Asylum Seeker and Refugee Patient Satisfaction: A comparison of differing health strategies in the North East of England

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Abstract

This study explores the two different models of healthcare provided to asylum seekers/refugees in North East England; *dedicated practices* and *integration into mainstream services*.

This study utilises the framework of "othering" to explore the perceptions and experiences of healthcare for asylum seekers/refugees. The theory of "othering" provides a novel way to analyse the continued treatment of the asylum seeker/refugee population throughout the UK.

This study focuses on the Zimbabwean community in the three locations - Middlesbrough, Sunderland, and Newcastle. A total of 19 semi-structured interviews have been conducted. An initial analysis of the transcripts demonstrates that, overall, participants appeared satisfied with the health services they received. Further, 14 participants reported no problems in registering or accessing services. Ten participants stated a direct preference for mainstream services whilst six participants stated preference for dedicated services. The main reported disadvantage of dedicated services was that they may further segregate and stigmatise those who use them. A further analysis of the transcripts highlights six main themes: Discrimination, Understanding, Others, Voice and Movement, Inclusion/Exclusion, and Legitimacy. These themes begin to provide more detail to the findings and are discussed at greater length within Chapter 5 - Results and Discussion.

This study is unable to draw any generalised conclusions, since the study sample is not representative of the wider asylum seeker/refugee population. Nevertheless, I argue that the fundamental issue is the lack of choice and autonomy that asylum seekers/refugees have with regards to their healthcare.

I argue that no one service will be ideal for the whole asylum seeker/refugee population, therefore, they must be informed of the various services on offer and provided with the autonomy to choose which model will suit them best.

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1 Introduction

Healthcare in the UK is provided free by the National Health Service and is available to all residents, including asylum seekers/refugees[1] (Department of Health and Refugee Council, 2003). However, there is no standardised model for providing healthcare to this population. This results in various models being used throughout the UK between different Primary Care Trusts (PCT). The health issues of asylum seekers/refugees are well documented (Clinton-Davis and Fassil 1992; Doyal and Anderson, 2005; Rodger, 2008; NHS, 2009) and will later be discussed, however, the best system to address these needs remains unknown.

Since 2000, there has been a significant increase in the number of asylum seekers/refugees within the North East. This has resulted in many services quickly adapting to accommodate this new population. For instance, interpretation services have increased from 3,000 sessions a year to 42,000 sessions during the period of 1998 to 2007 (Rodger, 2008). The health services have also adapted to the needs of this population by providing assorted assistance through support workers, dedicated practices, language support, to name a few (Department of Health and Refugee Council, 2003).

Three of the main models for providing healthcare to the asylum seeker/refugee population are (Ibid):

1. Integration into the mainstream services. This may include additional support teams.
2. Dedicated services or practices to include the asylum seeker/refugee population.
3. Salaried GPs within a mainstream practice, who are able to offer specialist resources in areas of high density asylum seeker/refugee populations.

[1] Throughout the duration of this study the term asylum seeker/refugee will be used to include both asylum seekers and refugees, since they regularly overlap. Further, it is often difficult or unethical to differentiate between people of the two statuses.

The first two models are utilised within this study's locations. Both Middlesbrough and Sunderland use dedicated or specialised practices for newly arrived asylum seekers/refugees whilst in Newcastle they are integrated into mainstream services with the assistance of a support team. Within this a relatively small region, two different systems are being used. It is the purpose of this study to examine the differences between these two systems from the perspective of the users themselves, the patients.

The two models discussed have been surrounded in controversy. It has been argued that specialist healthcare services may simply fill in the gaps that should be provided by mainstream services (Feldman, 2004). Therefore, the aim should be to ensure that mainstream service provision is able to provide all services without the additional support from specialist services. There are also concerns from asylum seekers/refugees that separate services may further segregate and stigmatise them (Kibondo *et al.,* 2000).

It has been proposed that specialist services may only be required for a period of time whilst healthcare services are able to adapt to this new population (Feldman, 2006). Since it has been recommended that integration into the mainstream should be the ultimate goal, it must be questioned whether after nearly a decade of increased asylum seeker/refugee population in the North East, there is still the need for these specialised practices. Over the last decade services have adapted to the asylum seeker/refugee population. For instance, the interpretation services have greatly improved. Therefore, it must be questioned whether mainstream services are now equipped to offer the appropriate care to this population or whether specialised practices remain the most appropriate option for newly arrived asylum seekers/refugees.

In order to answer this question, the experiences and perceptions of the service users themselves, asylum seekers/refugees, must be understood. There is a lack of current research that focuses on evaluating the health services offered to this population (Feldman, 2004). It is not possible in the scope of this research to fully reveal which healthcare model can provide the most appropriate care. However, this research will explore the perceptions, experiences, and opinions of Zimbabwean asylum seekers/refugees within Middlesbrough, Sunderland, and Newcastle.

The Zimbabwean community has been the focus of this research, since there are well established communities throughout the three study locations. Indeed, Zimbabwe has also been one of the main countries from which asylum seekers/refugees in the North East originate (Knowledge Inclusion Project, 2008; NHS, 2009).

1.1 Aims and Objectives

My research aim is to evaluate the two different models of healthcare provided to asylum seekers/refugees in Middlesbrough, Sunderland, and Newcastle.

The key objectives can be summarised as follows:

1. To explore the health services provided for asylum seekers/refugees in Middlesbrough, Sunderland, and Newcastle.
2. To explore patient satisfaction and experience of healthcare received within the UK.
3. To explore previous expectations and perceptions of healthcare within the UK.
4. To understand patient perceptions, opinions and utilization of specialised practices and mainstream for asylum seekers/refugees.
5. To evaluate the advantages and disadvantages of specialised healthcare centres for asylum seekers/refugees.
6. To assess whether dedicated practices are still required to provide appropriate healthcare to asylum seeker/refugee population

2 Background

2.1 Definitions and Entitlements

According to the 1951 UN Refugee Convention a refugee is someone who *'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 to or, owing to such fear, is unwilling to avail himself of the protection of that country'* (Oxfam GB, 2005: ix). An asylum seeker is someone who has applied for asylum, whilst a refugee is someone who has been granted asylum and has permission to remain (Newcastle PCT, 2008). In 2000 the UK had approximately 1.7 asylum seekers per 1000 national population. This ranked 78th in the world, contrary to the common perception that the UK takes in vast numbers of asylum seekers (Burnett and Fassil, 2000).

The 1999 Immigration and Asylum Act was introduced in the UK in response to increased number of asylum claims during the 1980's and 1990's (Great Britain Home Office, 1998). Following this act, accommodation is now appointed to asylum seekers in dispersed locations throughout the UK (Immigration and Asylum Act, 1999). This is to reduce clustering around London and the South East (Jones and Gill, 1998).

Approximately 6% of asylum seekers/refugees live in the North East and one third of these live in Newcastle. The other major cities also receiving asylum seekers/refugees in the North East are Middlesbrough and Sunderland (Knowledge Inclusion Project, 2008). The North East has typically been the smallest and least ethnically diverse region within the UK, yet over the last decade has seen over 10,000 asylum seekers enter the region (Rodger, 2008). Many services have quickly adapted to this new population, for instance, the number of interpretation services have increased 14 fold in the period from 1995 to 2007 (Ibid).

