their art form. Creative therapies have been shown to offer benefits to people who have lived through situations of political conflict, in conjunction with practical support and healthcare.

Further reading

Kalmanowitz D and Lloyd B
The Portable Studio – art therapy and political conflict: initiatives in former Yugoslavia and South Africa, London, Health Education Authority 1997

Pavlicevic M
Music Therapy in Context,
London, Jessica Kingsley Publishers 1997

In addition, other art-related projects, including acting, music, writing and poetry may be helpful

in combating isolation, communicating meaning, enhancing self-esteem and strengthening identity and belonging.

For more information contact:
Artists in Exile, The Riverside Studios,
Crisp Road, London W6 9RL

Tel: 0208 237 1115

Fax: 0208 237 1001

Email: artistsinexile@hotmail.com

The Comfrey Project in Newcastle

*c/o The Rights Project, 292 Wingrove Ave,
Newcastle upon Tyne, NE4 9AA
Tel: 0191 273 1838
Fax: 0191 272 1114*

Established with Health Action Zone funding and practical support from the Rights Project, this allotment-based scheme aims to promote mental and physical well-being among refugees and asylum seekers in the West End of Newcastle. A small group of asylum seekers from different countries meet once a week with the project co-ordinator. The emphasis is on creating a safe, pleasant and friendly place for people to meet, rather than on maximizing horticultural output, but they have cultivated a good selection of vegetables and flowers. Clients enjoy the opportunities for learning, freedom, joy, relaxation and meeting new people.



6. Torture and Violence

6.1) Survivors of torture and organised violence

6.2) Psychological health following torture and violence

6.3) Physical effects of torture and violence

6.3.1) Musculo-skeletal, fractures and soft-tissue injuries

6.3.2) Head injuries and epilepsy

6.3.3) Ears and eyes

6.3.4) Effects of chemical attack and nerve gas

6.4) Children who are survivors of torture and violence

6.5) Sexual violence

6.6) Sex trafficking

6.7) Domestic violence

Key Points

- *Torture and violence have been experienced by many asylum seekers and refugees in the UK*
- *Much can be done by health workers to alleviate the physical and psychological difficulties that face survivors*
- *Survivors of torture may not volunteer their history due to feelings of guilt, shame or mistrust*
- *Consideration must be given to building a relationship of trust*
- *Children may have experienced torture themselves or have witnessed others being tortured*

- *Many women and some men are survivors of sexual violence, including rape*
- *Many people feel deep shame*
- *Some women and children are trafficked to the UK for the purposes of working in the sex industry. They are a very vulnerable group*
- *Domestic violence may be hidden*

6.1) Survivors of torture and organised violence

Torture is "... the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused."

Article 7.2 (e) (excerpt) of the Rome Statute of the International Criminal Court 1998

Organised violence is considered to have a political motive. Survivors of torture or organised violence may have been ill treated by government agents such as the army, police or security forces, or rebel groups perpetrating organised violence. Estimates of the proportion of asylum seekers who have been tortured vary from 5 - 30%, depending on the definition of torture used and their country of origin.

Many people do not initially admit to their experiences of torture. This may be through shame or embarrassment. It may be difficult to disclose sensitive information of, for example, sexual violation to an immigration officer of the opposite sex. Health workers may be in a better position to build trust and empathy and to ask about experiences of torture or ill treatment. If direct questioning appears to be too uncomfortable, it may be possible to introduce the subject indirectly.

" I know that some people in your situation have experienced torture or ill treatment or rape. This is something that we may be able to help with. Has this ever happened to you?"

People have commonly been beaten, kicked and slapped. Many women and some men have experienced rape or other sexual violence (see section 6.5 - sexual violence). Some methods are typical of certain geographical areas: falaka in the Middle East and Turkey (beating on the soles of the feet), and in India the ghotna, (a pole placed across the legs, on which the torturer stands). People may be burned with cigarettes, or given electric shocks. Finger or toenails may be forcibly extracted and fractures inflicted. People may be forced to witness visually or aurally others being tortured, or may be forced to participate in torturing others, and mock executions may be performed. More detailed information on the prevalence of torture methods can be found on the Amnesty website (Campaign to Stop Torture) www.stoptorture.org

General Considerations

The effects of torture are an accumulation of physical violence, detention (unhygienic cells, inadequate diet), and the psychological consequences of one's own and witnessing others' experiences. A survivor of torture may have a preoccupation that his or her body has been irreparably damaged and may experience chronic pain, leading to repeated consultations. The essentials are time, a sympathetic approach, and, if language is not shared, a trained interpreter who is not a family member or friend. The continuity gained by using the same interpreter and health worker for each session may help to engender feelings of trust and safety for the client. However, be aware that this work is stressful for interpreters and may re-stimulate feelings about similar experiences of their own. If possible, it is helpful to spend some time with the interpreter, both at the beginning of a session to discuss both your ways of working, and after the session is over, in order to address any issues which have arisen.

If a referral is made, ensure that the complexity of the person's situation, including their social circumstances, is clear. (S)he should be seen by an experienced member of the team.

The family of a survivor of torture may also need support. Children may feel additional pressures and should be given an opportunity to talk about their feelings.

Medical Foundation for the Care of
Victims of Torture,
96-98 Grafton Road, London NW5 3EJ
Tel: 0207 813 7777
Fax: 0207 813 0011
Email: clinical@torturecare.org.uk
Website: www.torturecare.org.uk

Provides services for survivors of torture and other forms of organised violence and their families, providing case work, counselling, advice regarding welfare rights, physical and mental health care, individual and group therapy, physiotherapy and complementary therapy, family therapy and child and adolescent psychotherapy. Care is provided for individuals, for families and in groups.

Medico-legal reports may be written, by referral from solicitors, in support of asylum claims.

Advice and help with access to health care throughout the country.

Staff run training sessions and workshops for professional groups working with refugees and survivors of torture and can discuss issues with health care workers.

The Medical Foundation is no longer able to see clients without an appointment. Details of how to refer can be found on the website (<http://www.torturecare.org.uk/refer.htm>)

The Traumatic Stress Clinic, Camden & Islington
Mental Health NHS Trust,
73 Charlotte St, London W1T 4PL
Tel: 020 7530 3666
Fax: 020 7530 3677
Email: refugee@traumaclicin.org.uk
Website: <http://www.traumaclicin.org.uk>

Provides specialised multi-professional NHS mental health services for adults, children and families in this country as refugees or asylum seekers. Interventions include individual (child, adolescent and adult) and family assessment and therapy services. Consultation, advice and/or supervision are offered to other services working with refugees. Referrals may be made by practitioners in secondary care, primary care and social services – chiefly from across north London. Referrals should be made to the address above, specifying if they are directed to the child & family service or to the adult refugee service in the Clinic.

Expert witness reports may be prepared on instruction from solicitors in relation to asylum applications or appeals. Training sessions are offered in conjunction with other services. Advice on refugee-related research is also available

Further reading

Burnett A and Peel M
The Health of Survivors of Torture and Organised Violence BMJ 2001; 322: 606-9

Forrest D and Hutton F
Guidelines for the examination of survivors of torture
London, Medical Foundation for the Care of Victims of Torture, 2000

Basoglu M
Torture and its Consequences
Cambridge University Press 1992

Amnesty International
Take a Step to Stamp Out Torture 2000

Amnesty International
Broken Bodies, Shattered Minds -
Torture and ill-treatment of women 2000

Amnesty International
Hidden Scandal, Secret Shame -
Torture and ill-treatment of children 2000

British Medical Association (Sommerville A ed.)
The Medical Profession and Human Rights: a handbook for a changing agenda,
London, British Medical Association and Zed Books 2001

6.2) Psychological and mental health following torture and violence

(see also Section 5.3 Psychological well-being)

Presentation

Some people experience atrocities without developing any serious psychological symptoms beyond a natural increase in anxiety and occasional nightmares. Others show more marked signs of anxiety, depression, guilt and shame as a result of their experiences and also due to their current situation.

Some may present with symptoms of mental illness, which may be long-standing, or which may be linked with their experiences.

Anxiety

panic attacks, pain, headaches, psychosomatic symptoms, poor concentration and memory, sleep disturbance, flashbacks (distressing memories of traumatic events), worries, anticipating the worst, confusion, avoidance of situations, aggressive behaviour, impulsive behaviour, withdrawal from others, passivity.

Hyper-arousal

increased nervous system arousal, sleep problems, excessive anger, irritability, memory and concentration problems, hypervigilance, jumpiness.

Loss and bereavement

loss of family, friends, home, social support network, job, lifestyle. Grief, numbness, anger, denial, yearning, preoccupation with a lost person, and the effect of those who have disappeared. Anxiety, emptiness, apathy and despair, anger; altered behaviour in relationships such as increased dependency, fierce self-sufficiency, compulsive care-giving and suspiciousness; fear about relationships such as fear of intimacy, ready devaluation and idealisation of others; depression, pessimism, sleep disturbance, appetite disturbance, poor concentration, self blame, hopelessness, suicidal thoughts and plans.

Shattered core beliefs

loss of trust and meaning, capacity to trust damaged, loss of sense of future, sense of identity shattered, loss of sense of a just world, and powerlessness to change society.

Guilt and shame

guilt at having failed to prevent violence, particularly if members of family have been threatened, tortured or killed, survivor's guilt, self-destructive behaviour, avoidance of others due to shame, self-blame, ability to experience pleasure inhibited; inability to disclose experiences, which results in secrets within the family and which may lead to breakdown of family relationships and social isolation.

Intrusions

re-experiencing aspects of the original traumatic event in nightmares or as intrusive memories or flashbacks.

Avoidance

avoiding reminders of the event(s), inability to recall parts of the trauma, sense of detachment from others, flattened affect.

Low mood

depression, loss of interest, withdrawal, loss of self-esteem, social isolation, loss of motivations, loss of interest in activities.

Assessment

Common expressions of psychological and emotional distress do not necessarily mean the same in different cultural and social settings. For a discussion of cultural issues affecting psychological health see section 5.3 (Psychological well-being). It is important to maintain an open mind over a longer period of assessment. Carefully consider before pathologising what may be the natural expression of grief and distress concerning highly abnormal experiences. Diagnoses such as post-traumatic stress disorder (PTSD) and depression should be used cautiously as they may not address the complex way in which historical, social and political factors interact and impact on the experiences of communities¹.

" We are unfortunately medicalising refugees when their prime needs are non-medical."
(Psychiatrist, London)

No psychiatric illness is specific to trauma or torture and PTSD is not in itself a marker for past trauma².

Symptoms need to be understood in context and through the meaning they represent to the person experiencing them³. Someone politically active and familiar with the use of torture may be able to make more sense of their experiences and feelings than someone for whom detention and ill treatment appear more arbitrary.

Risk of suicide and issues of child protection (see section 7.10 Child Protection) should be assessed. There may be cultural and religious taboos regarding talking about self-harm.

However the description of psychological state is formulated, care for survivors of torture and violence is paramount. Using an approach wider than a biomedical base may offer more appropriate treatment models.

Support and treatment

For many people, the most valuable inputs are supportive listening and practical assistance to rebuild their lives. Community, religious, spiritual and creative links may be important. Refugees have survived against huge odds, and their resilience may be a strength to be tapped into. Consider antidepressants for concurrent depressive illness. Tricyclics and SSRIs may be useful for the treatment of intrusion and avoidance symptoms and if drug treatment for depression is indicated.

Symptoms which may need specialist help include:

Consistent failure to function properly with daily tasks

Frequently expressed suicidal ideas or plans

Social withdrawal and self-neglect

Behaviour or talk that is abnormal or strange within the person's own culture

Aggression

Shackman J, Gorst-Unsworth C and Summerfield D

Further reading

Harris K and Maxwell C

A Needs Assessment in a Refugee Mental Health Project in North-East London: Extending the Counselling Model to Community Support Medicine, Conflict and Survival 2000; 16, 201-215

Summerfield D

The Impact of War and Atrocity on Civilian Populations: Basic Principles of NGO Interventions and a Critique of Psycho-social Trauma Projects London: Relief and Rehabilitation Network, Overseas Development Institute 1996

Bracken P and Petty C (Eds.)

