What refugees need to know to live healthily

Living Well in Glasgow
Research Report

livingwell inglasgow

Living Well *connecting people, improving lives*

Prepared by Community InfoSource

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Photograph on front cover:
Final day of the very successful Mental Wellbeing Workshops
December 2013

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Chapter One: Introduction

1.1 Introduction and overview

The dispersal of large numbers of asylum seekers to Glasgow started in 2000 and is still ongoing. These are people who have asked the UK government, in the form of the Home Office, to give them refugee status under the 1951 Refugee Convention and who are currently waiting to have their applications assessed. There are currently around 3,000 asylum seekers, supported and housed by the Home Office, in the City. In addition, over these 14 years, many have received status of some kind which entitles them to stay in the UK, many of whom have decided to make Glasgow their home rather than moving elsewhere in the UK. Netto (2011) found that just over two-thirds of her interviewees reported that they were 'very likely' to stay in Glasgow and she points to the 'connectedness to place' which many refugees felt after living in the city. Mulvey (2013) similarly found the majority of his research participants planning to stay in Glasgow.

Terms

Our project Living Well in Glasgow (LWiG) generally uses the term ‘refugee’ to cover all those who have come to the UK seeking refugee status. In this report we use the word “refugee” to refer to people at various stages of the process, namely:

- British citizens from a refugee background
- Those with full refugee status
- Those who have indefinite leave to remain
- Those who have leave to remain in the UK for a limited time
- Those who are still in the formal asylum process and who are on Home Office section 95, 98 or section 4 support
- Those who have been refused asylum, are destitute and are trying to get back into the system, while living in Glasgow

We only differentiate between these categories where it is necessary for a better understanding of the analysis.

Community InfoSource (CIS) has been involved with refugees and asylum seekers (referred to as refugees from here, unless there is a need to differentiate), through its individual directors, since 2000 (and before). We are a group of six people, four of which come from a refugee background and two which have worked with refugees.
Living Well in Glasgow came about through conversations between CIS directors and different refugees about problems to do with health and well being. Some of the issues for newcomers which are commonly related to knowledge and information are listed below:

- How do people deal with the transition of working with their community in hard work on the land to being forbidden to work and so having a sedentary lifestyle, probably living in a high rise block, and being socially isolated
- How do people from a hot climate learn methods of dealing with our relatively cold weather
- How do people learn what food here is nutritious and reasonably priced and how to cook it
- How do people cope with mental health issues from: the traumas of their previous lives; their lives in the asylum system here, and then, after receiving status, adjustment to a completely different life in UK
- Cultural differences – how do newcomers learn what behaviour is acceptable (or not) here, especially if they are isolated

Initially a partnership was set up between CIS and Ypeople Glasgow Residents' Association (YGRA), an organisation with an elected committee of people who lived in housing provided by Ypeople, the main Home Office accommodation provider in Glasgow at that time (2011). YGRA was particularly concerned about how to identify mental health issues and about how to provide some kind of supportive sign- posting for the many affected people which they could identify from their own general experiences.

YGRA were based in 33 Petershill Drive, in Springburn. This is where Ypeople rented the whole building, where they had a reception desk on the ground floor, offices on the 1st and 2nd floors, and temporary housing where they accommodated people under the Initial Asylum Service for their first few weeks until they were re-housed. They also provided accommodation for some large families and some single people in shared flats. Ypeople also provided a community space (called Ycommunity) on the 28th floor, using the four flats. They had also donated a room to YGRA as an office.

The research idea

Originally, the idea being developed was to set up a project which focussed on the health and well being of newcomers to Glasgow, and in the spirit of partnership, work alongside Ypeople (who had agreed to support the project) and National Health Service Greater Glasgow and Clyde's asylum seeker base "Health Matters", on the 1st floor of the building at 33 Petershill Drive. Ypeople no longer has the asylum support contract (now held by Serco) and Health Matters has now become a different project with a change of staff, so this partnership arrangement became inappropriate. LWiG therefore took the idea forward independently.

After long discussion, a decision was made to develop the project for refugees.

The aim of LWiG is to develop a pilot project for health and wellbeing activities to address what refugees need to know to live healthily. Ideally these could be incorporated into mainstream services in Glasgow.

The project is to be developed as a pilot one which could be rolled out to other community groups or neighbourhoods. It was acknowledged that every community could benefit from awareness raising on the issues we wish to address, although we focus on ones particularly relevant for refugees who have come to the UK to escape persecution and violence.

While developing ideas for workshops and starting to fundraise, we realised that all of the evidence of what refugees needed to know for

healthy living and wellbeing was anecdotal up to the present time. Therefore we decided that the first part of the package has to be the accumulation of evidence of what is actually needed. So we agreed to carry out research by and for refugees, with the aim of providing the information needed to develop activities for LWiG. What better way of finding out than carrying out an action research project whereby refugees developed the research methods, carry out the surveys and then analyse the data.

Fundraising

A successful funding application was made to The Scottish Community Foundation (now Foundation Scotland) for a grant to facilitate the research project.

We also accessed a small grant from the European Year of the Volunteer (through the Voluntary Action Fund) which helped us finance the setting up of the Volunteer Project and the volunteer costs of administering the project.

1.2 Project development

From September 2011 onwards Living Well in Glasgow recruited some volunteers to be trained in office administration and research methods.

A Steering Group was set up, consisting of people who understand the situation of our target group (the refugees), and had its first meeting in October 2011. The Steering Group discussed how they could assist Living Well in Glasgow and suggestions were made for others to join the support structure. There were small discussion groups to gather participants' views on what refugees needed to know to live healthily here, and how information should be presented to make it accessible for them. Details from these discussions are in Methodology in Chapter Four. The second meeting took place at the end of February 2012 and looked at the findings of the pilot research (the first 50 surveys of individuals) and involved helpful discussion of some of the issues

identified (such as the use of the term GP (General Practitioner) by professionals and the word Doctor by newcomers).

The research data was collected until April 2012 with the analysis following. The data from both individual surveys and surveys of staff at relevant organisations was input to Survey Monkey research package and the results were generated in excel and pdf formats.

During Refugee Week 2012 we held a successful and professional event which highlighted some of the results from the individual surveys. Using some of the data based on what refugees felt they needed to know to live healthily here, we also delivered two pilot workshops to help teach stress management techniques, which were very highly acclaimed.

The nature of working with volunteers is that often they find themselves having access to formal employment, no longer having the time to give to projects, or gaining the confidence to go on to education courses, which is as it should be.

By advertising for support, we were very pleased to find a volunteer who helped us with the detailed analysis of the organisation interviews. The analysis of the individual interviews took longer to find a successful volunteer placement, with at least two false starts, but finally in 2013 we found not only a refugee volunteer but someone who had academic experience of analysis.

Meanwhile, in spring 2013 we advertised and interviewed for a second group of volunteers to help develop three types of workshops. We used the results of primary data analysis to address the highest demand issues that refugees think they need to know to live healthily in Glasgow.

There was a lot of work involved in the development of workshops: finding accessible locations where refugees would be comfortable to come and could get to without too much trouble; finding accessible premises where everyone could get in; developing the content of the workshops; finding suitable practitioners with skills and experience of working with refugees; taking decisions about support for childcare and even finding a suitable source for the provision of lunch.

Three types of workshops took place between October 2013 and January 2014 and involved: a) Zumba classes on a Saturday, both mixed gender and women only ones; b) a Healthy Eating & Cooking workshop on Mondays, both mixed gender in the afternoons and women only in the morning and c) Mental Wellbeing workshops fortnightly on Tuesday mornings, for men and women separately.

These workshops were all very well received and there has been great demand from participants and other professionals, that they should be repeated for other groups.