Asylum seekers/refugees are entitled to free healthcare from the NHS (British Medical Association, 2001) and must register with a GP shortly after arrival.

Registration however, can often prove to be difficult as GPs may ask for proof of asylum status (Citizens Advice Bureau, 2009), a passport, or utility bills. Without such documentation some practices refuse to permanently register asylum seekers/refugees (Personal communication, Jennifer Yuen, 04/06/2009; Geraldine Nuttall, 11/06/09). Documentation may not be available or may be with the Home Office (Personal communication, Jennifer Yuen, 2009). This may result in temporary registration (Jones and Gill, 1998) and patients may miss out on full health checks, screenings, follow ups, and advice (Montgomery *et al.*, 2000). This results in substandard care.

Asylum seekers/refugees are a vulnerable population and have experienced three central components – pre-flight experience, flight, and exile upon arrival within the new country (Department of Health and Refugee Council, 2003). Moreover, asylum seekers/refugees have often faced violence, torture, grief and loss, persecution, and hazardous conditions during their flight. Even within a new country the turmoil may continue with fears of deportation, anxiety about their asylum claim, and loss of family, friends and culture (Ibid). Mental and physical wellbeing have been found to deteriorate after arrival in the UK (Feldman, 2004) whilst vulnerability increases. This is a result of unstable legal statuses, continued discrimination, low income or support, poor housing, cultural isolation, and restriction of entitlements (Rodger, 2008).

Asylum seekers/refugees are not a homogenous population due to many cultural, linguistic, religious, and national differences. However, similar experiences may create similar health issues (Karmi, 1998). Whilst the majority of asylum seekers/refugees are young and healthy (Rodger, 2008), the nature of their forced migration may present specific health problems.

2.2 Healthcare Strategies

In the last decade, Primary Care Trusts (PCT) within the North East have utilised two main strategies to provide healthcare to the asylum seeker/refugee populations; 1) specialised healthcare practices, and 2) integration into mainstream practices with the assistance of a support team. In 2000 a report by the Regional Refugee Forum (RRF) showed there were several problems refugees faced when accessing healthcare. Conducted in Sunderland, the study highlighted lack of awareness of the specific

needs of refugees and also a lack of specialised services such as limited access to translators (Kibondo *et al.*, 2000) as two main issues. A debate continues as to which of the two healthcare strategies is most appropriate, specialised practices or mainstream integration.

Different healthcare strategies have emerged within Newcastle, Sunderland, and Middlesbrough. In Sunderland and Middlesbrough, specialised healthcare centres for the asylum seeker/refugee population have been utilised - the Haven practice in Middlesbrough and the Pegasi practice in Sunderland.

Both practices have trained staff to deal with the health needs of asylum seekers/refugees. In the city of Middlesbrough all newly arrived asylum seekers are directed to the Haven practice through the local housing provider. The Haven practice ensures that appropriate interpreters are available at every consultation and that full health screening and checks are conducted. Alongside routine healthcare, the practice also provides additional resources for mental wellbeing, such as, visiting mental health practitioners. Patients are only moved to mainstream practices once they have their refugee status and they are deemed to be at a stable point in their healthcare, although this is decided by practice staff not patients. Patients who have ongoing health problems that may make them vulnerable to a change in doctors, are kept on within the Haven practice (Geraldine Nuttall, Personal Communication, 11/06/2009). A similar procedure is in place within the Pegasi practice in Sunderland.

In contrast, Newcastle city operates a Health Improvement Service for Ethnic Minorities (HISEM) which assists new migrants to get access to the mainstream health services. The team consists of seven trained, bilingual support workers. Newly arrived asylum seekers are referred to HISEM by the housing providers, who then send out a support worker to assist them in registering within a mainstream GP surgery. (Jennifer Yuen, Personal Communication, 04/06/2009). The HISEM also provides information on health, wellbeing, and the various health services available such as dental surgeries. Unlike Middlesbrough or Sunderland, within the Newcastle PCT all newly arrived asylum seekers are registered within mainstream GP and the HISEM service is provided to all new migrants, including asylum seeker/refugees.

Both the specialised practices and HISEM offer information on health issues such as: men's and women's health, sexual health, healthy living, smoking cessation, exercise, and so forth.

2.3 The Zimbabwean Community

This research focuses on the Zimbabwean communities within Sunderland, Middlesbrough, and Newcastle. The Zimbabwean community was chosen for three reasons. First there are well established communities within all three research locations and relatively large numbers of Zimbabwean asylum seekers/refugees continue to arrive in the North East (Knowledge Inclusion Project, 2008; NHS, 2009). In 2007 and early 2008 Zimbabwe was one of the top ten nationalities that applied for asylum in the UK, comprising 8% of all asylum applications. It was also the third main nationality to be granted asylum in the same year (Home Office, 2008a; Home Office, 2008b). Secondly, although Shona and its dialects are widely spoken the official language of Zimbabwe is English (UK Border Agency, 2009). Whilst English may not be spoken by all Zimbabweans, everyone I encountered through my research spoke good English which eliminated the need for interpreters. The third reason for choosing the Zimbabwean community is that the language barrier is often the most commonly stated problem in providing healthcare to the asylum seeker/refugee population. Therefore, it is hoped that by using an English speaking population, it will be possible to explore other issues that may act as a barrier to healthcare.

3 Literature Review

3.1 Introduction

The following is a review of relevant literature regarding asylum seeker/refugee healthcare. Appropriate healthcare for asylum seekers/refugees is a critical issue worldwide. Despite this, no system has been found to be entirely satisfactory (Bodenman *et al.*, 2007). It has been recommended that integration within mainstream services is the optimal model however, dedicated services may be required until this can be achieved (Department of Health and Refugee Council, 2003). Within the UK, healthcare is freely available to residents, including all asylum seekers/refugees (Ibid). The main debate, therefore, is which system – either specialised or mainstream NHS services, can offer the most appropriate care to this population.

The first two sections of this review address the health issues of asylum seekers/refugees and the main barriers to care that have been identified. The theoretical framework of Explanatory Models is used to reflect on the different perceptions and experiences that will shape individuals' understanding of illness and the health system. The theory of "othering" will also provide a theoretical lens through which to understand the treatment and strategies used in relation to the asylum seeker/refugee population. Finally, the role of patient satisfaction is explored since any examination of health services should investigate the opinions and experiences of the service users.

3.2 Health issues for asylum seekers/refugees

Whilst the asylum seeker/refugee population is extremely heterogeneous there are several common experiences - leaving their homes under extreme circumstances, living in the UK under the asylum support system (Newcastle PCT, 2008), and an increasingly limited sense of autonomy (Grove and Zwi, 2006). Other common difficulties include adapting to the loss of a homeland, a new culture, a different lifestyle and diet, a different social position, a new language, and waiting for a

decision on their asylum claim (Clinton-Davis and Fassil, 1992; Newcastle PCT, 2008).