Rethinking the Trauma of War

London and New York: Save the Children Fund and Free Association Books 1998

¹ Bracken P *Hidden agendas: deconstructing post traumatic stress disorder*. In Bracken P, Petty C Eds. *Rethinking the trauma of war*. London, New York, Save the Children and Free Association Books, 1998

² Hutton F *Psychological assessment of torture survivors*. In Forrest D, *Guidelines for the examination of survivors of torture*. London, The Medical Foundation for the Care of Victims of Torture 2000

³ Summerfield D *Addressing human response to war and atrocity*. In Kleber R et al eds. *Beyond trauma*. New York: Plenum, 1995

Bracken P, Giller J, Summerfield D
Psychological responses to war and atrocity: the limitations of current concepts
Soc. Sci. Med. 1995; 40: 1073 - 82

Watters C
The Mental Health Needs of Refugees and Asylum Seekers: Key Issues in Research and Service Development in Nicholson F *Current Issues of Asylum Law and Policy*
Avebury 1998

Webster A and Rojas Jaimes C
The Mental Health Needs of Refugees in Lambeth
London, 2000 Available from Refugee Health Team, Master House, Dugard Way, off Renfrew Rd, London SE11 4TH Tel: 0207 582 5247

6.3) Physical effects of torture and violence

6.3.1) Musculo-skeletal, fractures and soft-tissue injuries

Torture, landmines, shrapnel and other violent trauma may result in injuries, which may have received inadequate medical attention, resulting in a high prevalence of limb injuries, including malunited fractures, osteomyelitis or amputation. Wounds and burns may be infected or inadequately treated. Pain, weakness and other non-specific symptoms are common, and these may be helped by physiotherapy, non-steroidal analgesics, complementary therapy such as massage, relaxation and techniques to manage symptoms.

Prolonged suspension by the arms can lead to neuropathies and muscle weakness, much of which recovers subsequently, but which can lead to permanent disability. In the Indian subcontinent, techniques such as the ghotna tear and crush muscle, sometimes permanently. Keloid scars from burns and cuts may be distressing to the individual. Electric shocks are a very painful method of torture, and equipment for this purpose is still exported to countries in which torture is common.

6.3.2) Head injuries and epilepsy

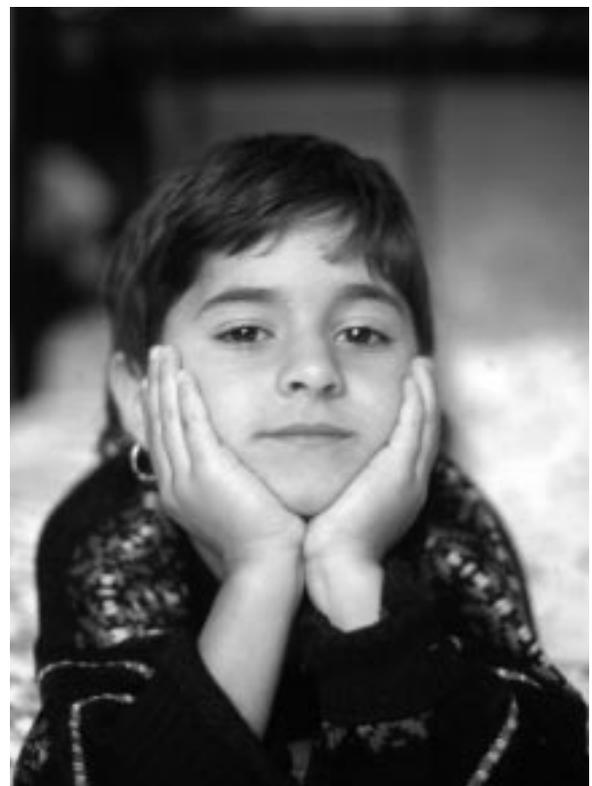
Many people subjected to violence have been hit on the head, sometimes resulting in epileptiform convulsions. These should be managed as for all

post-traumatic head injuries. Post-concussion syndromes may present with problems of memory and concentration, but these symptoms can also be stress-related.

6.3.3) Ears and eyes

Slapping around the ears is common during interrogations. There is usually a history of pain, bloody discharge from the ears, and persistent hearing loss. Otitis media may result from traumatic perforation. Scarring of the eardrum may be present.

People who have been detained in darkness for long periods often complain of soreness and watering of the eyes in bright light. This finding has not yet been fully documented or investigated. Occasionally on a very bright day redness of the eyes can be observed, but it is rarely bright enough in the UK for this to be overt.



6.3.4) Effects of chemical attack and nerve gas

Chemical warfare agents were used in World War 1 and have been employed or allegedly employed in approximately 12 conflicts since. The most recent large-scale use of these weapons was by Iraq in its war with Iran in the late 1980s and by Saddam Hussein against the Iraqi Kurds, notably in Halabja in 1988. The chemical arsenal comprises mustard gas, which causes blistering of the skin and lungs, and several types of nerve gas - tabun, sarin, soman and VX.

All of these, with the possible exception of VX, were used at Halabja. During the attack 5,000 people are thought to have died. The major long-term effects of mustard gas include¹

- respiratory disorders including asthma, bronchitis, bronchiectasis and pulmonary fibrosis
- respiratory cancers (nasopharyngeal, laryngeal and lung)
- pigmentation abnormalities of the skin
- chronic skin ulceration and scar formation
- skin cancer, including rapidly advancing basal cell carcinoma
- chronic conjunctivitis
- recurrent corneal ulcerative disease (may result in blindness)
- delayed recurrent keratitis, causing soreness and itching of the eyes.
- Leukaemia
- Bone marrow depressions resulting in immunosuppression
- Psychological disorders (mood and anxiety disorders)
- Sexual dysfunction as a result of scrotal and penile scarring

The incidence of birth defects such as harelip, cleft palate, spina bifida, congenital heart defects, Downs Syndrome and other major chromosomal disorders have been found to be more common in Halabja since the attack, as have miscarriages and unexplained infant deaths. Infertility, childhood leukaemia, lymphomas and neurological disorders have been noted in the population².

See section 6.1- Survivors of torture and organised violence, for organisations and further reading.

6.4) Children who are survivors of torture and violence

Children may have experienced violence or torture themselves, or may have witnessed members of their family being tortured. Some may have been abducted to become child soldiers and forced to commit violent acts themselves. They will also have suffered multiple loss.

Children react to such experiences in different ways (See section 7.7 - children and adolescents). In order to assess their needs, time and trust are needed. Children may feel under pressure to keep secret both information and their feelings. Providing an opportunity for children to talk about their experiences over time and imparting to them a sense of belonging will enable them to develop confidence in their new surroundings. It is vital that children are able to join mainstream schools as quickly as possible as it has been found that this may be the most therapeutic event for a refugee child³. However, they may experience bullying and racial abuse at school.

Family and Children Consultation Services may be able to offer support. Children may benefit from both individual and group work. The latter gives them an opportunity to be with other young people from similar circumstances, who understand the impact of war and conflict, multiple loss and the difficulties of adjusting to life in a new environment and with family pressures. It is important to take a multi-disciplinary approach, where all those who have responsibility for different aspects of the child's welfare work in partnership.

See section 6.1 – Survivors of torture and organised violence, for organisations and further reading.

¹ Sidell F and Hurst C Long-term Health Effects of Nerve Agents and Mustard Gas, in *Medical Aspects of Chemical and Biological Warfare*
² Gosden C <http://www.oneworld.org/ips2/mar98/iraq2.html>
³ Melzak S and Kasabova S *Working with children and adolescents from Kosovo* London: Medical Foundation for the Care of Victims of Torture, 1999

6.5) Sexual violence

Many female, and some male, asylum seekers are survivors of sexual violence including rape. This has throughout history been used as a weapon of warfare to degrade and humiliate an enemy. In many cultures, sexual violence and rape are taboo subjects, and survivors may feel very uncomfortable discussing their experiences. If possible, offer a choice of gender of the health care worker and interpreter. A relative, and particularly children, should not be used to interpret. Persistent unexplained distress and anxiety may be due to a history of sexual violation. Women who have experienced sexual violence may have particular difficulties with cervical screening.

It may be possible to ask directly about experiences of sexual violation, but if direct questioning appears to be too uncomfortable, it may be preferable to introduce the subject indirectly:

“ I know that some people in your situation have experienced sexual violation. Has this ever happened to you?”

Sexual violence is motivated by a wish to dominate and degrade and is a very powerful weapon against individuals, families and communities. For both male and female survivors, the dominant emotion following is usually that of deep shame. Women may be shunned by their community and family as having been defiled, and are no longer accepted.

Rape and other sexual violation, including electric shocks applied to the genital area, rarely leave any long-term physical signs, particularly for women. Absence of physical signs does not mean that sexual violation has not taken place. For men, objects forced into the meatus may lead to scarring of the distal urethra, and sometimes thickening can be felt. It should not be assumed that dysuria is due to a STI. Men tend to under-report their experiences of sexual violence. They may have doubts about their sexuality and fear infertility. Both men and women commonly experience sexual difficulties following sexual violence and may need reassurance about sexual function.

Referral to a Sexual Health Clinic should be made, to exclude infection. Women who have experienced sexual violence may experience difficulties with internal examination, but may however be reassured by being examined. Some clinics run a sexual assault service with experienced doctors, health advisers and psychologists.

Although some people may benefit from talking about their experience of sexual violence, others may feel very uncomfortable. It may be more effective to help people to develop their own support networks by facilitating the development of meetings and activities and by addressing current practical difficulties that they are facing. It is important to address sexual violation in the context of the many traumas and losses experienced.

Organisations that can take referrals and offer assistance:

Medical Foundation for the Care of Victims of Torture 96-98 Grafton Road, London NW5 3EJ
Tel: 0207 813 7777
Fax: 0207 813 0011
Email: clinical@torturecare.org.uk
Website: www.torturecare.org.uk
See section 6.1 Survivors of torture for further details.

Victim Support:

Provides practical help and emotional support to victims and witnesses of crimes.

Tel: 0207 735 9166 (Office)

Tel: 0845 3030 900 (Victim support line)

9am - 9pm weekdays, 9am -7pm weekends
and 9am - 5pm Bank Holidays

Rape Crisis Centres

Branches throughout the UK. For further information ring

Tel: 0207 916 5466 (office)

6.6) Sex trafficking

Some women and children are trafficked to the UK for the purposes of working in the sex industry. They may not have made an application for asylum but may have a case and may need legal advice. They have a wide range of physical and psychological health needs but may be hard to reach, as they may be fearful of contact with statutory services. Outreach healthwork has been initiated in London to provide health services.

For further information contact:

Cathy Zimmerman, Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT
Tel: 0207 927 2490 / 2412
Fax: 0207 637 5391
email: cathy.zimmerman@lshtm.ac.uk

Further Reading

Reports of trafficking of children to the UK,
www.antislavery.org/homepage/resources/Children
www.immigrationindex.org/human-trafficking

6.7) Domestic violence

Women experiencing domestic violence are particularly vulnerable because they may lack family and community support. Their access to accommodation, and sometimes to asylum, may be linked with their partner, so it may be difficult

for them to leave. In some cultures, domestic violence is tolerated or is kept within the family, and women may be unaware that help is available. Their partner's violent behaviour may be tolerated because of the violence that he may have experienced himself. Physical punishment of children may be common within families and a distinction needs to be made between discipline and physical abuse.

Organisations

Refugee Women's Resource Project,
Asylum Aid, 28 Commercial St, London E1 6LS
Tel: 0207 377 5123
Fax: 0207 247 7789
E-mail: info@asylumaid.org.uk
Website: www.asylumaid.org.uk

Provides advocacy on the rights of refugees and advice on individual asylum claims, legal advice and representation, outreach work, research, publicity and campaigning, sharing expertise and promoting good practice. Current work is looking at the issue of domestic violence.

Victim Support:

Tel: 0845 3030 900 (Victim Support line)
Open 9am – 9pm weekdays, 9am – 7pm weekends and 9am – 5pm Bank Holidays

Provides practical help and emotional support to victims and witnesses of crimes.