Finally, the LWiG Planning Group is still meeting regularly (we are up to meeting number 31) and has a committed group of six volunteers (four of whom are from a refugee background) who are eager to move forward with new ideas which are being developed based both on the research findings and personal knowledge. Funding applications should be submitted shortly.

A Timeline of the development of the project to date is attached as Appendix One

First Steering Group meeting, 2011

Stefan and Mavis preparing for our Refugee Week event

Chapter Two: Review of previous literature

2.1 Barriers and Misunderstandings

There are a considerable number of reports, advice documents and papers written about the importance of good health and lifestyle in relation to refugees and asylum seekers.

A significant number of these are concerned with the initial arrival of refugees and the importance of helping them to register with health services, most importantly a General Practitioner (GP) but also with a dentist or other health professional. The Scottish Executive (as it then was) for example, provided advice to local authorities and other agencies in 2004, emphasising the importance of alerting refugees to their entitlements under the NHS, how to register with a GP, and how to access out-of-hours services through the NHS24 helpline. Similarly, the Scottish Refugee Council issued guidance in April 2011 on 'How to Access Health Care in Scotland' and, in February 2013, a Health Information Briefing on the health rights and entitlements of refugees and asylum seekers in Scotland. As well as providing basic information on registering with a GP and on, for example, out-of-hours services, the briefings also provided information on how to obtain help with additional healthcare costs (such as dental care, glasses, contact lenses and wigs), and on how to make a complaint in the event of poor service by the NHS.

There have, subsequently, been a number of studies which have explored the barriers to accessing healthcare which have been experienced by refugees. In an important study of the health experiences of refugees in north Glasgow, Roshan (2005) found that there was a high level of GP registration but that refugees experienced a number of difficulties in making use of the NHS. Principal among these was language and communication, with many refugees requiring the use of an interpreter. Other problems included the length of time some refugees had to wait for appointments, uncertainties as to their rights and entitlements, difficulties in travelling to surgeries and health centres, and interactions with NHS staff – sometimes because staff themselves were unsure how to deal with refugee patients.

In another Glasgow study, O'Donnell *et al* (2007) noted in relation to language barriers that there is sometimes a tension between interpreters translating verbatim and acting as patient advocates. Additionally, access to interpreters in other settings, for example in-patient hospital stays could be problematic. They also found that refugee families with limited resources sometimes found it hard to afford over-the-counter medication such as children's paracetamol.

Barriers to health care are particularly significant in the case of older refugees whose knowledge of English may be poorer and who may be less able to articulate their needs. Yet they may be experiencing ageing faster, possibly due to traumatic experiences and many refugee women require health support during the menopause. Older refugees may be particularly affected by isolation because of the stereotype that BME communities 'look after their own' and therefore that care support is not needed (Connelly *et al* 2006).

Indeed, there has often been a marked variation in the ability of different parts of the NHS in responding to cultural diversity. In areas with long-established black and minority ethnic communities, health services have experience of meeting the needs of people with different religious, language or cultural backgrounds (Johnson 2006). But perhaps in Scotland, with a much smaller BME population prior to the late 1990s, this was not necessarily the case. Nevertheless, the Race Relations (Amendment) Act 2000 has laid a statutory duty on the NHS and other public bodies to develop race equality strategies and to ensure equal treatment of all users.

Szczepura (2005) therefore argues that providing appropriate access to health care for a diverse population is about more than simply providing the service. She draws attention to the need for services not just to demonstrate linguistic competence (in terms of interpreting and translation services) but also cultural competence. Cultural dimensions of health might include:

- Patients' health, healing and wellness belief systems
- How illness, disease and their causes are perceived

- The behaviour of patients seeking health care and their attitudes towards healthcare providers
- The views and values of those delivering health care

At the end of the day, as Szczepura points out, the aim is for BME service users to have equal access to and appropriate information about the NHS, to have appropriate and sensitive services, and to be able to use the NHS with ease.

The extent to which users actually feel at ease depends not just on removing barriers to access but also in improving knowledge of how the NHS actually functions on a day-to-day basis. Those refugees who have come from countries without a well-developed system of primary healthcare, for example, may expect a hospital referral for conditions that in the UK would be treated by a GP or Practice Nurse (Burnett and Peel 2001). There have therefore been various misunderstandings, where refugees have used Accident and Emergency services inappropriately, either for routine health problems (Ager and Strang 2008) or during the night because of a lack of knowledge of out-of-hours services (Mulvey 2013).

Research by Wasp *et al* (2004) suggests that heads of households have a generally better understanding of the workings of the NHS, as do young refugees, who tend in any case to be healthier and to make less use of health services. Wasp *et al* also draw attention to the fact that many refugees do not understand the treatments administered due to a lack of explanation compounded by language differences. By way of example, Papadopoulos *et al's* (2004) study of Ethiopian refugees notes how traditional remedies are more likely to be used in Ethiopia and so there was a lack of understanding of the treatments prescribed by the NHS.

Health Promotion

As part of the process of removing barriers to health care, it is widely recognised that health authorities can do much actively to promote good

health and to ensure refugees are made aware of the availability of services.

A number of cities, for example, have outreach teams who target recent refugee arrivals. In London, for example, Kensington, Chelsea and Westminster's Equal Access to Health Care Project use community health workers to work with new arrivals, while Lambeth, Southwark and Lewisham have a special outreach team with a specific focus on single homeless BME people, many of them refugees (Refugee Health Consortium 1998). Health visitors do similar work in the West Midlands, while in Nottingham, there is a community-based asylum seeker and refugee health outreach team to provide health promotion and to build knowledge and capacity in mainstream services (Bunting 2009).

There are similar approaches in other countries. In the Australian state of Victoria, a Refugee Health and Wellbeing Action Plan seeks to work with refugees to promote improvements in refugee health, sometimes through promoting access to services and sometimes through improved diet (Victorian Refugee Health Network 2008). New Zealand has established a Refugee Health and Wellbeing Project to promote healthy living and has had considerable success. After a 10-month health education programme, they reported significant increases in awareness of the importance of cancer screening, of the symptoms of meningitis and the availability of immunisation for communicable diseases. There was also a significant drop in the number of people who said they smoked (New Zealand Red Cross 2013).

The process of promoting good health amongst refugees has been portrayed as a 'journey to wellness' by Palinkas *et al* (2003). In an important study, they draw attention to the 'health burden' with which refugees arrive, including trauma and stress-related disorders, depression, substance abuse, infectious and parasitic diseases and an increased susceptibility to chronic diseases. The journey to wellness therefore focuses on treatment of psychiatric disorders and of infectious diseases, and prevention of chronic diseases. Working in San Diego, California, the consortium working with refugees has implemented a number of health promotion programmes and developed a range of educational materials aimed at improving knowledge of treatments for

cancer, diabetes and cardiovascular diseases. They portray this as a 'two-way process affecting both the migrant and the organisations dedicated to helping the migrant on the journey to wellness'.

2.2 Health, happiness and 'wellness'

This concept of 'wellness' or wellbeing as a journey leads us to consider the importance of wellbeing as a key part of living in the wider society. Johnson (2006), for example, argues that good health enables better participation in society and the supply of appropriate health care shows the responsiveness of society to the needs of new members. Indeed, although health is not always cited as a core factor in integration, fieldwork by Ager and Strang (2008) suggests that good health was widely seen as an important resource for active engagement in a new society. So good health and wellbeing are key to long-term integration by the new refugee communities.

In clarifying what is meant by integration, Johnson (2006: 57) suggests that the key factors must be:

- Equity of access to relevant health services;
- The ability of health and social care services to respond to the specific needs of the relevant minority groups; and in the long-term
- A parity of health outcomes and life expectancy or disease experience.