The health of asylum seekers/refugees can be greatly affected by the asylum process. For instance, the time it takes to make a decision on an asylum claim can negatively impact health (Clinton-Davis and Fassil 1992). This is because asylum seekers are typically confronted with poverty, dependence, lack of social support or networks, isolation, loss of status, and hostility or discrimination in their new host community (Karmi, 1998; Wilson *et al.,* 2002; Stockton International Family Centre, 2003; Spicer, 2008). While not all of these are resolved immediately upon receiving refugee status, one important change is the right to work (Haroon, 2008). The ability to work legally can reduce dependency and poverty, further, it can help to relieve anxiety and depression (Burnett, 2002)

Themes of racism and hostility are deeply embedded within much of UK society, and discrimination can persist within institutional structures and policies, such as, healthcare (Muecke, 1992; Williams and Mohammed, 2009). Further, members of ethnic minorities are often aware of discriminatory behaviour against them. Perceived discrimination has been identified as a stressor which has adverse health consequences (Williams and Mohammed, 2009).

The contribution of pre-flight conditions, the process of flight itself, and the experiences of poverty, isolation, and discrimination within the host population can result in increased prevalence of health problems in asylum seeker/refugees. These can include: poor nutrition, endemic diseases, such as TB, mental health issues which often include anxiety and depression, poor dental health, skin conditions, upper respiratory tract infections, sexual health issues, such as, Sexually Transmitted Infections (STIs) and unwanted pregnancies, HIV/AIDS, and musculoskeletal problems (Doyal and Anderson, 2005; Rodger, 2008; NHS, 2009).

Asylum seekers/refugees can be susceptible to these health issues due to their vulnerable and extreme experiences. It is the shared experience of forced migration and the asylum process that creates the health similarities and vulnerabilities of this otherwise heterogeneous population.

It must be remembered that there are more differences than similarities between asylum seekers/refugees and they should not be seen as a simple, homogeneous population.

3.3 Barriers to health

The asylum seeker/refugee population not only faces similar health concerns but may also experience similar issues in accessing healthcare in the new host country. The main barriers to healthcare are well acknowledged within the literature. The most significant barrier to health care is language (O'Donnell *et al*., 2007; Newcastle PCT, 2008) which can prevent patients from communicating their health needs (Phelen and Parksman, 1995). Thus, the first step required for cross cultural care is providing effective language solutions (Bischoff *et al.,* 2003). This can be achieved by using appropriately trained interpreters, or bilingual health professionals (Ibid). The asylum seeker/refugee population has high linguistic variety, so inevitably, even with bilingual staff there will be the need for interpreters. These are often seen as expensive making some practices reluctant to provide the service (Karmi, 1998). However, it should be noted that the costs of interpreting services are covered by local PCT's (Department of Health and Refugee Council, 2003). Hence, cost should not be a limiting factor for individual practices to provide the service.

Whilst language concordance has been associated with improved healthcare (Bischoff *et al.,* 2003), it is not the only barrier to healthcare. With this in mind, the Zimbabwean community was chosen for this research to allow the exploration of other barriers to healthcare. For instance, opening times and arranging appointments have been seen as another barrier to healthcare, particularly when there is little understanding of how the health system functions (O'Donnell *et al.,* 2007; Newcastle PCT, 2008; Rodger, 2008). A lack of knowledge about the health system also creates barriers to understanding how to access specialist or secondary care (O'Donnell *et al.,* 2007). Other issues also include difficulty in accessing medication, especially when it has to be paid for (Ibid), and a choice of gender in health practitioners and interpreters (Finley, 2002; Rodger, 2008).

Health professionals also report issues regarding the provision of care for asylum seekers/refugees. Among these are: lack of funding, costs of interpretation, lack of central government policy, need for translated material, unrealistic and conflicting expectations from patients, and lack of understanding about the system (Wilson, 2002). Many health professionals also feel that they lack any specialist knowledge

about asylum seeker issues (Karmi, 1998; Montgomery *et al.*, 2000). Considerable obstacles, therefore, stand in the way of healthcare for this population.

3.4 Health systems and Explanatory Models

Another issue in providing healthcare is that of differing expectations. The health service in the UK may vary considerably to other countries' systems (Clinton-Davis and Fassil, 1992). For instance, in the UK GPs account for 95% of contact that people have with the NHS (Uddin *et al.,* 1998), whereas, in many other countries healthcare may be oriented around secondary care, such as, hospitals (O'Donnell *et al.,* 2008). Therefore, previous experiences of healthcare will affect expectations, satisfaction, and perception of any healthcare received through the UK (Burnett and Peel, 2001).

All healthcare systems are cultural systems (Kleinman, 1991) and these systems should not be understood on a hierarchical basis. Since health systems across cultures and nations differ so too does people's expectations and experiences. These different expectations can be considered as part of an individual's Explanatory Model (EM). An EM is all the notions that individuals hold about a specific illness episode (Kleinman, 1988). They contain beliefs about the aetiology, pathophysiology, the onset of symptoms, course of sickness, and the treatment (Young, 1982). They allow an individual to create order and meaning of the illness episode (Ibid) and should not be considered static. They are continuously evolving as new experiences and information passes.

The EMs of asylum seekers/refugees may differ from those commonly held within a host population and need to be understood. Ignoring an individual's EM often signals disrespect and can undermine the patient-practitioner relationship (Kleinman, 1988) whilst conflicting EMs can be seen to impede healthcare (Kleinman, 1991). Often the patient's EM is considered to be created through beliefs, whilst the practitioner's EM is given the status as fact (Watters, 2001). Explanatory Models differ between individuals (Young, 1982) and will undoubtedly be different across cultures, but they should not be seen as a barrier to care. Jenkins *et al.,* (1996) found that among Vietnamese migrants in the US it was accessibility to healthcare that was the limiting factor, not the EMs traditionally held. Alternative EMs should not always be seen as barriers to medical care. However, to provide effective healthcare there is a need to understand and negotiate between different EMs.

It must be acknowledged that health cannot be reduced to a purely biomedical ideal; instead it is social and cultural. Therefore, in order to provide appropriate healthcare the social and cultural aspects must too be understood. For instance, Post Traumatic Stress Disorder (PTSD) is expected to affect many asylum seekers/refugees (Hondius *et al.*, 1989).Yet, this diagnosis of a disease is in danger of neglecting the social experiences that sufferers undergo; by placing too much emphasis on physiology and medical phrasing (Kleinman, 1995). Effective and appropriate healthcare can only be provided by comprehending individuals' EMs, their expectations, experiences, and perceptions. Furthermore, the understanding of individuals' EMs can create a better rate of adherence (Kleinman, 1991) and ultimately provide improved care.

3.5 Differences and "Othering"

Whilst most UK policy agrees that integration is the ultimate goal, a dedicated service to the asylum seeker/refugee population may be able to provide improved language support, trained staff who understand the issues, and necessary information to help patients comprehend and access the system (Burnett and Fassil, 2000; Kibondo *et al.,* 2000). This approach for a dedicated practice can be seen in Sunderland and Middlesbrough. However, it has been argued that specialist services will only continue to separate, stigmatise, marginalise, and discriminate asylum seekers/refugees (Kibondo *et al.,* 2000). Further, if it is perceived that asylum seekers/refugees receive better services than the native population hostility and resentment may develop (Burnett and Fassil, 2000).