7. Needs of specific groups

7.1) Health needs of women

7.2) Maternity Care

7.3) Female Genital Mutilation

7.4) Health needs of men

7.5) Health needs of older people

7.6) Health needs of families

7.7) Health needs of children and adolescents

7.8) Unaccompanied minors/separated children

7.9) Age Assessment

7.10) Child Protection

7.11) Disability and special needs

7.12) Carers

KEY POINTS

- *Particular difficulties which affect women are often not acknowledged*
- *Female Genital Mutilation is illegal in Britain and carries health risks. Refer to specialist clinics. There may be issues of child protection*
- *Men may find lower status difficult to deal with*
- *Older people are more likely to have chronic health problems and to be undernourished*
- *They may have responsibility for raising children*
- *Offer support services for older people and do not assume that the family can care for all their needs*
- *Engage at a family level and offer support to both parents and children*
- *Parents may need support with parenting*

- *Support for children needs to be multifaceted, aiming to provide as normal a life as possible*
- *Unaccompanied minors are particularly vulnerable*
- *X-Rays should not be used to assess age*
- *Address issues of child protection sensitively, whilst keeping the child's needs paramount*
- *Disability may be hidden and stigmatised*
- *Refugee carers are often isolated and unsupported*

7.1) Health needs of women

Displacement is difficult for all refugees, but women are often the most seriously affected¹. They face additional problems because of their lower status in society. They may have to take on unfamiliar roles and responsibilities, as head of a household and breadwinner, and be lacking their previously important family and community supports. Poverty and racial harassment add to difficulties. Some women living in hostels have experienced sexual harassment². Women's involvement in political activities may have been in the form of political activism or may have taken a different form, such as providing shelter or food to those in hiding.

The needs of women may not be identified, especially in cultures where men are traditionally the spokespeople. Women are less likely to have language skills in English, or to be literate. It is important to speak to women directly, using an independent interpreter rather than a family member. Women are more likely to report poor health and depression. They may be lonely and isolated but, if given the opportunity, welcome the opportunity to belong to a group, where they may benefit from the contact and support.

¹ Ferron S, Morgan J, O'Reilly M *Hygiene promotion – a practical manual for relief and development*. London Care International and Intermediate Technology Publications, 2000.

² Hinton T *Working with Refugees and Asylum Seekers in Lambeth, Southwark and Lewisham*. London, Health Action for Homeless People and Crisis, 2001

Many are survivors of violence, which may have been sexual in nature. In many cultures rape is a taboo issue which may not be discussed and which results in the woman being shunned by her husband, family and community. She is likely to feel very ashamed and unclean and may be unwilling to talk about her experiences. Women may also have experienced genital mutilation, domestic violence and enforced sterilisation. Some women may have an unwanted pregnancy, which may be a result of sexual violence.

Termination of pregnancy may be unacceptable in some cultures, but assumptions should not be made about what a woman may wish to do and information should be made available so that she can make an informed choice.

Screening and health promotion have tended to have a low uptake amongst refugee women. However this has been shown to be greatly improved by increasing the availability of female health workers and advocates in order to enable women to discuss their health and choices more easily, and to address misperceptions of health screening.

Women need to be offered sexual health care, family planning and maternity care that is sensitive to their cultures. They should be offered choice on the gender of health worker and interpreter. Health workers should be aware that some women may have undergone Female Genital Mutilation (FGM), which can affect sexual health and childbirth (See section 7.3 - FGM).

Some women may have previously been part of organised or informal women's groups. In the UK, groups can be an important form of support and of information sharing.

Organisations working with women refugees:

Refugee Women's Association, Print House,
18 Ashwin St, London E8 3DL

Tel: 0207 923 2412

Fax: 0207 923 3929

E-mail: rwa@womensassociation.freemove.co.uk

Provides advice, guidance and counselling for women refugees on education, training and employment; English courses with childcare and travel expenses; Community business for work placements and employment for refugee women; Capacity building for refugee women's groups

and women's sections of refugee community organisations; Partnership and network development between the refugee women's organisations; Health and Social Care; Advice and counselling on mental health; Bi-monthly newsletter - "Refugee Women's News"

Refugee Women's Resource Project,
Asylum Aid, 28 Commercial St, London E1 6LS
Tel: 0207 377 5123

Fax: 0207 247 7789

E-mail: info@asylumaid.org.uk

Website: www.asylumaid.org.uk

Provides advocacy on the rights of refugees and advice on individual asylum claims, legal advice and representation, outreach, research, publicity and campaigning, especially on gender-related persecution, casework and outreach services.

Refugee Women's Directory (1998) published by the Refugee Council

Lists organisations that assist refugee women.

Women's Health, 52 Featherstone St
London EC1Y 8RT

Tel (office): 0207 251 6333

Fax: 0207 608 0928

Tel (helpline): 0207 251 6580

(Mon – Fri 9.30am – 1.30pm)

Email: health@womenshealthlondon.org.uk

Website: www.womenshealthlondon.org.uk

Help and information on a wide range of issues concerning women's health.

Further reading

Hinshelwood G

Shame the Silent Emotion

Institute of Psychosexual Medicine Journal, (1999) 22; 9 –12

7.2) Maternity care

Pregnant women may be unfamiliar with the type of care available in the UK. If possible, offer a choice of female health worker and interpreter. Interpreters should also be arranged for antenatal classes. A hand-held antenatal record should be given, as for other pregnant women, and is particularly useful if women asylum seekers move accommodation.

HIV testing needs to be sensitively handled (see section 5.12 - HIV/AIDS). Some women may be at risk of hepatitis B and C. Counselling for haemoglobinopathies and for antenatal screening for malformations should be offered. Although in many cultures abortion is unacceptable, do not make assumptions about what the woman or couple might wish to do in the event of a malformation being discovered. They need access to information to make an informed choice.

A woman who is pregnant as a result of rape will need especially sensitive support. She may face particular difficulties relating to her baby, although this is not universal.

Women in many cultures are used to being supported by female family members when giving birth, and will feel their absence. Husbands and male partners are rarely the major sources of support and may be in an unfamiliar role. Dispersal can increase isolation, with separation from potential support networks.

“ Postnatally women are highly isolated; many described sitting at home crying endlessly – none had received support for post-natal depression” . Research officer, London

Pregnant women supported by NASS can receive a maternity grant worth £300 in vouchers. The application must be made to NASS not less than 4 weeks before and not more than 2 weeks after the birth. However it has been difficult for women in emergency accommodation to access this grant.

Asylum seekers currently have no access to milk tokens. Hygienic conditions may be difficult to maintain for the preparation of bottles.

Milk for babies of women who are HIV positive

*Dr Daya Nayagam
Tel: 0207 771 5423*

In Lambeth, Southwark and Lewisham, the Health and Local Authorities fund a scheme giving HIV positive women (including asylum seekers) sterilising equipment, bottles and formula milk.

Jenny McLeish,
Social Policy Officer, Maternity Alliance,
45 Beech St, London, EC2P 2LX
Author of report: Mothers in exile
(see further reading)

Tel: 0207 588 8583

Fax: 0207 588 8584

Email: jmcleish@maternityalliance.org.uk
info@maternityalliance.org.uk

Website: www.maternityalliance.org.uk

Jo Murphy Lawless,
Centre for Gender and Women's Studies,
Trinity College, Dublin
Co-author of report titled “ The Maternity Care
Needs of Refugee and Asylum Seeking Women
Email: jo.murphylawless@oceanfree.net

Further reading

McLeish J
Mothers in Exile: Maternity experiences of asylum seekers in the UK,
London The Maternity Alliance 2002 Tel: 0207 588 8583

7.3) Female Genital Mutilation

Female genital mutilation (also known as FGM or Female Circumcision) describes a range of practices involving the removal or alteration of healthy female genitalia. It is practiced in 28 African countries, in SE Asia and the Middle East and it is estimated that 100 – 140 million women are affected. The highest prevalence rates are found in Djibouti, Guinea, Somalia, Eritrea, Mali, Sierra Leone and Sudan. It is illegal in the UK.

Affected women may experience problems with sexual, reproductive and general health, including difficulties with passing urine and menstruation, recurrent urinary tract and pelvic infections, and fistula and keloid formation. Infections may result in infertility. Childbirth may be problematic, with increased risks of stillbirth and haemorrhage. Taking a cervical smear may be painful. Psychological sequelae include anxiety, depression and sexual difficulties.

Ideally, Female Genital Mutilation should be identified as early as possible in the antenatal period before 20 weeks gestation so that reversal can be performed before labour, though it can also be performed in the first stage of labour. Midwives and obstetric staff need training in

identifying and caring for women affected. The BMA suggests possible questions to ask: "Are you circumcised?" "Are you closed?" or "Are you open?"

A child thought to be at risk of Female Genital Mutilation is considered to be at risk of child abuse, and steps should be taken to initiate child protection proceedings (see Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. Department of Health, Home Office, Department for Education and Employment London: The Stationary Office 1999). There should be discussion with the family about the health and legal issues, with a sensitive approach to their beliefs and culture, the aim being to find effective ways of ensuring the protection of the child whilst promoting her overall welfare. The involvement of social services, community paediatricians, counsellors, local community groups and other health workers with experience in this area should be sought. A few women have been granted refugee status on the grounds that they would be at risk of Female Genital Mutilation if they were returned to their country, and the United Nations High Commissioner for Refugees (UNHCR) supports this.

(Summarised from the British Medical Association website - Female Genital Mutilation: Caring for patients and child protection BMA 2001 <http://www.bma.org.uk/public/ethics>)

Organisations working in this area include:

Foundation for Women's Research and Development (FORWARD)
6th Floor, 50 Eastbourne Terrace, London W2 6LX
Tel: 0207 725 2606
Fax: 0207 725 2796
e-mail: forward@dircon.co.uk
website: www.forward.dircon.co.uk

The website provides contact details for clinics with experience of caring for women who have been affected by FGM, under the heading Help and Advice.

Comfort Momoh, FGM Specialist Midwife, African Well Woman Clinic,
14th floor, Guy's and St Thomas's Hospital NHS Trust, St Thomas Street, London SE1 9RT
Tel: 020 7955 2381
Pager: 020 8345 6789 (881018)

A specialist clinic offering midwifery, obstetric, gynaecological care and de-infibulation for women who have undergone Female Genital Mutilation. It has a wide catchment area.

Women's Health Team of Central Manchester PCT, Robert Darbshire Practice, Rusholme, Manchester

Contact Zeinab Mohamed 0161 225 6699
zemohd@hotmail.com for further information

For details of your nearest specialist clinic, see the FORWARD website: www.forward.dircon.co.uk under the heading Help and Advice.

The African Well Women's Advice Clinic, Waltham Forest

Contact: Jennifer Bourne, The Refugee Advice Centre, 340 High Road, Leyton, E10 6JP
Tel: 0208 558 4077
Fax: 0208 556 0100

Set up to provide advice on women's health issues relating to female circumcision, the clinic is held weekly at the Refugee Advice Centre, Leyton. It is staffed by outreach nurses from the Community Health Project working alongside a Somali gynaecologist, who speaks English, Somali and Arabic, and who is in the process of revalidating her qualifications. Additional interpreting services can be arranged if needed. The clinic is open access and the following services are offered:

- Advice and guidance
- Cervical screening
- Referral to other services
- Referral for reversal of circumcision
- Health promotion advice on the menopause
- Advice on aspects of women's health
- Advocacy for clients with other services

It provides a service that women find culturally and linguistically appropriate and is an extremely effective setting for delivery of a wider range of services, particularly preventive and promotive services.

From Taket A: Health-related services for women: the views of Somali women living in Redbridge and Waltham Forest – report of a focus group, South Bank University, 2001

Further reading:

Adamson F.
Female Genital Mutilation: a counselling guide for professionals.
London: FORWARD 1992

Momoh C
Female Genital Mutilation - Information for Health Care Professionals (available from C Momoh, Specialist midwife, Guys and St Thomas's Hospital, see above for contact details)

Hedley R. and Dorkenoo E.
Child Protection and Female Genital Mutilation: Advice for health, education and social work professionals.
London FORWARD 1992

Mwangi-Powell F (ed.)
Female Genital Mutilation: Holistic care for women. A Practical Guide for Midwives. London FORWARD, 2001

Royal College of Nursing.
Female Genital Mutilation: The unspoken issue.
London: Royal College of Nursing, 1994

The Royal College of Midwives
Female Genital Mutilation (Female Circumcision) Position Paper No. 21, London: The Royal College of Midwives, 1998

McCaffrey M, Jankowska A, Gordon H
Management of Female Genital Mutilation: The Northwick Park experience.
British Journal of Obstetrics and Gynaecology 1995; 102:787-790

Snow R Female genital cutting: distinguishing the rights from the health agenda Tropical Medicine and International Health Vol. 6 No 2 pp89-91 Feb 2001

Video:

Another form of abuse London, FORWARD 1992. A general introduction, discussing health implications and including a woman who had genital mutilation performed on her.