Parity of outcomes can be achieved not necessarily through refugees adopting the lifestyle choices of the host population – which may not always be healthy ones! Rather, the long-term aim should be to ensure that there are no statistical differences between the health of the host and refugee communities.

Health and wellbeing are closely linked in many of the studies of refugee health. Wasp *et al* (2004) interviewed a number of refugees who found that the simple act of talking to others helped to relieve stress and had a positive effect on health. Papadopoulos *et al's* (2004) study of Ethiopian refugees identified six 'meanings' of health, namely:

- Happiness
- The ability to fulfil material needs and ambitions
- Harmonious relationships
- Positive personal qualities and attributes
- Physical, mental and spiritual wellbeing
- A healthy environment.

For the Ethiopians, ‘desta’ or happiness was the most important prerequisite and indication of health.

Finally, Lewis (2009) identifies the centrality of food to the long-term happiness and wellbeing of refugees. She identifies the importance of food to refugees’ sense of community and the lengths to which some refugees will go to obtain traditional produce. The emotional value of food lies in a link to specific places and times that people have left behind. Western diets may be unappealing to many refugees and are not always healthy; therefore a focus on traditional eating and cooking practices may assist with long-term health and wellbeing,

We move on now therefore to consider the wider aspects of diet, nutrition and the links to health.

Nutrition and diet

Deficiencies in diet and nutrition are common amongst refugees and asylum seekers. Pre-arrival factors which will affect nutrition include prolonged deprivation, malnutrition, drinking contaminated water, untreated or undiagnosed illnesses such as parasitic infections and chronic diarrhoea, and dental problems which cause difficulties when eating (Victorian State Government 2012).

However, once settled in a safe country, refugees continue to face nutritional challenges and research suggests that they often become accustomed to poor eating habits. Two American studies (Barnes and Almasy 2005, Rondinelli *et al* 2011) show how refugees became accustomed to an American lifestyle, including consumption of high-

calorie, nutrient-poor foods and this was a particular problem amongst children who were targeted by the fast food industry. In Barnes and Almasy's study, only 13% of refugees thought they ate healthily, acknowledging that they ate too many calories, too many sweets and too much fat. Closer to home, an Irish study (Manandhar *et al* 2006) identified a similar problem, with refugees eating too much protein and saturated fats and fewer carbohydrates. Although the intake of fruit and vegetables was adequate, it was perceived to be low by the refugees compared to their previous diets.

Although refugees recognised the fact that their eating habits were often poor, there were considerable barriers to eating better. These included the high cost of some fresh fruits and vegetables, the general cost of food in many western countries, the limited amount of time available to prepare food when adults had to work outside the home and the cheapness and easy availability of fast food (Barnes and Almasy 2005). Manandhar *et al* (2006) suggest that many parts of Ireland are 'food deserts' for refugees, especially when they are accommodated in peripheral housing with limited access to shops stocking preferred 'ethnic' foods and affordable healthy food options. This scenario would also apply to many parts of the UK.

Southcombe (2008), writing about refugees in Australia, defines the problem as 'food insecurity' which exists 'whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain'. She notes the high prevalence of food insecurity among refugees resettled in developed countries, associated with poor dietary practices, overweight and morbidity and she refers to various local Australian studies identifying a prevalence of food insecurity among refugees of over 70%.

The impacts of food insecurity and poor nutrition are significant. In Barnes and Almasy's (2005) study, 52% of refugees believed that they were overweight and 74% believed that they were less active than they should be to be healthy. 61% thought that they were less active since arriving in the United States, a key factor being an increased use of cars. There was a negative impact on oral health and vitamin deficiency and, in terms of disease, Rondinelli et al (2011) found that rates of diseases

that are commonly nutritionally influenced (such as diabetes, heart disease and high blood pressure) were increasing linearly with the length of time that refugees were living in the US. Poor diet was also impacting negatively on breastfeeding by reducing women's ability to eat and feed on demand, and refugees were increasingly using processed feeding products. Indeed, Sellen and Tedstone (2000) refer specifically to the nutritional risks posed to children because of refugee poverty and the difficulties of adapting eating and child feeding practices to new social, cultural and economic conditions. They suggest, however, that we have insufficient knowledge of these risks and call for more research.

There is therefore a growing recognition of the need to work with refugees to help them identify appropriate and healthy diets. In America, for example, the US Committee for Refugees and Immigrants has developed a Nutrition Outreach Toolkit and a range of educational materials for those working with the refugee communities[1], while in Australia, the government developed the Fairfield Refugee Nutrition Project[2] and, in Perth, the 'Good Food for New Arrivals' training resource[3]. These resources comprise a variety of materials, including advice to community workers and presentations and activities for using with refugees themselves.

The challenge in seeking to tackle the problem of poor nutrition in refugees is to change behaviour (Barnes and Amasy 2005). The easy availability and relative cheapness of fast food is clearly attractive. Research shows that refugees from many countries have a knowledge of healthy food choices, physical activity needs and the risks associated, for example with smoking. But knowledge does not always translate directly into healthy behaviours.

[1] http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/
[2] http://www.aifs.gov.au/cafca/ppp/profiles/cfc_fairfield_nutrition.html
[3] http://nutrition.asetts.org.au/

Specific health needs

So far, we have discussed the health and nutritional needs of refugees as a whole, but it is clear that, within the overall refugee population, specific health needs have emerged and have often been the subject of specific studies.

Mental health

Mental health is a significant issue for refugees and asylum seekers, with the trauma of migration leading to depression, stress, sleeplessness and anxiety. Social isolation and poverty in their new country can have a compounding effect on mental health. In a Cardiff study (Cardiff Health Alliance 2011), for example, a third of refugees were receiving medical treatment, most notably treatment for depression in the form of anti-depressants and / or counselling. We need to recognise, however, that refugees more often need social care than psychiatric treatment and so a standard medical model of care may not necessarily be appropriate (Simich *et al* 2010).

What is particularly significant in relation to mental health problems is their persistence. Mulvey's (2013) study in Glasgow uses a 'Warwick Edinburgh Mental Well Being Scale (WEMWBS) to measure problems. He found that, despite refugees accessing employment, being in more secure housing, securing status and often bringing family to Scotland, nevertheless WEMWBS scores actually rose over time. This appeared to be a hangover effect resulting partly from the trauma of migration and partly from the asylum process, so mental health problems were ongoing. Mulvey also noted significant under-reporting by refugees.

Women

Research suggests that women may have an insufficient voice in articulating their health problems and needs. Partly this may be a result of their being isolated at home in a childcare role, partly it may reflect (perhaps as a result) a poorer knowledge of English, and partly it may

reflect the fact that they may be from a patriarchal society, where women's voices are not well heard.

Some women may be reluctant to consult with a GP (particularly a male) if rape or sexual abuse has occurred. And there appears to be a low uptake of health promotion programmes, for example prevention measures amongst refugee women, in relation to cancer screening (Refugee Health Consortium 1998).

We have already referred to reduced breastfeeding rates, often caused by poor nutrition. McCarthy and Haith-Cooper (2013) also refer to the insufficient use made of maternity services by refugee women and their complex care needs, which midwives have to meet. They find that befriending schemes have had an impact in helping to remedy the position.

Older people

We have referred earlier to the particular difficulties facing older people in accessing health services, including poorer language skills, isolation and a belief that minority ethnic families 'look after their own' elders. But older people often need additional health support, linked to the process of ageing, possible disabilities and frailty. Carers too may need support, something that is increasingly recognised.

Older people may be financially disadvantaged and may struggle to understand pension provision and this may affect their ability to access support (Connelly *et al* 2006).