A person is many things and cannot be labelled by one characteristic; ethnic identity is just one aspect of a multifaceted self (Lock, 1990). By creating specialist services we focus purely on one aspect of their identity; their asylum status. Focusing on ethnic identity and the foreignness of asylum seekers/refugees we begin to 'other' them. 'Othering' is a process that acts to mark and name those who are thought to be different from oneself. It can be understood as an underlying component of human nature; the duality of the self and the other. As soon as a group is established as the one there must also be the other (de Beavoir, 1972). Therefore, it secures our own identity by placing distance and stigma on the 'other' (Grove and Zwi, 2006). This process can be seen in the treatment of asylum seekers/refugees, not just in the UK

but also globally. Immigrants are principally seen as negative within the media, and metaphors used to describe migration focus on themes of natural disasters, such as, 'floods, waves'. All of these continue to dehumanise immigrants, particularly asylum seekers/refugees (Leudar *et al.,* 2008). By dehumanising this group, distance is placed between 'them' and 'us'. In many instances this may also include physical distance, such as, the Australian Immigration Detention Centres (Grove and Zwi, 2006), or by placing accommodation at the edges of communities. The 'othering' of asylum seekers/refugees can be seen in legal, social, and physical terms (Ibid). They are no longer allowed back to their home countries, yet, they are not fully integrated within the new host country. They remain outside the boundaries (Ibid).

Douglas (1966) states that people and objects that either do not conform to or, cross social boundaries are regarded as dirty, polluted and often dangerous. Thus people who exist in a marginal state or without a place in the social system present a danger. Unable to help their situation, others must take precaution against this danger. Asylum seekers fall into a liminal state between their homeland and their new society (McLoughlin and Warin, 2008). The use of distancing, forced detention, and the reduction of autonomy, can all be seen as various methods used by society to protect themselves against asylum seekers. In contrast, refugees are provided with a status and therefore do not pose danger, instead they are understood as genuine victims (McLoughlin and Warin, 2008).

Therefore, the complexities of race, class, gender, age, language, and so forth are continuously ignored and reduced to a simple term – asylum seeker. It boils down all the issues and allows us to place these people into a group of 'other' (Besteman, 1996), rendering them outside our social system.

3.6 Patient Satisfaction

In order to assess which healthcare model provides the best form of care to this population, the quality of the healthcare must be measured. Patient satisfaction has become equated to quality (Williams, 1994) and is a widely used and accepted method of assessing the quality of a service provided (Young *et al.*, 2000). This importance placed on patient opinions and satisfaction has arisen from dominant themes of consumer sovereignty (Carr-Hill, 1992). Here, the consumer began to be seen as the central figure to which public services, such as, the NHS were accountable

to (Williams, 1994). Links between satisfaction and enhanced patient compliance (Wasserman and Inui, 1983; Merkel, 1984) further increased the interest in patient satisfaction (Williams, 1994).

The principal assumptions of satisfaction are that 1) there are expectations and 2) that satisfaction is linked with the fulfilment of these expectations (Williams, 1994; Williams *et al.,* 1998). However, these assumptions should not be taken without caution. There appears to be little evidence that satisfaction is actually a result of achieved expectations, and furthermore, it is contested whether expectations exist at all in some circumstances (Williams *et al.*, 1998).

Patient satisfaction is not a straightforward concept. One must understand that it is also highly influenced by the individual and numerous variables: education, age, class, medical history, patient's and societies' values, perceptions, and expectations (Dougall *et al.,* 2000). These variables, which interact with ethnic identity, should be taken into consideration for their influence over satisfaction (Young *et al.,* 2000; Xiao and Barber, 2008; Collins *et al.*, 2002). Further, satisfaction should be obtained from the patients themselves, since doctors had little accuracy when predicting how satisfied patients were (Merkel, 1984). Patient satisfaction can begin to provide an evaluation of the services provided, however, it is important to interpret findings with care.

The need to measure patient satisfaction remains important, since it can highlight opinions, concerns, and interests of patients. Understanding the patient, their needs, and wishes is central and is mandatory in order to continually improve the services on offer (Carr-Hill, 1992).

It is imperative that we continue to gather patient satisfaction, opinions, perceptions, and experiences, as it gives them a voice and can help to create patient centred services (Williams *et al.,* 1998). It can be argued that little has been achieved to allow the public the ability to shape their own healthcare system (Carr-Hill, 1992). However, continued interest and focus on patient's experiences is required to ensure that patient centred services are the next step in providing patients autonomy over their care.

As with all other populations, information on patient satisfaction and experiences is required from the asylum seeker/refugee population in order to identify and provide them with the best healthcare.

3.7 Conclusion

We must understand that asylum seeker/refugee health can be influenced by numerous factors, such as: pre-flight and flight conditions, dependency, isolation, discrimination, and poverty. Further, there may be significant barriers in accessing health, such as, language difficulties and a lack of knowledge about the system. I argue that there is the need to explore patient's Explanatory Models in order to understand their various perceptions, opinions, and experiences and that it is important to work alongside these EMs to ensure appropriate healthcare. Importantly, the theoretical framework of "othering" should be used to comprehend the treatment and continuous discrimination of asylum seekers/refugees. It must be remembered that patient satisfaction and narratives should be explored to truly understand the most appropriate forms of care for asylum seekers/refugees.

4 Methodology

This study explores Zimbabwean asylum seekers/refugees' experiences, perceptions, and opinions on the healthcare that they have received whilst being in the UK. Specifically, their opinions and experience regarding the specialised and mainstream healthcare services have been gathered in order to evaluate what forms of healthcare models we should provide to asylum seeker/refugee populations.

Ethical approval for this study was granted by the Department of Anthropology Ethics Committee, Durham University. Guidance and backing has also been provided from the Regional Refugee Forum (RRF).

4.1 Data Collection

This study uses qualitative methodology and is solely interview based. This was deemed the most appropriate method to employ in order to gather the narratives of participants. The data gathered was the opinions and experiences of participants. Quantitative methods, such as, questionnaires would not have been able to provide the in-depth exploration that was achieved through semi-structured interviews.

Two preliminary interviews were conducted that provided a basic understand of the two different forms of services on offer:

- With a health professional in Haven practice, Middlesbrough
- With the service manager of the HISEM in Newcastle

In total 19 semi-structured interviews (six men and 13 women) were conducted in the three locations: four from Middlesbrough, ten from Newcastle and five from Sunderland. Participants ranged in ages from 21 years to 52 years with the average age being 36 years. All participants were either asylum seekers or refugees from Zimbabwe. Due to confidentiality and to protect informants, no information was gathered on their legal status. Therefore no differentiation can be made between

whether participants were an asylum seeker or refugee. Please see Table 4.1 for detailed information on participants.