7.4) Health needs of men

Men, who find their changed, usually lower, status and powerlessness hard to deal with, often feel the change in circumstances affecting refugees more acutely. Depression and anxiety are common. Women may find it easier to gain employment, be it often low paid, and this may lead to changed family dynamics. Families in this situation may be at a higher risk of domestic violence. Levels of smoking, alcohol or drug consumption may be exacerbated by boredom. Young men may be frustrated by unemployment and have little to fill their day. In addition, they may not have the requisite cooking skills to eat well.

“ Men often do not take their health seriously enough and do not access services”
Community Practitioner, London

“ There is less help available generally for men's health issues” Health Visitor, Salford

Although men may be more reluctant to access health care, outreach services, including health sessions held in hostels and education colleges by community workers, can be a good way to engage them, such as are carried out in Lambeth, Southwark and Lewisham (See section 3.4 – information on access to healthcare and on health for contact details). Some clinics have established good rapport with men, who readily access their services.

7.5) Health needs of older people

Older people are not represented in large numbers amongst newly arrived refugees, but they face particular difficulties and their needs are rarely a priority in the planning and delivery of services.

Older people have comparatively poor health and are more likely to have chronic health problems (as with other older people). Their nutritional status may be vulnerable due to a poor diet and dental problems. Food may not be culturally acceptable and familiar.

They may be grieving for losses already sustained and may be fearful of death and burial in a foreign place. Isolation and loss of support mechanisms on which they have relied in the past may compound this. Short-term memory loss and so much change, with few familiar markers, may

result in confusion and disorientation, especially when familiar patterns and environments are disrupted and they may be less able to cope with activities of daily living.

With families disrupted, older people may have responsibility for bringing up children, challenged by poverty and lack of access to social services and compounded by displacement from traditional homes and the destruction of traditional social structures.

Although dependent older people from refugee communities are more likely to be cared for by families, there may be an assumption that the family (if indeed family are present) will look after all their needs, and services that are available may not be offered.

Older people are often considered to be less able to acquire new language and skills, and education programmes are rarely targeted towards them. In fact a range of coping strategies and contributions have been identified amongst older people. They have a wide range of indigenous knowledge and experience, including traditional healing and crafts. They preserve and transmit cultural heritage, stories and activities, and may play an important role in the resolution of family or community conflict.

Further reading

Older people in disaster and humanitarian crises: guidelines for best practice

Available from HelpAge International,
PO Box 32832 London N1 9ZN

Tel: 0207 278 7778

Fax: 0207 843 1840

Email: hai@helpage.org

Website: <http://www.helpage.org>



7.6) Health Needs of Families

Families may be incomplete, with members missing through death or separation (see Section 8.3 for details of the Red Cross Family Tracing Service). Critically important to a child's health and development is the ability of parents or care-givers to ensure that the child's needs are being responded to. Asylum seeking and refugee parents may be struggling with their own needs, and this may affect their ability to parent effectively. Parenting capacity should be considered in the context of the family's structure and functioning, and who contributes to the parental care of the child or children. Children of asylum seeking and refugee families should be considered and assessed as children first, using the statutory framework of the 1989 Children Act.

An understanding of how the family usually functions, and how it functions under stress can be very helpful in identifying what factors may assist parents in carrying out their parenting roles. Of particular importance is the quality and nature of the relationship between a child's parents, and how this affects the child, and also the quality of relationships between siblings. Account must be taken of the diversity of family structures, who is considered to be family and who is important to the child. The family's social integration and access to community resources are also important, but for many refugee families, these may be limited.

Multi-disciplinary working is important, involving whenever appropriate the GP and primary care team, health visitor, school nurse, child and family consultation services, social services, education services, mental health services and voluntary Sector.

Offer support to both parents and children. Parents have additional stresses from children taking on the values of the host country, and may be concerned about younger generations losing their cultural identity, language and customs. Young people often describe their difficulties of being "caught between two cultures", that of their parents and that of their peers. The effects of displacement and dislocation faced by refugee families may be passed down to further generations, long after the original migration.

Figure 2 – The Assessment Framework (Appendix A from Framework for the Assessment of Children in Need and their Families 2000 Department of Health, Department for Education and Employment Home Office.



[Further reading](#)

Framework for the Assessment of Children in Need and their Families (2000)
 Department of Health, Department for Education and Employment, Home Office.

7.7) Health needs of children and adolescents

Children may be living in fragmented families, having lost their parents, siblings and other close relatives. They may be with unfamiliar carers, may have arrived alone or may live with parents who have changed under the pressures of torture, exile and loss and who are experiencing great difficulty in parenting. They may feel that their parents have failed to protect them. Some may have been abducted to become child soldiers and forced to commit violent acts themselves.

Young people experience loss of family, friends, home, culture etc. and may have difficulty making friends. They may appear to be mature beyond their years, and in a caring role with their parents, particularly when they are with them, but be

immature in other situations e.g. when in school. They may face exclusion from school due to disruptive behaviour.

They may exhibit:

- withdrawal, lack of interest and lethargy
- aggression and poor temper-control
- irritability
- poor concentration
- repetitive thoughts about traumatic events
- poor appetite, over-eating, breathing difficulties, pains and dizziness
- regression (e.g. bed-wetting) and will feel humiliated by this
- nightmares and disturbed sleep
- nervousness and anxiety
- difficulty in making relationships with other children and adults
- lack of trust in adults
- clinging, school refusal
- hyperactivity and hyperalertness
- impulsive behaviour

Very few children need psychiatric treatment. Although vulnerable, children are resilient – they may develop a range of coping strategies and manage well. Interventions need to be geared to the enhancement of resilience and protective factors, which include:

- A feeling of belonging, with a special relationship with an involved adult carer (ideally a parent)
- Time and space to think about their experiences and the feelings connected with these experiences, alone and with others. This includes the time and space to play and express feelings in a creative way e.g. through art, drama, music, story-telling etc.
- Being able to make active choices - e.g. involving children in decisions about them
- Belonging to their own community and taking part in cultural events
- Belonging to and being part of the local community in the UK. Befriending towards active involvement in youth groups, after school activities, homework clubs etc.

Children will have to get used to a new language and to learn how to communicate. Expression of language takes approximately two years to reach the equivalent of the indigenous population¹. Most children will be behind in their schooling. Families may not be able to afford toys for children.

“ Visiting refugees’ homes, an apparent lack of stimulation in the form of visible toys etc emerge as obvious needs.” Midwife, Bedford

The most therapeutic event for a child who is a refugee, whether living with familiar carers or strangers, is to become part of the local school community, to learn and to make friends². However, they may experience bullying and racial abuse at school.

“ Schools can play a crucial role in promoting the well-being of refugee children and can often represent the most important community outside the home. An atmosphere of warmth,

¹ Levenson R and Sharma A *The Health of Refugee Children - Guidelines for Paediatricians*. London: Royal College of Paediatrics and Child Health 1999

² Melzak S and Kasabova S *Working with children and adolescents from Kosovo*, London Medical Foundation for the Care of Victims of Torture, 1999

safety and stability can go a long way to restoring the sense of security many refugee children have lost.”

Young Minds Report, War and Refugee Children, October 1994

“ It is no exaggeration to say that refugee children’s wellbeing depends to a major degree on their school experiences, successes and failures ... School policies are a powerful tool for helping refugee children feel safe and normal again, and begin to learn.”

Naomi Richman, *In the Midst of the Whirlwind - a manual for helping refugee children*, 1998

Most refugee children have to live with enormous uncertainty. This may lead to noticeable behavioural and emotional difficulties and distress. These children may benefit from supportive listening in schools, and both individual relationships with staff and guided group relationships with other refugee children. Enabling young people to come together in a group to discuss their situation amongst their peers who understand the particular stresses and issues can be helpful. Supplementary mother-tongue schools may encourage cultural identity.

The needs of young refugees in Lambeth, Southwark and Lewisham

The Health Action Zone Young Refugee Project, Elizabeth Blackwell House, Wardalls Grove, Avonley Road, London SE14 5ER Tel: 0207 771 5282/5105

Aim: to produce a strategy to improve the health of young refugees and facilitate access to services. Interviews with refugee children, community workers, health workers and policy officers showed:

- *Refugee children’s perceptions of health relate to both their emotional and social well-being*
- *Factors negatively affecting health include poverty, housing, bullying at school, separation from family, worrying about family, loneliness, boredom, language barriers and lack of interpreters*
- *More than half the children interviewed felt their health had deteriorated since arrival in the UK*

- They want more information about services, an advice worker, a telephone hotline and a website
- Health workers identified nutritional needs and a need for health education, particularly on sex and drugs for older children
- Health workers had concerns about the mental well-being of refugee children, mostly in relation to their experiences in the UK
- Concerns were expressed about the vulnerability of unaccompanied minors placed inappropriately, whether in foster placements or in hostels with other adults.
- Some children face long waits for school places (up to 8 months)
- Health workers were keen for training on refugee issues and requested a telephone hotline
- The need for an inter-agency approach was identified.

As a result of this work, it is planned to develop support for young refugees in the following areas:

- mental health, health promotion, unaccompanied teenagers in adult accommodation, a foster carers resource pack, and bullying.
- A training programme for health workers and for refugee community workers
- Inter-agency working, linking relevant agencies in the area
- Employment opportunities for refugee health professionals

Further reading

Richman N.

In the Midst of the Whirlwind - a manual for helping refugee children,

City and Hackney NHS Trust and Save the Children. Trentham Books, UK 1998

Levenson R and Sharma

The Health of Refugee Children - Guidelines for Paediatricians.

London: Royal College of Paediatrics and Child Health 1999

Gosling R

The Needs of Young Refugees in Lambeth, Southwark and Lewisham
Health Action Zone Lambeth, Southwark and Lewisham, Community Health South London NHS Trust 2000

Rutter, J

"Supporting Refugee Children in 21st Century Britain - a compendium of essential information" London, Trentham Books 2001.

Lynch M

Health Care for Refugee Children and Unaccompanied Minors, *Medicine, Conflict and Survival* 2001; 17: 2

Melzak S and Kasabova S

Working with children and adolescents from Kosova, London, Medical Foundation for the Care of Victims of Torture, 1999

7.8) Unaccompanied minors/separated children

The Asylum Directorate Instructions define an unaccompanied minor as follows:

An unaccompanied child is a person who, at the time of making his application, is under 18 years of age or who, in the absence of documentary evidence appears to be under that age, and who is:

applying for asylum in his own right

without adult family members or guardians to turn to in this country:

Asylum Directorate Instructions, Chapter 2 Section 5 www.homeoffice.gov.uk/ind/hpg.htm

Unaccompanied children are especially isolated and vulnerable. Ongoing contact with social services is important to ensure that they have a needs assessment and care plan, which are regularly monitored. Inter-agency working should improve planning and co-ordination.

Young people aged 15 and below will usually be "looked after" by the local authority. They are usually defined as "in need" and services are provided under Section 20 of the Children Act (1989), including foster care or residential home placement, an allocated social worker, a care plan, cash financial support and full leaving-care

services. Those aged 16 and 17 usually receive services under Section 17 of the Children Act. Accommodation may be a bed-and-breakfast or hostel and they have no allocated social worker. They may be particularly vulnerable.

“Young separated refugees need help in learning cooking skills as well as other independent living skills.”
Researcher with young people, London

Resources:

Refugee Council Panel of advisers for unaccompanied refugee children
240 – 250 Ferndale Road, London, SW9 8BB
Tel: 0207 582 4947
Fax: 0207 820 3005

Offers support to children and young unaccompanied minors under the age of 18 when they arrive, and people 18 –21 years who are the main carers for younger brothers and sisters.