Children and young people

Children and young people may be particularly affected by the trauma of migration, if they are unsure what is happening to them and such trauma may lead to drug or alcohol abuse. Adolescence is in any case, a time of transition from childhood to adulthood and a period often associated with

mental disorders and behavioural difficulties. For young refugees, it can clearly be a particularly complex process (Milosevic 2002).

Where young people attend school, their language skills will improve markedly and they may find themselves as the main interpreter or advocate for their family's health needs. They therefore take on a responsibility unmatched to their age and this can be somewhat traumatic in itself.

Schools need to be alert to health issues affecting refugee children and adolescents and have an important role to play, for example, in promoting immunisation in young people (Refugee Health Consortium 1998)

2.3 Conclusion

The literature clearly demonstrates a situation where refugees need substantial support and advice in relation to health and wellbeing, including a healthy lifestyle. The initial arrival of refugees prompts a focus on GP registration and access to health services but longer-term settlement means that the focus of support needs to shift towards the promotion of good health, good diet and good nutrition, while recognising that certain groups within the refugee population need particularly intensive support.

Some researchers have stressed the value of befriending schemes, particularly for women who may experience isolation and who may require advice and support in relation to issues such as childcare and breastfeeding (McCarthy and Haith-Cooper 2013). Counselling services are also valuable in relation to mental health and other sensitive issues. The concept may be unfamiliar to many refugees but it can be helpful if it is culturally sensitive to the needs of ethnic minorities; indeed there is a strong case for refugee communities to develop their own counselling skills (Burnett and Peel 2001).

Finally, there are various ways in which the wellbeing of refugees can be supported. We have already referred to nutritional advice but other

approaches can be highly successful. In Manchester, the Refugee Wellbeing Project[4] delivered a wide range of activities including gym sessions, cycling, self-defence, laughter workshops, trips around the city, multi-sports sessions and cookery contests. As well as the group sessions, practical help and health advocacy was provided and the project appears to have been highly successful.

Ready to leave after another invigorating Zumba class, November 2013, Vivace Theatre School in Sauchiehall Street

[4] http://www.groundwork.org.uk/Sites/targetwellbeing/pages/refugee-well-being-project-tw

Chapter Three: Methodology

3.1 Introduction

The information for this study was gathered in a variety of different ways, including background information on refugees, obtained from 'desk top' research, a survey of 100 refugees, using a questionnaire and interviews with key professionals involved in the refugee process in Glasgow, including staff in the Scottish Refugee Council, British Red Cross and Freedom from Torture.

The main driver for the type of methodology using "action research" was the principle of using researchers from the group of people being interviewed to develop and carry out the research. Therefore we aimed to recruit around 80% of the research planners, interviewers and analysts from refugee backgrounds. The inclusion of 20% from a local background was expected to aid integration and could provide additional local knowledge for the group.

Accordingly therefore, the interviews with individual refugees and organisations were also conducted by refugees. This approach has been shown to have a number of advantages (Mestheneos 2006). Participation in the research can be a valuable professional experience, enhancing skills and boosting self-esteem. In addition, there is satisfaction in working on a project which has the ability to influence policy and practice and to benefit others. We also found that refugee researchers have a clearer understanding of the issues facing other refugees.

This 'peer research' approach, in which individuals are interviewed by their 'peers', has been used successfully in other studies. Within Glasgow, Roshan (2005) assessed the health needs of refugees and asylum seekers in north Glasgow using peer researchers, suggesting that they gained both professionally and personally from their involvement in the work. In London, Dumper's (2002) skills audit of refugee women for the Mayor of London's office used other refugee women to carry out the interviews. Dumper suggests that barriers arising out of a mistrust of strangers and people in authority were

overcome, and the exercise helped to empower those refugee women who became involved.

Identifying potential research and administration volunteers

Potential researchers were identified through advertising widely and by the provision of information about the benefits of volunteering in such a project. Organisations which had contact with refugee communities were provided with the advertising (emails, flyers and posters) and it was also sent to individual refugees who were contacts of our organisations. As the project was developed and managed by people who were either refugees or who worked with refugees, there was significant word of mouth advertising as well.

At the same time, Living Well in Glasgow was also advertising for administrative volunteers. The development of the whole project was being taken forward by volunteers, from the Volunteer Coordinator to the Planning Group. The administration of the project was also supported by volunteers who had learnt office skills or practised them in college but had not had the opportunity to use them in a professional setting.

Potential researchers were asked to complete an application form and were then to come for a discussion with the Team. These meetings took place in the Ycommunity space on the 28th floor of 33 Petershill Drive, which is a building which still houses induction stage asylum seekers during their first weeks in Glasgow, and some asylum seekers. The Residents' Association had been provided with office space on there, which was used for the interviews.

The applicants had already been asked to decide whether they wanted to volunteer on the research or the administration parts of the project. The work involved and the commitment being made by both the volunteer and the project team was discussed by a person from a refugee background from the Planning Group plus the Volunteer Coordinator. By October 2011 we had recruited a starting group of 4 administration and 6 research volunteers.

The whole Living Well in Glasgow volunteer project started with an induction into the organisations involved in the project and with information about what Living Well in Glasgow was hoping to be able to do as a result of the research. There was also a discussion opportunity for the new volunteers to contribute their thoughts.

3.2 Methodology

Aim of the study

This study is a baseline study with the aim of providing information needed to develop activities for the Living Well in Glasgow (LWiG) project. The aim of LWiG is to develop pilot health and wellbeing activities to address what refugees need to know to live healthily here and which could ideally be incorporated into mainstream services in Glasgow.

Training research volunteers

In total, ten research volunteers were recruited during the research period. Seven were female and three male. The research volunteers came from Algeria, Cameroon, England, Kurdistan (Iraq, Kurdish Sorani speaker), Scotland/France, Sierra Leone, Sudan and Zimbabwe. The range of countries of origin meant that we were able to use a wide range of languages during the interviewing process.

Each researcher was asked to commit to volunteering until the interviews were completed and the data uploaded for analysis, as a minimum (unless they had a change of circumstance).

Following recruitment, training was provided by Community InfoSource. The training focused on types of survey development, interviewing skills, cultural and ethical issues, methods of recording interviews and analysis, dissemination and, where necessary, IT skills.

The training also sought to provide support in terms of confidence building for the interviewers, in order to enable them to carry out the survey. In addition, support was put in place in case the interviews raised difficult issues for the interviewers and/or interviewees.

Developing the research methods and analysis

Following the training, the research group started development of the research plan. They met twice a week to do this. It was agreed that the main research would focus on the views of individual refugees and additional information would be requested from organisations or individuals who worked closely with refugees.

The research method used for both individual and organisational surveys was individual interviews where a questionnaire with mostly closed-ended questions was used (Appendix Two and Three).

Both the individual and organisational surveys were developed by the volunteer researchers who were mainly refugees, plus one or two people living in Glasgow who had close contact with the refugee communities.

Each interview was expected to last about 30 minutes, but could take longer if an interpreter had to be used. The interviews mainly took place in local community facilities where the interviewee and interviewer felt comfortable, although some took place at other locations to suit the interviewee.

The volunteers who carried out the primary analysis used Survey Monkey software for this initially.

After consideration, it was decided to use Survey Monkey to produce a basic analysis of the information collected in the individual survey interviews. Two of the volunteers taught themselves how to use this format and set up the survey based on questions the group decided were appropriate. After piloting this, a hard copy was then used in the actual interviews. The resulting data from the interviews was then input to Survey Monkey and the completed survey forms returned to the office.

Unfortunately the volunteer who started the analysis had to leave before the report was done. As a result the work stopped for a while until a new volunteer resumed it.

The new volunteer decided to use SPSS statistics software, and she trained a volunteer to help her with data entry, after which the analysis was developed.