Table 4.1 Participant Information

Name	Gender	Age	Location
Mr A	Male	40	Middlesbrough
Mrs B	Female	38	Middlesbrough
Mrs C	Female	28	Middlesbrough
Mr H	Male	26	Middlesbrough
Mrs P	Female	On behalf of her 52 year old mother	Newcastle
Mrs D	Female	39	Newcastle
Mr E	Male	21	Newcastle
Mr F	Male	37	Newcastle
Mr G	Male	43	Newcastle
Mr I	Male	47	Newcastle
Mrs K	Female	45	Newcastle
Mrs L	Female	40-45	Newcastle
Mrs M	Female	30	Newcastle
Mrs N	Female	35	Newcastle
Mrs O	Female	37	Sunderland
Mrs R	Female	31	Sunderland
Mrs S	Female	30-35	Sunderland
Mrs T	Female	28	Sunderland
Mrs U	Female	48	Sunderland

Participants were referred to me by key community leaders in the three locations. The RRF was instrumental in providing links with community leaders. The community leaders were provided with a brief description of the study and only individuals who agreed to being contacted were referred to me.

Each participant who was referred to the researcher was contacted and the research was explained to them. They were then asked whether they would still like to be

involved and if they would be willing to be interviewed. Two participants declined because they were not asylum seekers/refugees and one declined because they were not sure what they would say. Arrangements were made to meet and interview participants.

At the beginning of each interview the research was again explained. This also provided a chance for people to ask questions about me and the research. Each participant was reminded that they had to right to stop the interview at anytime or reframe from answering any questions. Consent was sought to use a Dictaphone for each interview, and no one declined to being recorded.

To further protect the anonymity of each participant no real names have been used, in either the analysis or this final report. This was explained to participants to ensure them that all their responses would be kept anonymous.

All interviews were conducted on a one-to-one basis with individual participants. However, in one case a daughter spoke on behalf of her mother who was seeking asylum. Interviews were conducted in a variety of places, such as an international community centre in Middlesbrough, a birthday party in Newcastle, and within people's homes in all three sites. Interviews ranged in length from seven to 35 minutes and included five key topics. As shown in Box 4.1.

Box 4.1 Interview Topics

1. Perceptions and expectations of health service
2. Comparison of the health service to Zimbabwe
3. Utilisation of the health service
4. Opinions on problems with the services
5. Ideas of what services should be offered to refugees and asylum seekers

A basic set of predefined, opening questions were used for the majority of interviews. These can be seen below in Box 4.2. These questions did not form a rigid interview structure and were often adapted in response to a participant's answers. The use of general opening questions provided participants with a framework within which to guide the structure and topics under discussion.

Box 4.2 Opening Interview Questions

1. Can you tell me about how you came to live here Newcastle/Middlesbrough/Sunderland?
2. How have you found access to healthcare here?
   What made it easy/difficult?
3. Can you tell me about the last time you or your family were ill?
   What did you do?
4. What health care should be offered to asylum seekers/refugees?

4.2 Data Analysis

All the interviews were transcribed and a basic analysis was then conducted. I coded for themes using Grounded Theory. This consisted of looking for basic themes that arose out of the transcripts. Many of these themes had been informed by previous readings of the surrounding literature. With each transcript that was analysed themes were confirmed and further themes were identified. The themes identified will be dealt within the next chapter, Results and Discussion.

A key feature of this research has been the continued assistance provided by the RRF. It has been through the forum that contact with participants was made possible. Furthermore, once the data was analysed, the findings were discussed with two key informants; Bini Araia who is member of the Eritrean community, Chairs the RRF and works within North East of England Refugee Service (NERS), and Chantal Breka who originates from the Ivory Coast and runs the Teeside African Health Community. The insight from these two key informants proved indispensible in providing information to form the discussion and implications elements of this study.

4.3 Ethical Reflexions

There were several ethical issues during this research since asylum seekers/refugees are a vulnerable population, who have been forced to flee their homes. It is vital that participants are not distressed and that my research does not harm their safety, dignity or privacy (AAA, 1998). Therefore, no one was asked about their status or how they came to live in the UK. Instead, I asked participants how they came to live in their current city. This provided them with the ability to choose how much information about their past they wished to share and where their narrative began.

Throughout the research I found it imperative not to probe about "ordeals" or "bad experiences"; unless they were directly related to healthcare. I wanted to avoid reducing a complicated narrative into a trauma story or image of victimisation (Kleinman and Kleinman, 1996). Since the stories of violation and trauma of asylum seekers soon become commodities or symbolic capital which are used as evidence of being a genuine victim (Ibid). Refugees are recognised as genuine victims (Leudar *et al.,* 2008; Mcloughlin and Warin, 2008), forcing these trauma stories to be retold in order to prove legitimacy. I felt it essential that participants were not reduced once again to trauma stories but had the freedom to create their own identities and stories, however they wished. For this reason, there were no questions about the events or experiences that forced them to seek asylum. Instead all questions were strictly around healthcare within the UK.

3.4 Sampling Reflexions

Due to the nature of the study population the sampling within this study should briefly be considered. Participants were referred to me by community leaders; this may mean that certain people were more likely to participate. For instance, people who were in close contact to the local communities and their leaders. Further, a large proportion of my sample were female, this again may be due to sampling biases since two community contacts were female, as am I. The combination of female researcher and recruiter may have resulted in more women than men being included within the study. The method of sampling conducted for this research was deemed the most efficient, in the time scale and most appropriate. However, considerations must be taken before these results are generalised to any wider populations.

5 Results and Discussion

5.1 Results Overview

Before any discussion can take place, a brief overview of the results obtained is needed. The following summary of results is only a generalised picture, but one that must be formed before any detailed discussion can take place.

From the 19 interviews, several key areas of interest arose: preferences for mainstream and dedicated services, perceived advantages and disadvantages of the two healthcare systems, registering and accessing the system, previous expectations and comparisons to Zimbabwe, and general levels of satisfaction with the services.

5.1.1 Preferences for Mainstream and Dedicated Services

One of the key objectives was to understand patient perceptions, opinions, and utilization of specialised and mainstream practices. One way this was explored directly was to gather participants' preferences for mainstream or dedicated services. Before and within each interview the different healthcare models were described to participants. This was vital since many participants were unaware of any dedicated services. Sixteen participants stated a direct preference for either service and two participants gave no directly stated preference. Only one participant gave no information on this topic.

Table 5.1 Preferences for Mainstream and Dedicated Services

	Newcastle	Sunderland	Middlesbrough	Total
Dedicated Services	4	1	1	6
Mainstream Services	4	3	3	10
Not Stated Directly	2	1	0	3

5.1.2 Perceived Advantages and Disadvantages of the Two Healthcare Systems

This topic directly links to one of the key objectives; to evaluate the advantages and disadvantages of specialised healthcare centres for asylum seekers/refugees. Overwhelmingly, 12 participants said that the negative aspects of specialised services were that they segregate, discriminate, or differentiate between people. The majority of participants saw it as an advantage of the mainstream services that you are able to be treated in the same places with everyone else. However, the benefits that were mentioned of a dedicated service were better interpreting resources, mentioned by three people, and a sense that they may be more understanding which was stated by five people. It was clear that the majority of participants perceived the mainstream system to have more advantages than the dedicated practice.