Further reading:

Ayotte W and Williamson L
Separated Children in the UK: An overview of the current situation, London, Save the Children and Refugee Council, 2001
Available from Refugee Council, 3 Bondway, London SW8 1SJ Tel: 0207 820 3000

Stanley K

Cold Comfort: Young separated refugees in England, London, Save the Children 2001
Available from: Save the Children Fund London Development Team, Cambridge House Cambridge Grove, London W6 0LE
Tel: 0208 741 4054 extension 124
http://www.savethechildren.org.uk/functions/indx_pubs.html

7.9) Age Assessment

Doctors may be asked to give an opinion on the age of a child, in particular as to whether a young person is a child under the age of 18, as this age represents a change in NASS support arrangements. An estimation may be made based on serial growth measurements and attainment of the stages of puberty¹, but the margin of error can be as much as 5 years in either direction. The

timing of pubertal onset is variable, and is affected by gender and ethnicity². Poor nutritional status and illness may delay puberty. It is inadequate to use only two measurements to determine a pubertal growth spurt.

In the Indian subcontinent, a slightly earlier onset of puberty is common, and boys may develop facial and body hair at an earlier age than a boy of Caucasian heritage³. Dental development may be part of the examination – estimates of a child's age from dental development are accurate to within 2 years in either direction, for 95% of the population⁴.

It is not possible to determine the chronological age from bone age, and it is inappropriate for X-rays to be used merely to assist in age determination. The Royal College of Radiologists in 1996 advised that X-rays should not be requested by immigration officials for this purpose⁵.

The possible margin of error is wide, and it may be best to word a clinical judgement in terms of whether a child is probably, likely, possibly or unlikely to be under the age of 18³.

Adapted from Levenson R and Sharma A The Health of Refugee Children: Guidelines for Paediatricians 1999 Royal College of Paediatrics and Child Health, London

7.10) Child Protection

Child protection issues need to be addressed sensitively, following procedures outlined in Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children⁶. Issues which may give cause for concern may include physical abuse, including disciplining using excessive force, and female genital mutilation (see Section 7.3 Female Genital Mutilation), emotional abuse, sexual abuse, or neglect. Parents may be

1 Tanner JM *Growth at adolescence*, 2nd edition. Blackwell Scientific Publications 1962

2 Tanner et al *Assessment of skeletal maturation and prediction of adult height (TW2 method)*. Academic Press. New York 1983

3 Levenson R and Sharma A *The Health of Refugee Children: Guidelines for Paediatricians* Royal College of Paediatrics and Child Health, London 1999

4 Miles AEW *Assessment of age of a population of Anglo-Saxons from their dentitions*. *Proc R Soc Med* 1962; 55: 881-6

5 Watt I *Dean of Faculty of Clinical Radiology. Letter ref BFCR (96) 9 to all clinical radiology fellows and members*

6 *Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children* London Department of Health, Home Office, Department for Education and Employment 2000

struggling with their own needs and this may affect their ability to parent effectively. Mental illness may affect their ability to care for a child. Parents should be offered as much support as possible, but the welfare of the child is paramount and his/her needs given priority.

If the child is suffering or is likely to suffer significant harm and this harm is attributable to a lack of adequate parental care or control, compulsory intervention in family life is deemed to be justified in the best interests of children (Concept of significant harm). Concerns should be discussed with your local child protection co-ordinator in order to establish what action, if any, to take. If you think that a child may be disclosing an act of abuse, ask only what you need to know to take the next step. Repeated investigative interviewing may lead to retraction of an allegation.

In the case of refugee families, health workers need to be sensitive to differing family patterns, lifestyles and child rearing patterns, as well as the broader social factors which discriminate against black and minority ethnic people. The effects of racial harassment, racial discrimination, institutional racism, cultural misunderstandings and misinterpretations should be understood.

The GP or Community Paediatrician should ensure that there is discussion with the family about health and legal issues. In all cases, the interests of the child should be foremost. Co-ordinated working with social services and refugee community organisations is important.

Further reading

Working together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children. London Department of Health, Home Office, Department for Education and Employment 2000

7.11) Disability and Special Needs

Disability amongst refugees is a hidden issue and little relevant information exists. In one study¹ 10% of the sample reported "some sort of disability affecting their daily life" A more recent study in 2001² has identified some of the demographic characteristics of refugees living with a disability. As would be expected, many different kinds of disability are experienced,



resulting from chronic ill health, accidents, torture, war-related injuries, mine injuries, amputations, infections such as polio, strokes, cancer, arthritis, visual impairment and congenital disabilities. Disability may be recent or long-standing. The incidence of disability is higher amongst survivors of torture or war. Those with amputations may not have been able to obtain prostheses, or they may be ill-fitting. People with physical disability may have difficulty reaching shops that accept vouchers if they are not nearby. Deaf people may not know British Sign Language, and a suitable interpreter may be hard to find.

Asylum seekers supported by NASS (the National Asylum Support Service) are not eligible for social security benefits (including disability benefits). It is worth applying for a Community Care Assessment, as disabled asylum seekers may be able to get additional support from NASS or from the Local Authority. Those with refugee status or Exceptional Leave to Enter/Remain can apply for the full range of social security benefits, including Disability Living Allowance and Attendance Allowance. Special needs should be identified at the initial claim for NASS support.

"There is a lack of adequate services as support is based on immigration status, I try to offer people adequate support using voluntary services and support groups." Community Practitioner, London.

¹ Carey Wood et al *The settlement of refugees in Britain*, London: HMSO, 1995 (Home Office research study 141)

² Roberts K and Harris J *Disabled refugees and Asylum Seekers in Britain: Numbers and Social Characteristics* York, University of York 2001

In many cultures, disability is associated with stigma and people may be fearful that their asylum claim may be jeopardised. Support may not have been available in their original country and may not be expected. Similarly, education for children with a disability may not be expected.

Refugee Children with Special Needs/Disability

*The Lambeth, Southwark and Lewisham Health Action Zone Young Refugee Project has a link worker dedicated to working with children who are asylum seekers/refugees with special needs/disabilities. For more information contact The Health Action Zone Young Refugee Project, Elizabeth Blackwell House, Wardalls Grove, Avonley Road, London SE14 5ER
Tel: 0207 771 5282/5105*

Contacts:

British Council for Disabled People,
Tel: 01332 295 581 (text)
Website: www.dlcc.demon.co.uk

Disability Scotland, Princes House, 5 Shandwick Place, Edinburgh, EH2 4RG
Tel: 0131 229 8632

Childhood Disabilities:

Contact a Family, 150 Tottenham Court Road, London W1P 0HA
Tel: 0207 383 3555
Website: www.cafamily.org.uk

Provides information and advice to families who care for children with any disability or special need. Puts families in touch with each other if they would like contact.

Family Welfare Association 501 - 505 Kingsland Road, London, E8 4AU Tel: 0207 254 6251

Helps families with a child with a disability with holiday grants. Applications need to be made by a professional on behalf of a family.

The Family Fund Trust, PO Box 50, York, YO1 9ZX
Tel: 01904 621115
Website: www.familyfundtrust.org.uk

Gives grants for e.g. toys, clothes, holidays, washing machine (if child incontinent)

National Holiday Fund for Sick and Disabled Children, Suite 1 Princess House, Princess Parade, New Road, Dagenham Essex RM10 9LB
Tel: 0208 595 9642

Gives grants for holidays

Visual impairment

Royal National Institute for the Blind
Tel: 0207 388 1266
Helpline: 0345 669999 (local rates)
Website: www.rnib.org.uk

Hearing impairment:

Royal National Institute for Deaf People
Tel (freephone): 0808 808 0123 (voice)
0808 808 9000 (text)
Website: www.rnid.org.uk

Education

IPSEA offers advice for parents of children with special educational needs
Tel: 0800 0184 016 (freephone)

Skill gives information and advice to disabled students about further and higher education
Tel (freephone): 0800 328 5050 (voice)
0800 068 2422 (text)
Website: www.skill.org.uk

Policy issues

Bharti Patel, Social Policy Adviser, Refugee Council, 3 Bondway, London SW8 1SJ
Tel: 0207 820 3000
Fax: 0207 582 9929
Email: Bharti.Patel@refugeecouncil.org.uk

Dr Keri Roberts (researcher),
Social Policy Research Unit, University of York
Tel: 01904 433608
Fax: 01904 433618
Email SPRU@york.ac.uk
Website: <http://www.york.ac.uk/inst/spru/>

Special needs and learning disability

Consideration needs to be given to how best to address special needs. Such needs may not initially be evident because of language difficulties. Lack of knowledge of a person's history may mean that needs are inaccurately assessed. Some asylum-seeking children have been thought to have learning difficulties, when

in fact they were suffering from the effects of emotional trauma.

Ideally a bilingual assessor should carry out assessments in the child's first language, but if this is not possible an interpreter should be used for the assessment.

Stigma and isolation may affect those people who have a learning disability and their families.

They may have a lack of information and appreciation of help that may be available to them, including education for children.

Contacts:

MENCAP (Royal Society for Mentally Handicapped Children and Adults)

Tel: 0207 696 5503

Website: www.mencap.org.uk

Information, advice and support services in England, N Ireland and Wales

ENABLE, 6th Floor, 7 Buchanan St,
Glasgow, G1 3HL

Tel: 0141 226 4541

Information, advice and support services in Scotland

National Autistic Society, 393 City Road,
London EC1V 1NG

Tel: 0207 833 2299

7.12) Carers

Refugee carers are often isolated and may not be receiving their entitled social support, benefits or respite care. The majority of carers are women, who are generally unsupported.

Asylum seekers may not be entitled to welfare benefits, although it is worth advocating to your local social services office. Language barriers and a prevailing myth that black and minority ethnic communities "look after their own" also contribute to the exclusion of many black carers from support services.

Carers National Association

Carers line on 0808 808 7777

10 - 12am and 2 - 4 pm Monday - Friday

"Who cares?" report available from the Sheffield Carers Centre, price £6.99

Tel: 0114 278 8942

"We Care Too" Report by National Black Carers Workers Network, in association with the Afiya Trust 2002. Available from:

Tel: 0207 582 0400



8. Other related issues

- 8.1) Socio-economic issues and support
- 8.2) Spiritual support
- 8.3) Tracing missing family members
- 8.4) Housing
- 8.5) Schooling and education
- 8.6) Learning English
- 8.7) Training and employment for asylum seekers and refugees
- 8.8) Work Permits
- 8.9) Legal support
- 8.10) Medico-legal reports and letters of support
- 8.11) Detention of asylum seekers
- 8.12) Racism, discrimination and hostility
- 8.13) Media contact
- 8.14) Contact with the police
- 8.15) Linking with local communities and befriending

Key Points

- Anything that health workers can do to alleviate poverty and poor living conditions may be beneficial to the health and well-being of asylum seekers and refugees
- Other factors impacting on health include multiple loss and bereavement, separation from family and friends, exile, loss of identity and status, unemployment, poor housing,

racism, discrimination, isolation and lack of cohesive social support

- Religion is an important source of sustenance for many refugees and asylum seekers. Religious groups are playing an important supportive role
- The Red Cross may be able to trace missing family members
- Asylum seekers may be moved frequently, making the planning of care difficult
- Schools can play a vital role in providing safety and stability for children
- Be aware of the possibility of bullying
- Demand for English classes outstrips supply in many areas
- People who have been tortured may find it hard to concentrate, impeding their ability to learn
- Refugees have high rates of unemployment or under-utilisation of their skills, impacting negatively on health
- Asylum seekers cannot work for the first 6 months, after which they can apply to the Home Office for permission
- Access to good legal support is important
- Health workers may be asked to write a report in support of an asylum application
- Some asylum seekers are held in detention
- Torture survivors should not be detained
- Refugees experience racism in many different forms
- Racist behaviour towards asylum seekers and refugees needs to be challenged
- Be aware of the implications of the amended Race Relations Act 2001 on the NHS
- Use the media to disseminate positive and balanced messages about refugees

- *Asylum seekers do not contribute to increased crime, and are as likely to be the victims of crime*
- *Improve services for everyone, not just for refugees*
- *Assist integration within the local community*

8.1) Socio-economic issues and support

Poverty has a negative effect on both physical and mental health, and anything that health workers can do to alleviate poverty and poor living conditions may be beneficial to the health and well-being of asylum seekers and refugees. Other factors which impact on health include multiple loss and bereavement, separation from family, exile, loss of identity and status, poor access to education, unemployment, poor housing, racism, discrimination and isolation and lack of cohesive social support. Diminished self-esteem, and self-confidence and increasing dependence on others may result.