The interview process and sample

Individuals

Prior to the interviews, a request letter with basic information about the project, its aims and objectives, contact details for the team, and how the results would be used was given to the expected respondents. This letter emphasised the confidential nature of the process. (see Appendix Two). This letter was translated into several languages including Arabic and French.

To overcome the language barrier we used an interviewee's mother tongue whenever it was possible, otherwise we used interpreters.

The sampling method was opportunistic whereby we accessed interviewees wherever we came across them, although we tried to cover, as far as possible, a range of different countries, different lengths of time living in the UK, different age groups, as well as achieving a gender balance. The sample size was 50 for the pilot study. A further 52 took part in the final study. As little change was made to the questionnaire after the pilot research, it was decided to amalgamate the two samples. However, two questionnaires were excluded from the analysis due to incomplete data leaving a total of 100 respondents.

Organisations

A list of suitable organisations and individuals who were known to work with refugees and be sympathetic to their needs was drawn up by the research volunteers. It was agreed that this list should be limited to 20

organisations in order to be manageable. The survey form which was developed was much shorter than the one for individuals and was intended to gather organisational information, details of any services which were provided and the views of the individual taking part on what was needed to help refugees live healthily here.

The Steering Group were asked the basic questions below in a workshop at their first meeting (before the formal interviews took place). Their answers are amalgamated.

A- From your experience, what do you think asylum seekers and refugees need to know to live healthily in Glasgow?

A number of responses were received, with the main ones being:

- How to access cheap/healthy food (fruit and vegetables etc)
- Correct signposting: language needs, where to get own country food
- What GP offers & other health services they are entitled to
- Mentoring, befriending, preventing isolation
- Accessible information on health, housing, education, lawyers, sport, budgeting and travel

B- How can information be presented to people whose first language is not English?

Responses included:

- Forming Languages groups
- Have multi-lingual audio/video resources & provide information in all useful formats
- Use social media/Facebook etc
- Combination of different choices: DVDs, leaflets in all languages, translators.
- Using images rather than words but make sure to get the basic signs translated with the help of volunteer translators/interpreters

Chapter Four: Individual survey results

This section covers the core part of the report: data analysis and findings. It is divided into four main parts: the first one describes the statistics of the target group, the second is an exploration of their food habits, the third part is on access to health services, and the last is on a subjective estimation of the gaps of knowledge among the target group.

4.1 Overview of respondents

The sample used in this study was composed of 100 refugees and asylum seekers, 40 of them females. They were of different cultural backgrounds, ages and residential status as well as length of time living in the UK. These factors will be considered in turn.

4.1.1 Cultural background

Knowing the cultural background is important to explain barriers that face integration of newcomers in their host society and access to public resources, as well as indicating needs for each group that might help policy makers to target specific group(s). Cultural background, here, is indicated by the country of origin of the respondent. Respondents were originally from 30 different countries. However, for simplicity and research ethic they are divided into three groups based on geography and cultural similarity: Middle East and North Africa (MENA)[5], Africa[6], and East and South Asia (Asians).

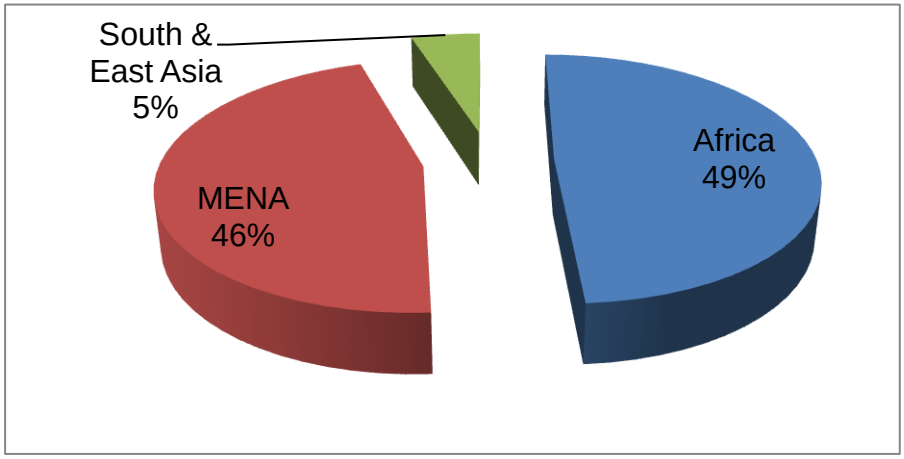
All of the respondents answered the question about their country of origin. As Figure (1) shows, most of the respondents are from Africa (49%) and MENA (46%), while only a few of them (5%) are from East and South Asia. Though the sample is random, this is not a surprising

[5] The term covers an extensive region, extending from Morocco to Iran, including the majority of both the Middle Eastern and Maghreb countries. The term is roughly synonymous with the term the Greater Middle East. (http://en.wikipedia.org/wiki/MENA)

[6] Africa is the rest of African countries that are not included in MENA

result, since Africa and the Middle East have been suffering from protracted political instability and economic crisis for decades.

Figure (1): Respondents by Region

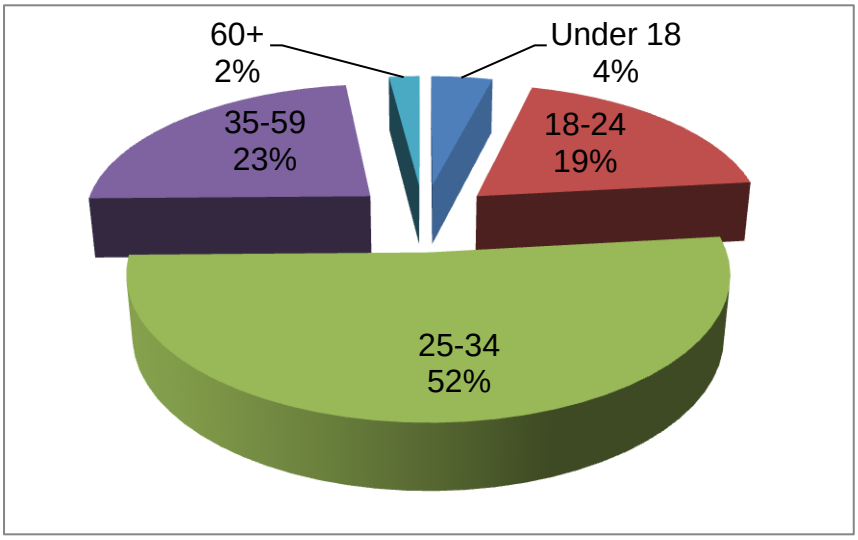


4.1.2 Age

The ages of the respondents might reveal barriers that face specific age groups, and help in accurately addressing such barriers. As mentioned above, for example, old people have different barriers in accessing health services, and young ones have different health needs. 98 per cent of the respondents stated their ages.

The age of the respondents is grouped into five categories. Though the sample was random, as mentioned above, we tried to cover different age groups as shown in Figure (2). The sample is dominated by those between 25 and 34 years old (51%), followed by those between 35 and 59 years old (23%), and the group between 18 and 24 (19%), while four percent are under 18 and two percent are seniors. Under-representation of those under 18 and senior people in the sample could be explained by restricted mobility of these categories.