5.1.3 Registering and Accessing the System

One of the opening interview questions was on accessing healthcare. This was an important topic because previous literature continues to highlight the barriers that asylum seekers/refugee face when accessing healthcare including language difficulties and requirement of specific documents. In 17 interviews the topic of registering or accessing the system was discussed and 14 participants said they had a positive experience. However, three participants had great trouble registering, one participant lacked the specific documentation that the GP surgery insisted upon and two experienced several months delay. These two participants experienced these delays outside of the study locations, when they first entered the UK.

Even among the participants who had a positive experience a couple of issues were highlighted. The need for documentation was mentioned by four participants. This was seen as a problem for two participants who had difficulty registering without certain documentation. However, the other two participants reported that they were accepted without any documentation. A larger sample across various GP practices would be required to understand to what extent the requirement for documentation is a problem.

Interestingly, two participants felt that both nurses and receptionists could act as a barrier to care; by asking too many questions before allowing patients to have a consultation with the doctor.

5.1.4 Previous Expectations and Comparison to Zimbabwe

It is important to explore the patients' previous expectations and their comparisons of the UK and Zimbabwean healthcare systems in order to understand individuals' Explanatory Models. Only 10 participants stated having previous expectations or opinions about the UK healthcare before they arrived, seven of these expected the services to be of a higher standard than the healthcare available in Zimbabwe. The other three participants expected the healthcare system to either the same as the system in Zimbabwe or that it would be difficult to access. Of these 10 participants who expressed previous expectations, seven thought that the health services within the UK were exactly what they had hoped for, or exceeded their expectations. However, three participants commented that only some of their expectations had been met. Unmet expectations included unfriendly and unprofessional staff, longer waiting times, and a lack of choice in GPs.

There were two main comparisons between the UK and Zimbabwean healthcare systems. The first was that healthcare was free in the UK compared to paying for the services within Zimbabwe. The second was that everyone registered with a doctor in the UK whereas in Zimbabwe a doctor is only sought when an individual is ill. All the seven participants who made these two comparisons did so favourably to the UK system. However, three other participants made more favourable comparisons to Zimbabwe these included: ability to choose a doctor more freely in Zimbabwe, consultation of family for healthcare decisions in Zimbabwe, and the freedom for doctors to provide more radical treatment in Zimbabwe.

5.1.5 General Levels of Satisfaction

From the interview responses it was possible to identify general levels of patient satisfaction with the healthcare they had received in the UK. Overall, 12 participants appeared satisfied with their healthcare. They reported services as "good", "second to none", "first class" with several reporting "no problems at all". Unfortunately, four participants directly stated problematic experiences with the healthcare they received. These issues arose from lack of confidentiality, racial discrimination, inability to complain, and inappropriate treatment which in one case lead to the participant mistrusting the doctors.

5.2 Discussion of Emerging Themes

The general numbers and patterns described above only begin to demonstrate my findings. The following is a more in-depth discussion of the findings that have arisen from analysing the transcripts to look for themes within the narratives of my participants.

The 19 interview transcripts were analysed and within five transcripts several themes were evident. The remaining 14 interviews were analysed and used to either support or discard the themes. This resulted in finding six main themes: DISCRIMINATION, UNDERSTANDING, "OTHERS", VOICE AND MOVEMENT, INCLUSION/EXCLUSION, and LEGITIMACY. These final themes were deemed to be the most frequently occurring and fundamental from the narratives I analysed. No categories were used which did not occur in at least half of the transcripts, however, several smaller categories were incorporated to form the final themes. For instance, the categories of Mistrust, Fairness, and Genuine were incorporated to form the fundamental category of Legitimacy.

The process of coding for themes results in a deeper exploration of the data, since it searches for what links and separates each narrative. Further, the application of the theoretical framework of "othering" to these themes has enabled a richer understanding of the wider, societal issues than any numerical analysis could.

5.2.1 Discrimination

The theme of discrimination was often found alongside the themes of "Others" or Inclusion/Exclusion. It was analysed as an individual theme because it dealt particularly with the notions of stigma and negative differences, specifically in regards to being an asylum seeker, of black skin colour, or being foreign.

The examples in Box 5.1 below highlight how participants' narratives either referred directly to discrimination, or they expressed a feeling of being discriminated against. In the case of Mrs P, the receptionist's facial expressions were interpreted negatively. The outcome for Mrs P was ultimately positive as the receptionist registered her mother however; this example illustrates how easily one can feel discriminated against.

Box 5.1 Examples of Discrimination

"Whenever you are just like an asylum seeker person they just look, they just look below. They don't think you are a human being." Mrs U.

"…because already there is a stigma attached to refugee and asylum." Mrs S

"…because I am from Africa I am looked at in a different way. Like some kind of different species altogether. I can be treated in a totally different, like I'm weird." Mrs R

"You could tell like the faces that people were not really too sure whether to register her…." Mrs P

"You are not treated as, I mean, as an individual you are treated as AN asylum seeker." Mrs O

"Its kind of discrimination then, isn't it?" Mrs N

"There is always the assumption that because you are black then you are not a British citizen." Mr H

"…and why not doing that to all new migrants. Asylum seekers are new migrants it is just their situation…." Mr A

Interestingly, one argument for dedicated services is to provide culturally appropriate care to asylum seekers/refugees. Unfortunately, the example from Mrs O was in direct response to her experience within the Pegasi practice in Sunderland. This demonstrates that perhaps even within dedicated services all is not being done to eliminate discrimination.

Perceived discrimination can have negative health impacts (Williams and Mohammed, 2009) and should be a factor in evaluating healthcare services. Further, perceived discrimination has been linked to lower sociocultural adaptation in new migrants (Te Lindert *et al.*, 2008). Therefore, any discrimination experienced through healthcare will undoubtedly reduce patient satisfaction, and may have potentially damaging consequences for patients' health, both psychologically and physically.

5.2.2 Legitimacy

The theme Legitimacy incorporates the notions of mistrust, being genuine, and fairness. As discussed previously, refugees are viewed as genuine victims (McLoughlin and Warin, 2008; Leudar *et al.*, 2008) whilst the term asylum seekers, in both legal and routine use, denotes suspicion (Leudar *et al.*, 2008). This underlying assumption that asylum seekers may not be legitimate further allows society to distance itself from them. Thereby placing them in a category where they are viewed as immoral and dishonest. This notion was repeated in several of the participants' narratives; that they had to prove themselves in order to gain access to the doctor. This can be seen in the narrative of Mrs U and Mrs B with box 5.2. In contrast the doctors were described as "honest", further demonstrating the difference between "us" and the notion of the dishonest asylum seeker.

Another point that I noted within the narratives was the frequent use of the phrases "to be honest…" and "honestly…" by participants. These were used throughout eight of the narratives and in one case Mrs U repeatedly used the phrase "I don't want to lie…". Whilst these phrases were not used throughout all the interviews conducted, it highlighted that participants may be aware of their negative image within society. As a result they may tailor their responses to the perceptions and hostilities expressed towards them (Leudar *et al*, 2008).