“ Many problems are social or political in nature”
Psychologist, London

“ There is a need for accessible activities to encourage integration i.e. affordable and welcoming.”
Researcher with young people, London

Sports sessions, particularly football, have been set up in some areas and have proved popular with young men.

“ Sports sessions for young male asylum seekers reduce isolation, and introduce asylum seekers into the local community as well as being healthy exercise” .
Health visitor, Salford

Sports and social facilities that will also appeal to women are needed.

Asylum seekers often face isolation and confusion when they first arrive. Systems should be developed to ensure that people are linked into basic services when accommodation placements are made. Referrals should be made to agencies which are in a position to facilitate access to services such as education and health services.

Since asylum seekers are on very low incomes and are excluded from other benefits open to those in receipt of DSS benefits such as the Social Fund,

Social Services will inevitably need to provide practical or financial assistance to families to ensure that essential items such as clothing for children can be obtained. Even where mainstream assistance is available it may be discretionary, or the help available may not be enough to meet the full costs. Examples include school uniform grants and vouchers towards the cost of spectacles, milk tokens, etc.

8.2) Spiritual support

Religion is very important for many refugees, providing much sustenance and strength, and it may provide the framework in which they see their experiences, and derive identity and self-esteem.

“ It’s very hard to see your whole life turned upside down without it being your fault. I honestly can say we couldn’t cope with the change of life if it wasn’t for faith in God, as being a Muslim you are preparing for any difficulty that arises in your life and have to be resilient, accept it and move on.”

Hassan Farah L and Smith M, Somalis in London
Bow Family Centre, 1999

Religious groups and communities often provide much emotional and practical support, as well as social contact. Consider the possibility of co-working with spiritual or community leaders.

Further reading

Weller P (Ed.)

Religions in the UK – A Multi-faith Directory,
University of Derby and Inter-faith Network for the UK, 1997

8.3) Tracing missing family members

Many people will have been forced to leave family members behind and may not know whether they are safe or not. The Red Cross Family Reunion Department may be able to trace relatives whose whereabouts are unknown.

For people living in Greater London contact:

Red Cross Family Reunion Department:
International Welfare Service, 54 Ebury Street,
London, SW1W 0LU

Tel: 0207 730 6179, 0207 235 5454

Fax: 0207 730 5089

Email: iwd@redcross.org.uk

Website: www.redcross.org.uk

For people living elsewhere in the UK, contact the local British Red Cross Office (in the phone book under B) or write to International Welfare Department, British Red Cross, 9 Grosvenor Crescent, London SW1X 7EJ

When families are reunited, support may be needed to cope with what is a highly emotional event, including different degrees of adjustment and integration.

8.4) Housing

"I have no-one to talk to most of the time. I just go out and walk about most of the time I hate to go back to the hostel. I do not feel the hostel is a home"

male asylum seeker dispersed to Leeds

Asylum seekers may be housed in temporary accommodation. The length of time which they spend in one place varies considerably, making planning of services difficult. High mobility interrupts relationships with health and other workers and disrupts trust-building.

A recent report by Shelter (Garvie 2001) showed that much of the housing in which asylum seekers are living is substandard, with a high incidence of overcrowding and fire risk. There may be lack of room for children to play, and difficulties for particular ethnic and religious groups in preparing food in shared kitchens. Some asylum seekers and refugees may choose to live with relatives or friends, and may not be entitled to receive support. They may also be living in overcrowded situations and homelessness is becoming more of a problem.

The White Paper "Secure Borders, Safe Haven" includes plans for accommodation centres for asylum seekers. Initially 4 accommodation centres with 750 bed spaces each will open on a pilot basis. Current support and dispersal arrangements will continue for those not selected for an accommodation centre.

Further reading:

Garvie D

Far from Home – the housing of asylum seekers in private rented accommodation,

London, Shelter 2001 88 Old St, London EC1V 9HU Tel: 0207 505 2043

Organisations:

National Asylum Support Service (NASS),
Voyager House, 30/32 Wellesley Road,
Croydon CR0 2AD

Helpline: 0845 602 1739 (local rates)

Shelter, 88 Old St, London EC1V 9HU

Tel: 0808 800 4444 (Freephone 24hour helpline)

Email: shelterinfo@compuserve.com

Shelter gives advice to anyone in the UK who has a housing problem and can give information about local Shelter Housing Aid Centres. Uses Language Line.

Praxis, Pott St, London, E2 0EF

Tel: 0207 729 7985

Fax: 0207 729 0134

Email: admin@praxis.org.uk

Praxis runs a Hosting Scheme for asylum seekers in London, placing clients with suitable families in the community. This is for asylum seekers who are unable to claim welfare benefits and who have been referred to Praxis by a local authority social services department.



8.5) Schooling and education

Schools can play a vital role in providing a haven of warmth, safety and stability for children. They may represent the most important community outside the home and thus create a sense of continuity. If difficulties are encountered in finding a school place, the local Education Authority should be able to help.

Children benefit greatly from being part of the local school community, but be aware of the possibility of bullying. Contact with the school nurse or school health adviser is important. Schools may have a designated a support teacher for refugee children or an English as an Additional Language co-ordinator. For further information about refugee support teacher schemes in operation contact:

Newham Refugee Education Team,
The Credon Centre, Kirton Road,
London E13 9BT
Tel: 0208 548 5023/5094
Email: Bill.bolloten@newham.gov.uk
Tim.spafford@newham.gov.uk

Camden Language and Support Service, Medburn
Centre, 136 Chalton St, London NW1 1RX
Workneh Dechasa, Senior Refugee and
Community Education Adviser
Tel: 0207 974 8059
Administration tel: 0207 974 8141
Email: workneh.dechasa@camden.gov.uk
Special Educational needs: see section 7.11
Further Education: see section 8.7

8.6) Learning English

Information about local English language classes should be made available. Demand may outstrip supply in many areas. Adult and further education colleges may run classes, some of which may be free or may have reduced charges for refugees. Some may offer childcare and help with transport costs. Information about local English classes should be available from public libraries, community centres, refugee organisations, and adult and further education colleges.

However, it may not be possible for people to make use of these immediately. People who have been tortured or have experienced traumatic

circumstances may experience difficulties with concentration. Although people may not initially seem to get much out of English classes if they attend while very anxious or depressed, after some time they may settle and start to find the classes useful. At the beginning the regular routine and the social aspect of classes may be more crucial than what is being learnt¹.

8.7) Training and employment for asylum seekers and refugees

Many asylum seekers and refugees have professional qualifications, skills and experience, yet many are unemployed or are not using their skills in their work. Unemployment results in poverty and depression and impacts negatively on health. Information on training and employment opportunities are available from the following organisations:

Refugee Education and Employment Advisory Service (RETAS),
14 Dufferin St, London EC1Y 8PD
Tel (general): 0207 426 5800
Fax: 0207 251 1314
Tel (advice) 0207 426 5801
(Tues and Thurs 2.30 – 5pm)
Email: retas@wusuk.org
Website: www.wusuk.org.

Gives advice on education, training and employment for asylum seekers and refugees. Drop-in service on Tues and Thurs 10am - 12pm. Runs jobskills courses, preparing people for looking for and gaining employment – CV writing and interview skills. Offers one-to-one careers advice for refugee doctors, to enable them to get back to work.



¹ Kate harris personal communication

Refugee Council, Training and Employment Section (TES)

240 – 250 Ferndale Road, Brixton,
London SW9 8BB

Tel: 0207 346 6760 (Careers Advice Line)

Fax: 0207 737 3306

Website: www.refugeecouncil.org.uk

Advice to asylum seekers and refugees over the age of 25 on the education, training and employment options open to them. Drop-in centre is open Mon – Fri 10am – 1pm. Runs a range of courses, including English as an Additional Language, IT, Business Administration and Health and Social Care. Applicants must have been in the UK for at least 6 months. Gives help with travel and childcare costs.

Africa Educational Trust, 38 King St,
London WC2E 8JS

Tel: 0207 836 5075/7940

Fax: 0207 379 0090

Email: aet@mcmail.com

Offers advice on education and training for African students, asylum seekers and refugees. Grants and scholarships may be available for those in financial difficulty. An African Refugee Women's project gives free training advice to young, unemployed African women.

Further reading:

Rosenkranz H

A concise guide to Refugees' Education and Qualifications

RETAS London 2000

Prince B, Rutter J, Kerrigan M

A Handbook on Education for Refugees in the UK

RETAS See RETAS entry above for contact details

For information on qualified refugee health workers, see section 4.17

8.8) Work Permits

Asylum seekers are not permitted to work initially, but after 6 months they may apply to the Home Office for permission. People with a work permit may work during the appeals process. Those with Exceptional Leave to Remain (ELR) and refugee

status can work without applying to the Home Office. Dependents are only given permission to work in exceptional circumstances.

8.9) Legal support

Access to good legal advice is very important. The Immigration Law Practitioners Association can provide advice on lawyers who can act for the asylum claim and for other legal difficulties. Asylum seekers and refugees are entitled to legal aid.

Immigration Law Practitioners Association
1st Floor, Lindsay House,
40-41 Charterhouse Street, London EC1M 4JH
Tel: 0207 251 8383

Maintains directory of solicitors, barristers and other providers of immigration advice who are members of the association, including those who can arrange assistance for the Community Legal Service Fund.

Refugee Legal Centre
Nelson House, 153-157 Commercial Road,
London E1 2EB
Tel: 0207 780 3200

Free legal advice for asylum seekers on all aspects of the asylum procedure and conditions of staying. Also offers telephone advice for detained asylum seekers.

Immigration Advisory Service
County House, 190 Great Dover Street,
London SE1 4YB
Tel: 0208 814 1559 (24 hour helpline)
Tel: 0207 357 6917

(also has branches in Birmingham, Leeds, Liverpool, Manchester, Norwich, Oakington Detention Centre, Cardiff and Glasgow)

Free legal advice for asylum seekers on all aspects of the asylum procedure and conditions of staying. Also offers telephone advice for detained asylum seekers:

¹ Kate Thompson personal communication

8.10) Medico-legal reports and letters of support

Lawyers may request a report. This may be a report documenting your work with a refugee client or his/her symptoms.

For those who have experienced torture or violence, a healthworker may be asked to document evidence, although a significant amount of time may have elapsed. In some instances, torturers leave gross scarring, fractures and paralyses, but techniques may be used which cause only transient bruising or physical sequelae. The absence of any physical or psychological signs is not proof that torture has not taken place. Training can be provided by the Medical Foundation for the Care of Victims of Torture. Contact 0207 813 7777

Further reading

Forrest D and Hutton F
Guidelines for the examination of survivors of torture,
London, Medical Foundation for the Care of Victims of Torture 2000

8.11) Detention of asylum seekers

Some asylum seekers are detained in detention centres and prisons, although detention in prison should cease from 2002. Such detention is distressing. For those who have been detained in their own country, the experience of subsequent detention can be devastating. The experience of being locked up will generally evoke powerful memories and these may persist for a long time after release from detention.

Organisations

Bail for Immigration Detainees (BID), 28
Commercial St, London, E1 6LS
Tel: 0207 247 3590
Fax: 0207 247 3550

Organises bail for immigration detainees

Association of Visitors to Immigration
Detainees (AVID)
PO Box 7, Oxted, RH8 0YT

Co-ordinates visitors' groups to detention centres

Further reading:

Pourgourides C, Sashidharan S, Bracken P A
Second Exile: the Mental Health Implications of Detention of Asylum Seekers in the United Kingdom
North Birmingham Mental Health Trust 1996

8.12) Racism, discrimination and hostility

Agencies responsible for supporting asylum seekers and refugees should be aware of their potential vulnerability to racism, and ensure that effective policies are in place to deal with any incidents. The prevalence of racist attacks and harassment should be considered when deciding whether particular locations are suitable for the placement of asylum seekers.

Refugees face racist taunts, threats, arson, bullying at school and physical violence, which has in some instances resulted in death. People who are suffering racial harassment need support and advocacy in order to report the incident to the police and to access protection.