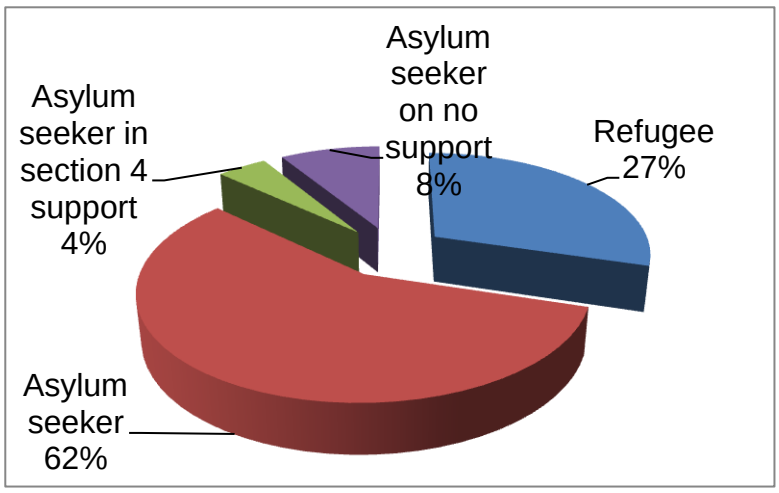
Figure (2): Respondents by Age



4.1.3 Residential Status

The residential status of the respondents varies between refugees, asylum seekers, asylum seekers in section 4 support and asylum seekers without support. The question about the residential status was added to the questionnaire after the pilot study, and as a result 48 respondents were not included. As Figure (3) shows 62% of the sample consists of asylum seekers, 27% are refugees, 8% are refused asylum seekers and destitute, and 4% are asylum seekers on section 4 support.

Figure (3): Respondents by Residential Status

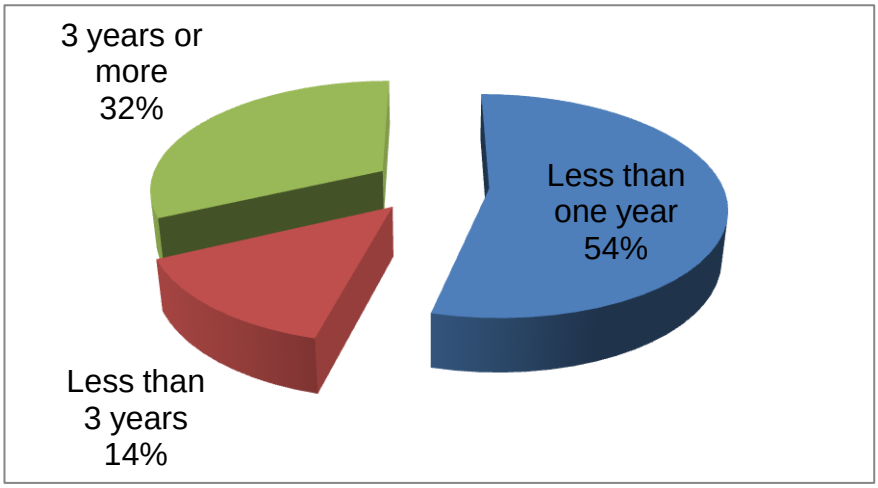


4.1 4 Length of time living in the UK

The period immigrants live in host countries is positively correlated with immigrants' integration. Therefore, we asked about the length of time each respondent has stayed in the UK. Two of the respondents did not answer this question.

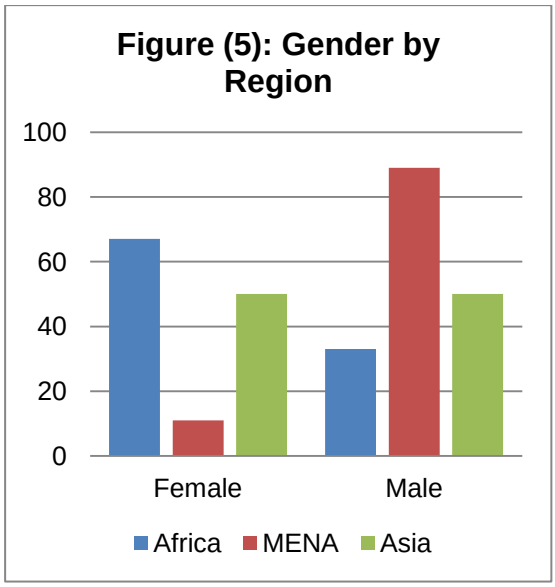
The period of time respondents lived in the UK, in this study, was divided into three categories: 'less than one year', 'less than three years', and 'three years and more'. Most of the respondents (54%) are newcomers; having lived less than a year in the UK, while fourteen percent have lived for less than three years, and the rest have been living in the UK for three years or more (Figure 4).

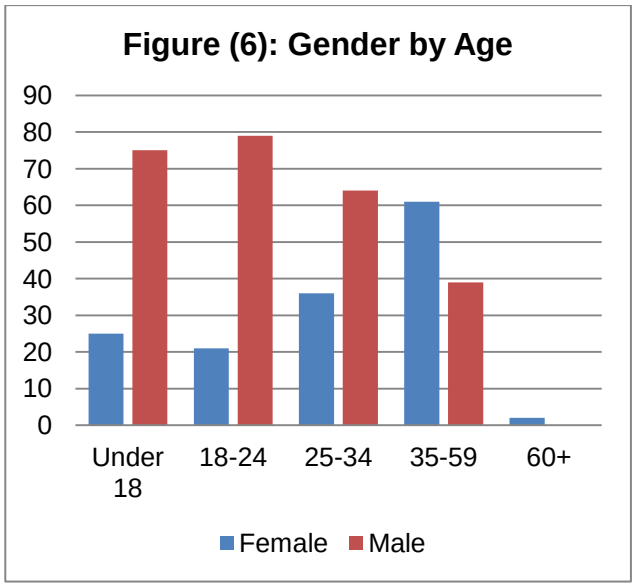
Figure (4): Respondents by length of time in UK



4.1.5 Gender

As mentioned above 40 percent of the sample are female. Gender, however, is an essential factor in the analysis; therefore we will break it down by age and cultural background. The dominant age category of both genders is between 25 and 34, followed by the older category among the females, and the younger among the males (see Figure 6). Considering the cultural background, while most of the women are from Africa, most of the male are from MENA (see Figure 5).





4.2 Food habits

Five questions were addressed to the respondents in order to assess their cooking skills, changes in their food habits and in their food intake both in quantity and quality. Additional questions were posed in order to find the reasons behind the changes (if any). In this section we analyse these questions broken down by some of the respondents' characteristics introduced in the previous section.

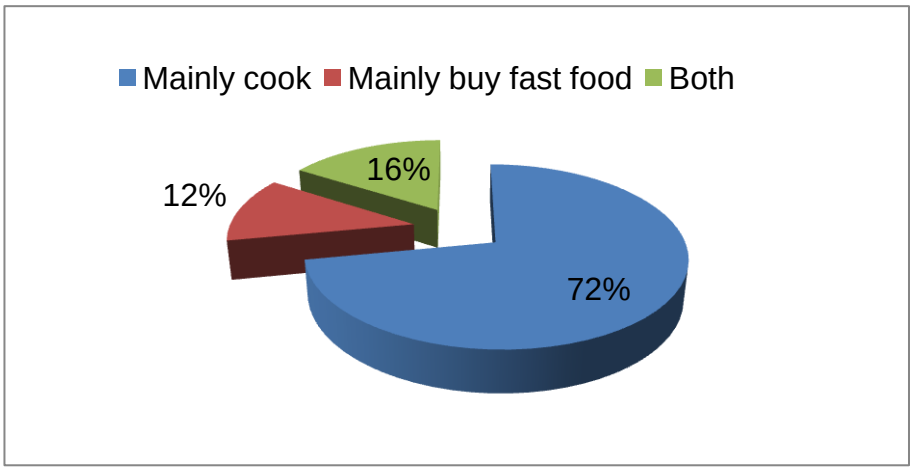
4.2.1 Cooking skills and access to nutritious food

Cooking is an essential daily activity for both genders in Northern countries, yet the situation might not be the same in the Southern countries. This skill is essential for accessing nutritious food, rather than buying fast food. Therefore, assessing newcomers' cooking skills reveals whether it is necessary to help them with developing such skills.