Box 5.2 Examples of Narratives within the Theme of Legitimacy

"They think that might be a lie that you are not feeling ok."
"[the nurses] ask you why you want to see the doctor." Mrs U

"I don't think it was ever explained that, maybe I might be lying but I don't think that…" Mrs S

*"…it can't be fair on people…"*Mrs R

"That's what they strictly insist on, they insist to see documentation" Mr G

"[in regards to the nurses/receptionists] So if you don't meet the criteria…you don't have the access to see the doctor"
[referring to doctors] "…they're honest." Mrs B

"they ask you how ill you are and the iller you are the faster you get treated." Mr E

5.2.3 Understanding

The second most frequent theme is Understanding with it being found throughout 13 of the transcripts. This category included topics about understanding and caring staff. In these 13 transcripts it was clear that for participants a health service and staff who were understanding and empathetic was fundamental.

Importantly, an understanding doctor or nurse was one a key factor to participants stating that they were satisfied or happy with their healthcare. This is important as it demonstrates the expectations of patients to have a health system that understands them.

Of the six participants who preferred the idea of a specialist practice, four stated the reason behind their choice was they would have been better understood in the dedicated practice. This can be seen in the examples of Mrs D, Mrs K, Mrs S and Mrs P. Even amongst those who did not state a preference for specialist practices, one perceived advantage was that they may understand asylum seekers/refugees and their situation better.

Box 5.3 Examples of Whether Participants Were Understood

"He is a very good doctor. He listens to me, he tries…." Mr A

"Y*ou get some connection and you understand each other.* Mrs B

"[in reference to what service would she choose]…a specialised one because then they would have listened and attended to my cries and everything." Mrs D

"[in response to why she would go to a dedicated service]I would be comfortable telling them my problems because I would assume they understand what I am on about." Mrs K

"No the doctor is alright he understands" Mrs U

"…probably in those specialised ones the specialist can actually understand and probably empathise..." Mrs S

"I think the specialised practice is a lot better…because first of all they would understand her situation." Mrs P

Obviously, language interpretation also fits within the theme of Understanding. Notably, language services were seen as a benefit of dedicated practices by two of the participants when reflecting on experience of other non-English speaking asylum seekers/refugees.

All participants were able to communicate confidently in English yet the issue of being understood remained a fundamental issue for 13 participants. Those who felt that the surgery staff understood them reported more positive healthcare experiences than those who felt they had not been understood. As seen above in Box 5.2, both Mr A and Mrs U has overall positive healthcare and both mentioned how understanding their doctors were. This illustrates the importance of being understood and that speaking the same language does not automatically mean that individuals will understand one another. Therefore, whilst language disparity is a fundamental barrier to being understood, it is not the only one. Participants felt it was imperative for staff and services to understand them, not purely in a linguistic sense, but to empathise and recognise their situation for instance, as new arrivals to this country.

5.2.4 "Others"

The theme "Others", was closely linked to discrimination, it remained a separate category because the differences or other people included within this theme were not necessarily described in negatives terms. The category of "Others" came up in eight of the interviews, this was just under half of all interviews conducted. Yet, I felt it an important theme because it is so closely linked to Discrimination and Inclusion/Exclusion. The majority of items covered in this theme dealt with my participants referring to other asylum seekers/refugees communities as separate or different from themselves.

Several participants made references to either non-English speaking or newly arrived asylum seekers/refugees as different from themselves. This can be seen through the bold words within the phrases in Box 5.4. None of this seemed to be done in a negative light. However, it demonstrates the intrinsic nature of separating "them" and "us" in humans.

It should be understood that many of the examples within Discrimination could also fit within this category of "Others". In order to discriminate a group such as asylum seekers/refugees they must first be defined as the "other".

Box 5.4 Examples of "Othering"

*"I guess especially for those just arriving, for **those** arriving that would be ideal but for **us**…"* Mrs D

"[in reference to a dedicated practice] I would go for that one for us…. Meet people who are like the same as me." Mrs K

*"I think for **other people** like the Kurdish, I could see them with interpreters"* Mrs O

*"…there will be countries where the culture is totally different, totally different, you know so maybe its better for those people. But then how do you differentiate **those** people?"* Mrs R

*"I think **they** should have a special, what do you call it, [practice] yea, yea for **them** so **they** wont be confused."* Mrs T

*"[in reference to dedicated practices] …in my mind, if I think this is for **different** people."* Mrs S

This illustrates how groups throughout society create the "other". No group can create themselves as the one, without placing all other groups as the "other" (de Beauvoir, 1972). This point made by de Beauvoir, is furthered even more to not only all groups within society but all individuals. She argues that otherness is as primordial as our consciousness and occurs as soon as man is viewed as a free being (Ibid). "Othering" is deeply rooted within society and the continued "othering" of asylum seekers/refugees continues to marginalise them. This illustration of "othering" within the asylum seeker/refugee population may demonstrate how some asylum seekers/refugees are even more marginalised than others.

5.2.5 Inclusion/Exclusion

As discussed, the category of Inclusion/Exclusion was closely related to the themes "Others" and Discrimination. However, it dealt more explicitly with the themes of exclusion and segregation mainly as a result of discrimination and "othering". Whilst the negative aspects of the theme included notions of segregation there were also many positive aspects when participants talked about being fully integrated or included. Therefore, both these contrasting elements were included within this theme.

Inclusion/Exclusion was the most prominent category and was found in 14 of the transcripts, in 13 of these transcripts the themes "Others" and/or Discrimination was also present.

Box 5.5 Examples of Inclusion/Exclusion

"I would be very happy if the system could involve us." Mrs B

"You have basically segregated and you know shown the difference between people… makes people in the community realise they are different and that's where segregation comes" Mrs C

"[in reference to using mainstream services] …since then I don't feel like I am different." Mr E

"What applies to you should apply to me." Mr G

"If you have a place for a certain group… it is marginalising from another group of people." Mr I

"…a human being is a human being." Mrs O

"It makes you feel like you are not part of the community." Mrs R

"That means that whenever I go to your hospital where you go I just feel like I am counted." Mrs U

"We should all be treated in the same place… then at least they will feel like they are part of it." Mrs S

Notably, participants focused on inclusion and the importance of being integrated as much as the feeling of segregation. This can be seen within the examples of Mr E, Mrs S, and Mr G who all talked about how it was positive to have a sense of inclusion. This is important since focus should not solely by on the negative aspects of segregation but must also be placed on the beneficial aspects of full integration.

It was a central feature of these transcripts that participants wished to be included within the same services as the rest of the population. Even two participants who had showed a preference for dedicated services pointed out that everyone should receive the same treatments and services. It was clear from all these 14 transcripts that dedicated services provided a sense of "segregation" and there was a need to allow for integration into the health services and community.

5.2.6 Voice and Movement

The final category of Voice and Movement deals with the idea that an asylum seeker/refugee has limited agency to speak out and be listened to, or the freedom to move and make choices. This theme occurred in 10 of the interviews and was particularly prominent when participants referred to examples of being an asylum seeker instead of a refugee. This theme linked closely Inclusion/Exclusion since several participants felt that asylum seekers/refugees had not been consulted in regards to using dedicated services. It can also be seen to link into the theme of "Others". For asylum seekers/refugees to remain as the "other" they need to be kept in a state of dependence, with the laws set against them. This can be seen historically in other groups who have been "othered" such as women (de Beauvoir, 1972).