Racist behaviour needs to be challenged. The amended Race Relations Act 2001(see <http://www.cre.gov.uk/duty/index.html>) imposes a new statutory duty on public authorities (including health services) to eliminate unlawful racial discrimination and promote equality of opportunity and good relations between persons of different racial groups. It aims to make the promotion of racial equality central to authorities' work, to provide fair and accessible services and to improve equal opportunities in employment. Public authorities are expected to take the lead in promoting equality of opportunity, good race relations and in preventing unlawful discrimination. This would include a General Practice discriminating against asylum seekers and refugees by refusing to register them when their list is open to other patients.

From the responses received from health workers, it is apparent that many had heard adverse comments about refugees from other patients and from some colleagues.

" One colleague expressed the idea that they should all be sent back"
Health visitor, Salford

It is important to address this issue. Informing people of the situation facing refugees and addressing their issues and misconceptions can help. People are often misinformed about the level of finance which asylum seekers receive.

“ I promote positive images of asylum seekers and explain why they come to the UK.”
Health visitor, Salford

“ I have discussions with staff and colleagues, trying to provide balanced information, so that they could influence others.”
GP Glasgow

For further information about the Race Relations Act and health services' response to the Act, contact your local Primary Care or NHS Trust.

Further reading:

Coker N
Racism in Medicine – an Agenda for Change
London Kings Fund, 2001

European Commission against Racism and Intolerance (ECRI)
Second Report on the United Kingdom,
Secretariat of ECRI 2000 (Tel: 00 33 388412964)

8.13) Media Contact

It may be useful to establish contact with local media, who can provide balanced information within local communities.

“It would help if the media portrayed some of the positive achievements and contributions of refugees to the host society.”
Refugee health advocate, London

8.14) Contact with the police

The police state that asylum seekers and refugees do not contribute to increase in crime, and are as likely to be the victims of crime. Asylum seekers and refugees are entitled to the same protection to live free from crime, harassment and intimidation as any other person, and the police share responsibility for their safety with other statutory agencies and the community. However, it can be difficult for people to approach the police. The language barrier and people's previous negative experiences of uniformed authority may make them reluctant to involve the police in their protection. It has been recommended that a

liaison officer be appointed in each region, with responsibility for the policing needs of asylum seekers and refugees in that area.

Refugee and Asylum Seeker Participatory Action Research (RAPAR)

c/o Faith and Justice Commission, Cathedral House, 250 Chapel St, Salford, M3 5LL
Cath Maffia: 0161 212 4452
Rhetta Moran: 0161 295 5277

RAPAR initiated a series of discussions/meetings with Salford Police Force, creating opportunities for asylum seekers to communicate with police about their experiences of harassment and abuse. Past experiences of law enforcement services, both at home and as people have moved to the U.K., have led to a severe lack of trust towards such agencies on the part of the overwhelming majority of displaced people that RAPAR has worked with to date. For this reason, RAPAR maintains a constant dialogue with the police over issues of community safety, while recognizing the sensitivity of this area of work.

Further reading

Association of Chief Police Officers (ACPO)
www.acpo.police.uk

ACPO Guide to Meeting the Policing Needs of Asylum Seekers and Refugees 2001

8.15) Linking with local communities and befriending

It is best to improve services for everyone, not just for refugees. If there is a perception that refugees are getting better services, this may result in hostility and resentment. Anything that can integrate the community should be encouraged.

“ I have reservations about providing different services for different groups as it does not enhance a community bond – there should be an attempt to find common ground.”
Nurse, London

Prior to receiving refugees, ensure that local people are aware of the situation. (See section 8.12 – Racism, discrimination and hostility). Befriending schemes run by the voluntary sector

provide support and combat isolation and help to bridge the gap between refugees and the local community. Befrienders need to make a regular commitment and should receive training and ongoing support.

"We frequently see people who seem to need more than anything an opportunity to talk."
GP Glasgow

"My main problem is loneliness. I have no-one to talk to"
Male asylum seeker dispersed

"Young people whom we spoke to seemed to warm to the idea of a personal advocate/befriender more than counselling."
Researcher with young people, London

Newham Refugee Link

The Children's Society East London Network, Wesley House (Manor Park Methodist Church), Herbert Road, Manor Park London E12 6AY
Tel: 0208 553 9619 or 0208 514 6602
Fax: 0208 553 3369
Email: elh@childrenssociety.org.uk

This befriending scheme is run by Hand-in-Hand Refugee and Homeless Support Group and the Children's Society. Volunteers, many of whom are refugees themselves, are trained to support newly arrived asylum seekers and those who are finding it difficult to settle. Help includes assistance with accessing services, listening to people's problems and accompanying them to interviews.

Leeds Asylum Seekers Support Network (lassn)

Gill Gibbons, Project Manager, 233-237 Roundhay Road, Leeds LS8 4HS
Tel: 0113 380 5690
Fax: 0113 380 5691 Email: lassn@lassn.org.uk

LASSN set up a befriending scheme to help to breakdown isolation and also an English at Home scheme, which is aimed at people who are unable to access English classes and who would benefit from English tuition at home.

LASSN offers training, one-to-one support and supervision and a monthly support group for all volunteers. It has drawn up a volunteer agreement, which clearly sets out the roles of the befriender, and English tutor. It gives advice on Health and Safety and guidelines on boundaries, in order to prevent over commitment and potential burnout. It stresses the importance of confidentiality, and volunteers sign a confidentiality declaration.



9. Resources

9.1) One Stop Services and national agencies working with refugees

9.2) Local resources

9.3) Background in-country information

9.4) Useful websites

9.5) International Human Rights Conventions

9.1) National agencies working with refugees and One Stop Services (OSSs)

S = Surgery Services

NB. Many OSSs provide a part-time outreach service in their local area – contact the nearest OSS for information.

MAP REF	ORGANISATION	ADDRESS	TEL/FAX
1	MIGRANT HELPLINE, Kent	Room 65, No 1 Control Building Eastern Docks Dover CT16 1JA	T: 01304 203 977 F: 01304 203 995
2	MIGRANT HELPLINE, Kent	17 High Street Dover, Kent CT16 1DP	T: 01304 226 830 F: 01304 226 831
S Wed 11.00-14.00	MIGRANT HELPLINE Kent	YMCA, The Roundhouse Overy Street, Dartford Kent DAI 1UP	T: 0702 1123 269
S Tues 9.30-13.30	MIGRANT HELPLINE Kent	Ashford Christian Fellowship Brook House, 25 Norwood Street, Ashford, Kent TN23 1QU	Contact main office
S Mon 9.30-15.30	MIGRANT HELPLINE Kent	The Friends Meeting House 6 The Friars, Canterbury, Kent, CT1 2AS.	Contact main office
S Tues & Fri 9.30-15.30	MIGRANT HELPLINE Kent	53 The Old High Street Folkestone, Kent, CT20 1RN.	Contact main office
3	MIGRANT HELPLINE East Sussex	48 Havelock Road Hastings TN34 1BE	T: 01424 717 011 F: 01424 717 098
S Mon & Fri 14.00-16.30	MIGRANT HELPLINE East Sussex	Braemar House, 28 St Leonard's Road, East Sussex, BN21 3UT Eastbourne	Contact main office

MAP REF	ORGANISATION	ADDRESS	TEL/FAX
4	MIGRANT HELPLINE Thanet	1 Cecil Street Margate, Kent CT9 1NX	T: 01843 292 921 F: 01843 232 085
5	MIGRANT HELPLINE West Sussex	7a Church Street Brighton BN1 1US	T: 01273 671 711 F: 01273 695 830
S Fri 14.00-17.00	MIGRANT HELPLINE West Sussex	Hove Drop – In Cornerstone Community Centre Church Road, Hove	Contact main office
S Thurs 13.00-14.00	MIGRANT HELPLINE West Sussex	The Red Cross Building West Green Drive, Crawley	Contact main office
6	NERS (North of England Refugee Service)	19 The Bigg Market Newcastle NE1 1UN	T: 0191 222 0406 F: 0191 222 0239
7	NERS	3rd Floor, Forum House, The Forum, Wallsend Tyne & Wear NE28 8LX	T: 0191 200 1109 F: 0191 200 5929
8	NERS	Ground Floor, Maritime Buildings St Thomas Street, Sunderland Tyne & Wear SR1 1BL	T: 0191 510 8685 F: 0191 510 8697
9	NERS	27 Borough Road Middlesbrough TS1 4AD	T: 01642 217 447 F: 01642 210 200
10	NICEM Belfast	3rd Floor Ascott House 24/31 Shaftesbury Square Belfast BT2 7DB	T: 02890 238 645 F: 02890 319 485
11	REFUGEE ACTION East Midlands	International Community Centre 61b Mansfield Road Nottingham NG1 3FN	T: 0115 910 7418 F: 0115 910 7419
12	REFUGEE ACTION East Midlands	Melbourne Centre Melbourne Road Leicester LE2 0GU	T: 0116 261 4830 F: 0116 262 7162
13	REFUGEE ACTION North West	34 Princes Road Liverpool L8 1TH	T: 0151 702 6300 F: 0151 709 6684
S Tues 10.00-13.00	REFUGEE ACTION North West	Toxteth Citizens Advice Bureau High Park Street Liverpool, L8	Contact Main Office
S Wed 10.00-15.00	REFUGEE ACTION North West	Anfield Citizens Advice Bureau 36 Breckfield Road North Liverpool L6	Contact Main Office
S Fri 13.00-16.00	REFUGEE ACTION North West	Great Homer Street Medical Centre 25 Conway Street Liverpool L5	Contact Main Office

MAP REF	ORGANISATION	ADDRESS	TEL/FAX
14	REFUGEE ACTION North West	1 Tariff Street Manchester M1 2HF <i>Postal Address</i> <i>Dale House 4th Floor,</i> <i>35 Dale Street Manchester M1 2HS</i>	T: 0161 233 1215 F: 0161 236 4285
15	REFUGEE ACTION South Central	50 Oxford Street Southampton SO14 3PP	T: 02380 248130 F: 02380 632995
16	REFUGEE ACTION South West	Senate House 36 Stokes Croft Bristol BS1 3QD	T: 0117 989 2100 F: 0117 924 8576
17	REFUGEE ACTION South West	Virginia House 40 Looe Street Plymouth PL4 0EB	T: 01752 519 860 F: 01752 519 861
18	RAP (Refugee Arrivals Project)	London Airports 41b Cross Lances Road Hounslow, Middlesex TW3 0ES	T: 020 8607 6888 F: 020 8607 6851
19	REFUGEE COUNCIL Eastern Region	1st Floor 4 – 8 Museum Street Ipswich IP1 1HT.	T: 01473 221 560 F: 01473 217334
20A	REFUGEE COUNCIL London	240-250 Ferndale Road Brixton London SW9 8BB	T: 020 7346 6770 F: 020 7346 6778
20B	REFUGEE COUNCIL London	Simpson House 6 Cherry Orchard Road Croydon CR0 6BA	T: 020 8603 0880 F: 020 8603 0885
21	REFUGEE COUNCIL West Midlands	1st Floor Smithfield House, Digbeth Birmingham B5 6BS	T: 0121 622 1515 F: 0121 622 4061
22	REFUGEE COUNCIL Yorkshire & Humberside	1st Floor, Wade House The Merrion Centre Leeds LS2 8NG	T: 0113 244 9404 F: 0113 246 5229
23	SCOTTISH REFUGEE COUNCIL	94 Hope Street, Glasgow, G2	0800 0856087 (advice line for asylum seekers) T: 0141 248 9799 F: 0141 333 1860
S Mon 14.30-18.00	SCOTTISH REFUGEE COUNCIL	Women's Group Quaker Meeting House 38 Elmbank Crescent, Glasgow	Contact Main Office Women's Group

MAP REF	ORGANISATION	ADDRESS	TEL/FAX
S Fri 10.00-13.00	SCOTTISH REFUGEE COUNCIL	Sighthill Surgery Sighthill Community Centre Fountainwell Square, Glasgow	Contact Main Office
S Every 2nd Wed Afternoon	SCOTTISH REFUGEE COUNCIL	Larkfield Centre Surgery Govanhill, Glasgow.	Contact Main Office
S Friday Mornings	SCOTTISH REFUGEE COUNCIL	St David's Centre Surgery Boreland Avenue, Knightswood, Glasgow.	Contact Main Office,
S Thursday	SCOTTISH REFUGEE COUNCIL	Scottish Refugee Council 200 Cowgate, Edinburgh EH1 1NQ.	T: 0131 225 9994
24	WELSH REFUGEE COUNCIL	Unit 8, Williams Court Trade Street, Cardiff CF10 5DQ	T: 02920 666 250 F: 02920 343 731
25	WELSH REFUGEE COUNCIL	1, The Kingsway YMCA, Swansea SA1 5JQ	T: 01792 301729 F: 01792 301721
26	WELSH REFUGEE COUNCIL	Suite 5+6, 5th Floor Clarence House Clarence Place, Newport NP9 7AA	T: 01633 252271 F: 01633 252273
27	WELSH REFUGEE COUNCIL	Trinity House Trinity Street, Wrexham, LL11 1NL	T: 01978 363240



The following organisations can offer additional information or advice

Refugee Council
3 Bondway, London SW8 1SJ
Tel: 0207 820 3000 Fax: 0207 582 9929

United Nations High Commissioner
for Refugees (UNHCR)
Millbank Tower, Millbank, SW1P 4QP
Tel: 0207 828 9191 Fax: 0207 630 5349

Joint Council for the Welfare of Immigrants,
115 Old Street, London EC1V 9JR
Tel: 0207 251 8708
Advice Line Tel: 0207 251 8706
(Tues, Thurs 2 – 5pm)
*Advice, information and representation for people
with immigration or nationality problems.*

British Red Cross,
9 Grosvenor Crescent, London SW1
Tel: 0207 235 5454 Fax: 0207 245 6315

Citizens Advice Bureaux – see phone directory for
number of your local branch
*Information and advice for asylum seekers and
refugees, particularly in the London area,*

9.2) Local resources

Information on local organisations working with
asylum seekers and refugees can be obtained
from your local One Stop Service (see map). We
recommend that each area nominate a named
person who has responsibility for compiling,
updating and circulating a list of local resources
to accompany this information pack.