To assess their cooking skill respondents were asked whether they mainly cook by themselves, bought fast food or used a mixture of both methods. Twelve percent of the respondents were found to depend totally on fast food, while sixteen percent used a mixture of both (Figure 7). This indicates that around 28% of the respondents need to develop their cooking skills, or to be helped to raise awareness of the importance of healthy food. Though no direct question was posed about the need

for developing cooking skills, this result does not imply that the rest have no need to develop these skills,

Figure (7): Do you mainly cook, or buy fast food



The sample reflects the gender division of labour in the South, where mostly cooking is females' responsibility. As Figure (8) shows, 84% of females cook their own food, while only 60% of males do so.

Considering cultural background, Figure (9) shows that all south-Asians mainly cook their food, while Africans cook more than the MENA people. This could be explained by gender division of labour, where in the culture of most MENA countries cooking is a females' role. Our sample supports this argument, as table (1) shows none of the MENA women depends on fast food, while a fifth of the men do.

Figure (8): Cooking Skill by Gender

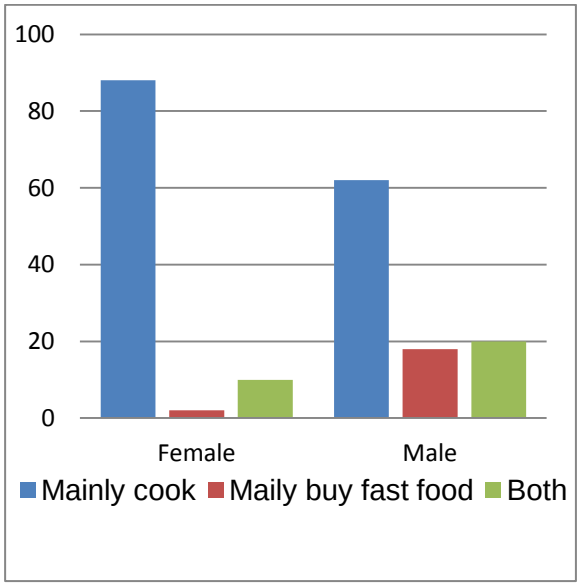


Figure (9): Cooking Skill by Region

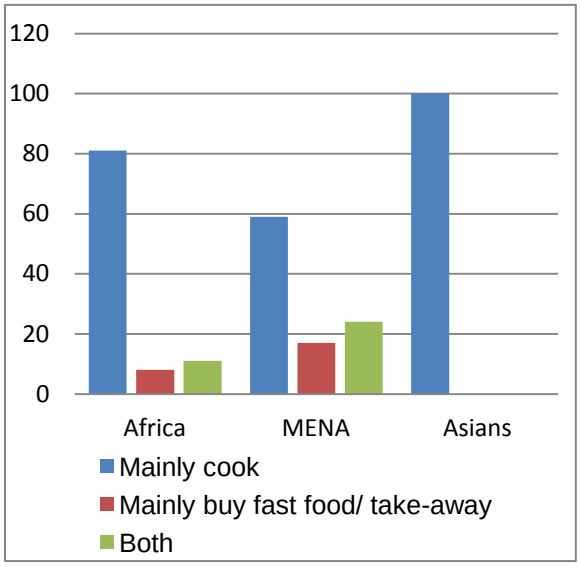


Table 1: Gender and Region in relation to Cooking Skills

Region of the respondents		Do you mainly cook or buy fast foods?			Total
		Mainly cook	Buy fast food	Both	
Africa	**Female**	88% (28)	3% (1)	9% (3)	100% (32)
	Male	69% (11)	19% (3)	12% (2)	100% (16)
	Total	81% (39)	8% (4)	11% (5)	100% (48)
MENA	**Female**	80% (4)	0% (0)	20% (1)	100% (5)
	Male	56% (23)	20% (8)	24% (10)	100% (41)
	Total	59% (27)	17% (8)	24% (11)	100% (46)
South & East Asia	**Female**	100% (3)	0% (0)	0% (0)	100% (3)
	Male	100% (3)	0% (0)	0% (0)	100% (3)
	Total	100% (6)	0% (0)	0% (0)	100% (6)

To sum up, at least 29% of the respondents need to develop their cooking skills and have their awareness of the importance of healthy food raised. The group that need this most are the men from MENA.

4.2.2 Kind of food

In the previous section around one third of the sample were shown to have poor cooking skills, which raises the question “Has this effect been due to the kind and amount of food they were used to in their home countries?” The second question addressed to the respondents was about whether they eat the same type of food they used to eat in their home country. 99 percent answered this question, and 45 percent of them gave an affirmative response. This result indicates that the majority of the respondents have experienced changes in the kind of food they were accustomed to. Considering the gender factor, we found slight difference where males (56%) were more likely to have changed their food kinds than females (53%). (See Table 2).

Considering the region, more Asians (67%) have not changed their kind of food, where the opposite is true in the case of the other groups (around 44% for each). This result indicates cultural similarity between Scottish and Asian people in term of food habits, while indicating a wider cultural distance between the host and the other two groups.

Figure (10): Do you eat the same kind of food?

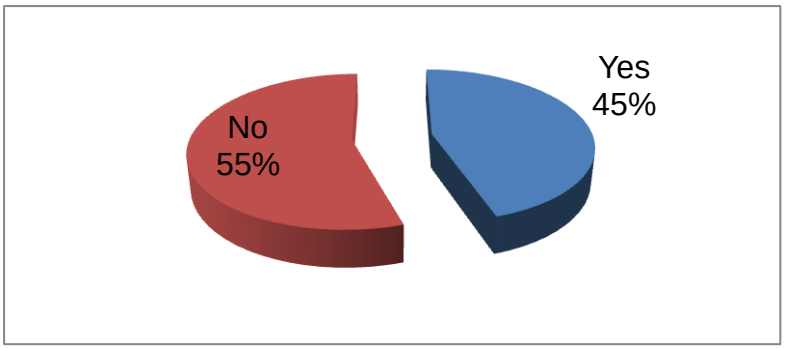


Table 2: By Gender * Do you eat the same kind of food?

	Do you eat the same kind of food		
	Yes	**No**	**Total**
Female	47.5% (19)	52.5% (21)	100.0% (40)
Male	44.1% (26)	55.9% (33)	100.0% (59)
Total	45.5% (45)	54.5% (54)	100.0% (99)

Table 3: By Region * Do you eat the same kind of food?

	Do you eat the same kind of food?		
	Yes	No	Total
Africa	43.8% (21)	56.2% (27)	100.0% (48)
MENA	44.4%(20)	55.6% (25	100.0% (45)
South & East Asia	66.7% (4)	33.3% (2)	100.0% (6)
Total	45.5% (45)	54.5% (54)	100.0% (99)

The majority of the respondents have experienced changes from the kind of food they were accustomed to; males being more adaptive to the new food than females.