Box 5.6 Examples of Voice and Movement

"It was something that was imposed on them [asylum seekers]."
"[in reference to Zimbabwe] you could just move…because there's choice." Mr A

"As an asylum seeker you are just taking the back seat and everyone is doing it for you, even if you know how."
"…to be given a choice…" Mrs B

"[in reference to booking an appointment] They ask you, they actually ask you when the best time for you." Mr I

"…my solicitor told me not to say such things…" Mrs M

"You should be given a choice whether you want a male or a female GP." Mrs O

"I am not allowed to go to school…I cannot work, now I cant even go to a GP… the system can allow people, should allow people to integrate." Mrs R

"So you don't have to complain, you don't have to say anything…you don't have freedom."
"…but if you are an asylum seeker how can you raise your voice." Mrs U

"…but its just that you have to go there." Mrs S

"They do, they always want her to say before they do anything with her." Mrs P

The two instances where this theme was applied in a positive light was when the participants felt that they were able to voice an opinion, or were asked by health professionals for their opinion. This can be seen in both the examples given by Mr I and Mrs P. All other examples of this theme refer to the inability of participants to speak, move, and act freely. A prominent opinion expressed by participants was their desire for choice, this ranges in the choice of both the practitioner and the type of practice.

5.3 Conclusion

From an analysis of the transcripts, it is possible to see that there are six linked themes. These themes when understood in light of the previous literature fit into the wider issues that face asylum seeker/refugees for instance, limited autonomy, barriers to healthcare, "othering", and discrimination. Some of the key findings were that few people were aware of the dedicated services, 10 participants stated a preference for mainstream services in contrast to six who preferred the dedicated services, and overall it was felt that mainstream service use allowed participants to be involved and included. In this instance dedicated services were seen as ways to further differentiate asylum seekers/refugees.

Due to the small and unrepresentative sample, it is not possible to generalise these findings into the wider asylum seeker/refugee community. However, these results can be used to provide an insight into experiences and perceptions of members of the Zimbabwean community in the three locations. These results can also be used as a starting point for understanding how asylum seeker/refugee healthcare may be affected by the interlinking relationships between discrimination, "othering", feelings of inclusion and exclusion, autonomy and choice, and a sense of understanding.

6 Implications for Policy and Research

The results from this study cannot be used to make recommendations for the wider asylum seeker/refugee population since the study sample only includes those of Zimbabwean nationality. Due to the heterogeneous nature of the asylum seeker/refugee population much more detailed research would be required with various nationalities and ethnic identities. This research whilst not applicable to all asylum seekers/refugees has been able to highlight several key findings which if further supported by additional research could suggest some implications for asylum seeker/refugee health policy. This study can also provide the beginnings of a theoretical model which might then be applied in other research contexts.

Consultation was sought with two experts both from and working within asylum seeker/refugee population. By discussing my results with experts from different asylum seeker/refugee communities it was possible to assess how my results from the Zimbabwean community compared to other communities.

Some of the key points that arose from the results were the sense of exclusion, and difference that could be created through the dedicated services. Ten of my participants preferred to be integrated into the mainstream services, with only six participants choosing dedicated services.

The sample of my study lacked language barriers and many were already familiar with English culture, due to previous English occupation of Zimbabwe (Chantal Breka, Personal Communication, 02/09/09). It would not be possible, from my study, to declare which healthcare model can provide the most appropriate care to all asylum seekers/refugees. Especially since many other ethnic communities may face additional health barriers and may benefit from the dedicated services. These dedicated services have been invaluable to many as they have the expertise in dealing with the circumstances of asylum seekers/refugees (Bini Araia, Personal Communication, 02/09/09). However, what is apparent is the need for more

information and choice to be provided to all asylum seekers/refugees regarding their healthcare.

Among the key themes that arose from my research were: Discrimination, "Others", Inclusion/Exclusion, And Voice and Movement. A common feature of all of these themes was the sense that asylum seekers/refugees have limited choice and autonomy and are constantly seen as an outside group. This sense of limited choice is reinforced by a general perception that people are unable to move out of the dedicated healthcare services until they have obtained their refugee status (Bini Araia and Chantal Breka, Personal Communication, 02/09/09).

The restriction and limitation of asylum seekers/refugees' autonomy continues to place them in a group as the "other" which further allows for discrimination and exclusion. To stop discrimination against asylum seekers/refugees they first need to be considered as a valid within society rather than an "other" group. One way this could be achieved would be to increase the choice provided to them regarding their healthcare. By increasing the amount of information supplied to asylum seekers/refugees about the healthcare services in their areas, individuals and families could make informed decisions about the best system of care for themselves.

The findings of this research cannot suggest the use of one healthcare model over the other. However, the results do suggest that it would be most beneficial to provide all asylum seekers/refugees with an increased choice of what service they access. For instance, all asylum seekers within Sunderland and Middlesbrough are currently referred only to the dedicated services. However, I argue they should be advised of both the dedicated services and the mainstream services and given the choice to choose which service they attend.

If we are to provide the most appropriate form of healthcare to this population then we must first provide them with the choice to make their own healthcare decisions. The use of a dedicated service may provide invaluable for some and may segregate others. Equally, not all asylum seekers/refugees may feel able to immediately integrate into the mainstream services. We cannot continue to impose these services on people without providing a choice for them. Asylum seekers/refugees will inevitably continue to be "othered" and restricted whilst they are treated as an "other" groups with different rights.

7 Conclusion

The aim of this study was to evaluate the two different models of healthcare provided to asylum seekers/refugees in Middlesbrough, Sunderland, and Newcastle. The findings of this study have been informative, although they have not provided a definite answer of which healthcare model may be best suited to providing asylum seeker/refugee healthcare. They can be used to better understand the viewpoint and experiences of communities of asylum seekers/refugees using the UK health services. Whilst this research cannot be generalised to all asylum seeker/refugee communities, it has been able to highlight areas of interest which could be explored further. For instance, the experience and perception of discrimination and exclusion should be furthered explored to find ways in which this could be reduced.

From this study, it can be understood that the dedicated services for asylum seekers/refugees may be able to provide improved and more specialist care. However, it can also be seen that these services act to further distance and separate this population. Whilst several participants stated their preference for mainstream services, several others stated their preference for dedicated services. Therefore, there seems to be no simple answer as to which is the most appropriate form of healthcare. Instead, more research is needed to follow on from this to explore other communities of asylum seekers/refugees and to provide them with the opportunities to speak out and have their voices heard.

This study has provided an insight into the experiences and opinions of asylum seekers/refugees patients within the healthcare system. The framework of "othering" has been particularly useful to provide a wider understanding of the discrimination and distancing that asylum seekers/refugees are continuously subjected too.

I argue that there needs to be more choice and information made available to asylum seekers/refugees when accessing healthcare. Without the freedom of informed choice, we continue to 'other' this population. We must actively listen to their voices and stories and stop placing distance between 'us' and 'them'. Ultimately, increasing this population's autonomy will the best way to provide appropriate healthcare to this population.

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