9.3) Background in-country information

Up to date information on in-country situations,
past and present, can be obtained from the
following websites:

Amnesty International: [www. Amnesty.org.uk](http://www.Amnesty.org.uk)

UNHCR
www.unhcr.org

U.S. Committee on refugees
www.refugees.org

However, it should be noted that the situations

described might not be universal experiences for
everyone. It is important not to make
assumptions about the person and their situation
without hearing their story.

9.4) Useful websites

East of England Consortium website
www.harpweb.org.uk

United Nations High Commissioner for Refugees
www.unhcr.ch

Refugee Council
www.refugeecouncil.org.uk

Medical Foundation for the Care of Victims of
Torture www.torturecare.org.uk

Amnesty International
www.amnesty.org.uk

Medact
www.medact.org

Asylum support
www.asylumsupport.info

Immigration index
www.immigrationindex.org

Immigration news
www.immigrationnews.org

Nottingham and Notts.Refugee Forum
www.nottas.org.uk

Other websites are mentioned in specific
sections throughout the text.

9.5) International Human Rights Conventions

The following international human rights
legislation is important for refugees and
asylum seekers

Universal Declaration of Human Rights:
<http://www.un.org/Overview/rights.html>

UN Convention against Torture: [http://
www.magnacartaplus.org.uno.docs/c-a-t.htm](http://www.magnacartaplus.org.uno.docs/c-a-t.htm)

UN Convention on the Rights of the Child:
<http://www.unicef.org/crc/crc/htm>

UK Human Rights Act: [http://
www.hmso.gov.uk/acts/acts1998/19980042.htm](http://www.hmso.gov.uk/acts/acts1998/19980042.htm)

Appendix 1

Guide to languages by the major countries from which asylum seekers and refugees originate

(with acknowledgement to Marsha Sanders)

Some people speak English, and many speak several languages. This list aims to cover the most common languages used by non-English speakers. English has been included where it is an official language.

Afghanistan	Pashto, Dari, Uzbek, Turkmen, Farsi, Balochi, Pashai
Albania	Albanian, Greek
Algeria	Arabic, French, Berber dialects
Angola	Portuguese, Chokwe, Herero, Kongo, Luvale, Ambo
Argentina	Spanish
Armenia	Armenian, Russian, Assyrian
Azerbaijan	Azeri, Russian, Armenian, Aramaic
Bangladesh	Bangla, Khasi, Bengali, Sylheti
Belarus	Belarussian, Russian
Benin	French, Fon, Yoruba, Hausa, Bariba, Gurman, Ewe
Bolivia	Spanish, Quechua, Aymara, Guarani
Bosnia and Herzegovina	Croatian, Serbian, Bosnian, Romani
Bulgaria	Bulgarian, Romani
Burma	Burmese, Wa, Jingpho, Karen, Kadu
Burundi	Kirundi, French, Swahili
Cambodia	Khmer, French, Vietnamese, S Chinese dialects
Cameroon	English (official), French (official), Bata, Hausa, Mbum, Ki Lamnso, Ewondo, Fang, Mungaka, Nyang, Tiv, Yaunde, Bassa, Mbo, Sukur, Oku
Chile	Spanish
China	Mandarin, Cantonese, Wu, Minbei, Minnan, Xiang, Gan, Hakka, Fukien, Hsiang, Tibetan, Yao, Mongolian, Jingpho, Min-nan
Colombia	Spanish
Congo-Brazzaville	French, Lingala, Kigongo
Congo,	
Democratic Republic of	French, Lingala, Kingwana, Kigongo, Tshiluba
Cote d'Ivoire	French, Dioula
Croatia	Croatian, Italian, Hungarian, Czech, Slovak, German
Czech Republic	Czech, Romani
Ecuador	Spanish, Quechua
Eritrea	Tigrinya, Tigre, Arabic, Afar, Saho, Bilen, Kunama
Estonia	Estonian, Russian, Ukrainian, Finnish
Ethiopia	Amharic, Tigrinya, Oromo, Somali, Arabic, Sidama, Harari, Afar
Georgia	Georgian, Russian, Armenian, Azeri, Abkhaz, Assyrian
Ghana	Twi, Fanti, Ga, Ewe, Dagbani, Asante, Hausa

Guatemala	Spanish, Quechua, Xinca
India	Hindi, Bengali, Tamil, Urdu, Gujerati, Punjabi, Kashmiri, Hindustani, Bihari
Indonesia	Malay/Indonesian, Dutch, Javanese, Minangkaban
Iran	Farsi, Turkic, Kurdish (Sorani/Kurmanji), Luri, Balochi, Arabic, Turkish, Armenian, Assyrian, Azari
Iraq	Arabic, Kurdish (Sorani/Kurmanji), Assyrian, Armenian, Aramaic
Kazakhstan	Kazakh, Russian
Kenya	English (official), Swahili, Dhopadhola, Luo, Kikuyu, Masaba
Kosova	Albanian
Kyrgystan	Kyrgyz, Russian
Latvia	Latvian, Lettish, Lithuanian, Russian
Lebanon	Arabic, Aramaic, French, Armenian
Liberia	English, Kpelle, Gola, Bassa, Kru
Lithuania	Lithuanian, Polish, Russian
Macedonia	(former Yugoslav Republic of) Macedonian, Albanian, Turkish, Serbian, Croatian
Moldova	Moldovan, Russian, Gagauz
Nigeria	English (official), Hausa, Yoruba, Ibo, Fulani, Ido. Abua, Bariba, Efik, Emai, Tiv, Idoma, Igbira, Oring, Kache, Katab, Bata, Ikwere, Isoko, Idon, Igala, Ora, Oron, Urhobo
Pakistan	Punjabi, Urdu, Sindhi, Siriki, Pashto, Hindi, Kashmiri, Brohi, Baluchi
Palestinian Territories	Arabic
Peru	Spanish, Quechua, Aymara
Poland	Polish, Romani
Romania	Romanian, Hungarian, German, Romani
Russia	Russian, Abkhaz, Mongolian, Moldovan
Rwanda	Kinyarwanda, French, Swahili, Chiga
Saudi Arabia	Arabic
Serbia and Montenegro	Serbian, Albanian
Sierra Leone	English (official), Mende, Temne, Krio, Kono, Limba, Gola, Kisi
Slovakia	Slovak, Hungarian, Romani
Slovenia	Slovenian, Serbo-Croat, Romani
Somalia	Somali, Arabic, Swahili, Italian
Sri Lanka	Sinhala, Tamil,
Sudan	Arabic, Nubian, Beri. Maudi, Dinka, Nuer
Syria	Arabic, Kurdish (Kurmanji) Armenian, Aramaic, French, English
Tajikistan	Tajik, Russian, Farsi
Tibet	Tibetan
Togo	French, Ewe, Mina, Kabye, Dagomba, Dagbane, Gurma
Turkey	Turkish, Kurdish (Kurmanji, Zaza) Arabic, Armenian, Greek, German
Turkmenistan	Turkmen, Russian, Uzbek
Uganda	English (official), Luganda, Swahili, Arabic, Acholi, Kakwa, Lango, Luo, Chiga, Masaba, Nyoro, Rutoro
Ukraine	Ukrainian, Russian, Romanian, Polish, Hungarian
Uzbekistan	Uzbek, Russian, Tajik, Turkmen
Vietnam	Vietnamese, Chinese, French, Khmer, Tring, Lati
Yemen	Arabic
Zimbabwe	English, Shona, Ndebele

Appendix 2

What to include in a welcome pack for newly arrived asylum seekers

Local map

How to register with a GP and dentist

Information on local interpreting services

HC1 form

Model prescription

“When and how to take your medication” card – using clocks and pictures

Explanation of help with travel costs

Emergency numbers

How to contact the police

Information on dental treatment

Appointment cards

Complaints procedure

Local organisations offering services to asylum seekers and refugees

Leisure facilities

How to register with a school

Where to get legal advice



Appendix 3

Interim guidance on screening for tuberculosis in refugees and asylum seekers

Aims

The aims of tuberculosis screening are twofold:

- a) to identify promptly those with active, especially infectious, tuberculosis, in the interests of the individual, but also to prevent transmission of infection to others;
- b) To identify those (particularly children and young adults) for whom BCG immunisation or preventive chemoprophylaxis may be appropriate in order to prevent tuberculosis developing in the longer term.

Who to screen?

Many asylum seekers come from areas with a high prevalence of tuberculosis; others will be at increased risk by virtue of their circumstances before, and after, entry into the UK. All asylum seekers are therefore recommended to be screened.¹

Where should screening take place?

For those going to reception centres or known addresses, it is sensible for screening to take place from there, as soon as possible after arrival. Where an address in the UK is uncertain, the minimum level of screening (see below) should take place at the port of entry.

The screening protocol^{1,2}

See below. Completion of the full protocol should be the aim. The minimum screening is that described in Point 1. This may be appropriate where an asylum seeker is unlikely to stay in the UK longer than about a month, when the immediate personal and public health risks are the main concern.

References

1. *Recommendations for the prevention and control of tuberculosis at local level* The Interdepartmental Working Group on Tuberculosis The Department of Health and the Welsh Office, June 1996
2. *Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000* Joint Tuberculosis Committee of the British Thoracic Society Thorax 2000; 55:887-901

TB screening protocol

1. All: *ask about past history and current symptoms of tuberculosis* (cough for more than 3 weeks; fever; night sweats; weight loss; loss of appetite; no energy; coughing blood)
Symptoms compatible with TB: refer for chest X-ray and/or examination
2. Asymptomatic, or chest X-ray negative:
check for a characteristic BCG scar
Scar present: *inform of risk, but no further action*
3. No scar: *perform a tuberculin skin test (Heaf or Mantoux)*
Positive test
(Children under 16: Grade 2-4 Heaf or equivalent;
Over 16 years: Grade 3-4 Heaf or equivalent):
refer for chest X-ray and examination
4. Positive test (as defined at (3) above), but no signs of active TB:
Children under 16 or young adult (16-34):
offer preventive chemoprophylaxis
Inform all of TB risk
5. Tuberculin skin test negative:
Children under 16 or young adult (16-34):
offer BCG immunisation Inform all of risk of TB*
* BCG is contra-indicated in HIV infected individuals. Relevant HIV prevalence rates should be taken into account.

Notes

- i. Further investigation of patients suspected of having TB and treatment (including chemoprophylaxis) should be under the supervision of a respiratory physician with experience in TB (normally at the local chest clinic).
- ii. All those performing tuberculin skin tests and administering BCG should be appropriately trained.

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