Figure (11): Kind of Food by Age

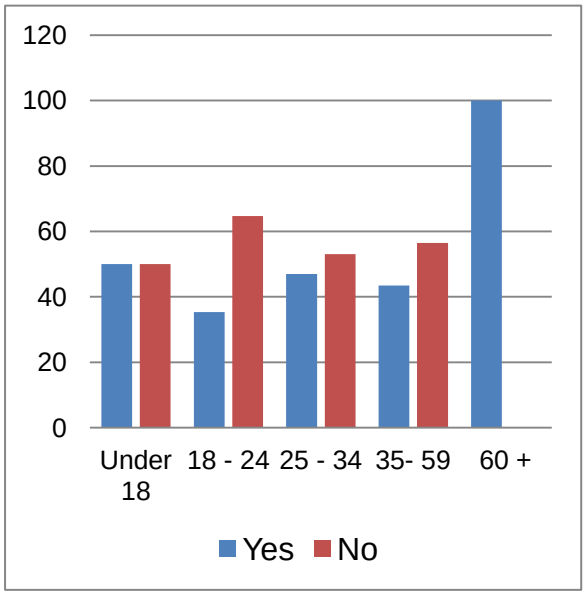
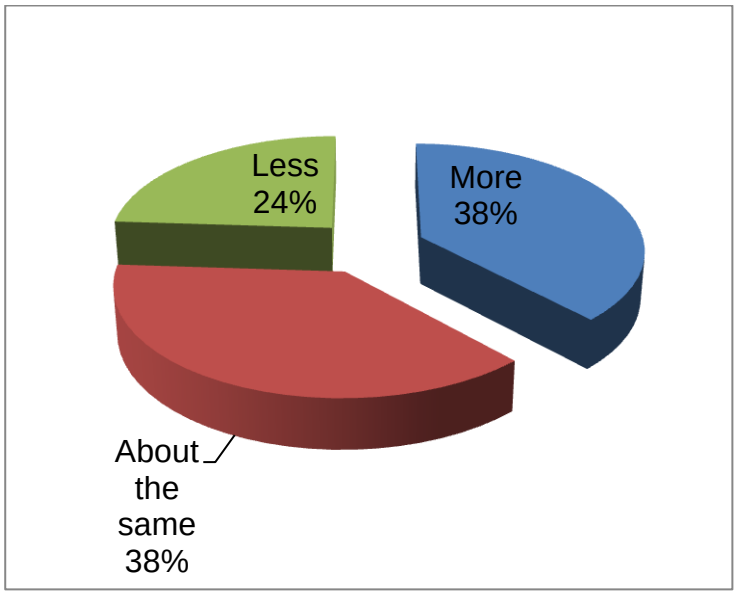


Figure (12): Amount of food eaten



Considering the age of the respondents, the group that experienced most change in the kind of food they ate were those between 18 and 24 years old. This might be explained by poor cooking skills, or easy adaptation to the new culture.

4.2.3 Do you eat the same amount of food?

Regarding the amount of food, a considerable number of the participants (41%), took almost the same amount of food, while 35 percent took less amount and 24 percent took more.

Figure (13): Amount of Food by Gender

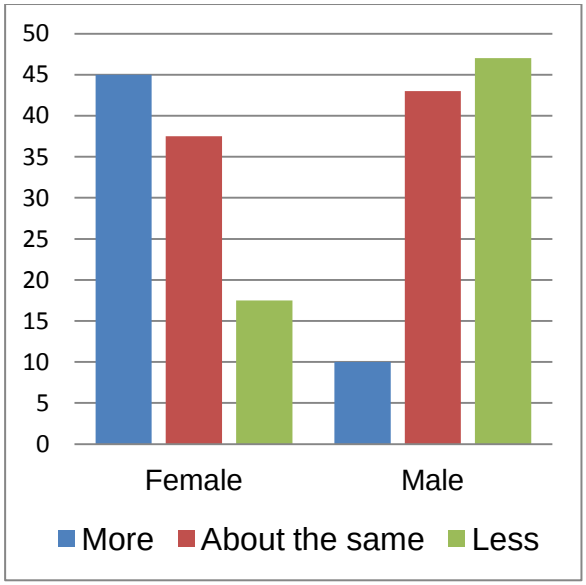
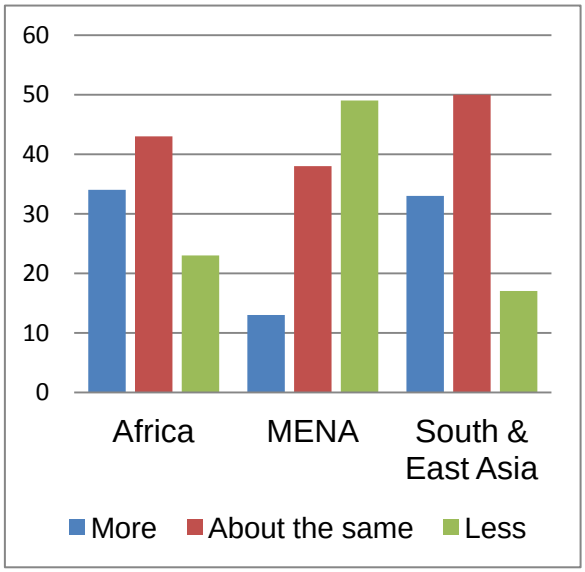


Figure (14): Amount of Food by Region



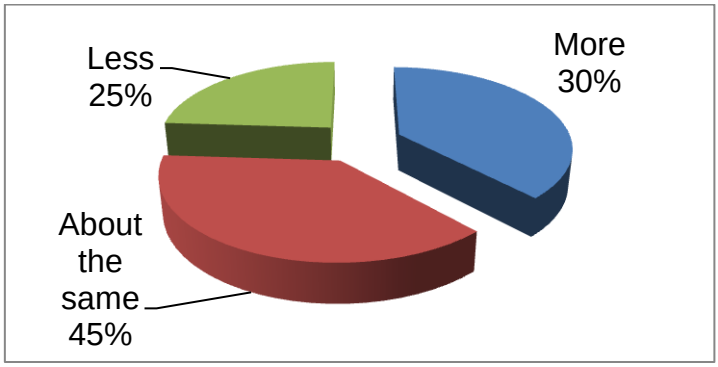
While most of the women eat more food than they used to before coming to the UK, most of the men eat less food. This difference might be related to the cooking skills mentioned above.

Most of the Africans and Asians said they eat about the same amount, while most participants from MENA countries eat less food.

4.2.4 Do you eat the same amount of fruit and vegetables?

67 respondents answered the question about fruit and vegetable consumption. 45 percent of them consume the same amount as they used to in their country of origin, 30 percent consume more, while 25 percent consume less.

Figure (15): Do you eat the same amount of fruit and vegetables?



Most of the females either consume the same amount of fruit and vegetables that they used to (50%), or more (37%); while 41 percent of the males consume the same amount, 24 percent more, and 35 percent less.

Table 4: By Gender * Do you eat the same amount of fruit and vegetables?

	Do you eat the same amount of fruit and vegetables?			
	More	About the same	Less	Total
Female	37% (11)	50% (15)	13% (4)	100% (30)
Male	24% (9)	41% (15)	35% (13)	100% (37)
Total	30% (20)	45% (30)	25% (17)	100% (67)

Table 5: Respondents' Regions * Do you eat the same amount of fruit and vegetables? Cross tabulation

	Do you eat the same amount of fruit and vegetables?			
	More	About the same	Less	Total
Africa	40.5% (15)	37.8% (14)	21.6% (8)	100.0% (37)
MENA	19.2% (5)	50.0% (13)	30.8% (8)	100.0% (26)
South & East Asia	0% (0)	75.0% (3)	25.0% (1)	100.0%(4)
Total	29.9%(20)	44.8% (30)	25.4% (17)	100.0%(67)

Considering the regions of the participants, 75 percent of Asians, and 50 percent of MENA said they consume the same amount of fruit and vegetables as before, while only 39 percent of the Africans did. None of the Asians consumed more, while 41 percent of the Africans and 19 percent of the MENA did. Respondents from MENA are dominant among those who consume less (31%), followed by the Asians (25%), and then the Africans (22%).

Numerous contradictory reasons are cited for changing habit of fruit and vegetables consumption. The most frequent cited reasons for those who consume more are: Affordable, available, cheaper, back home eat only rice or not eating it, I like it, I think it is good for health.

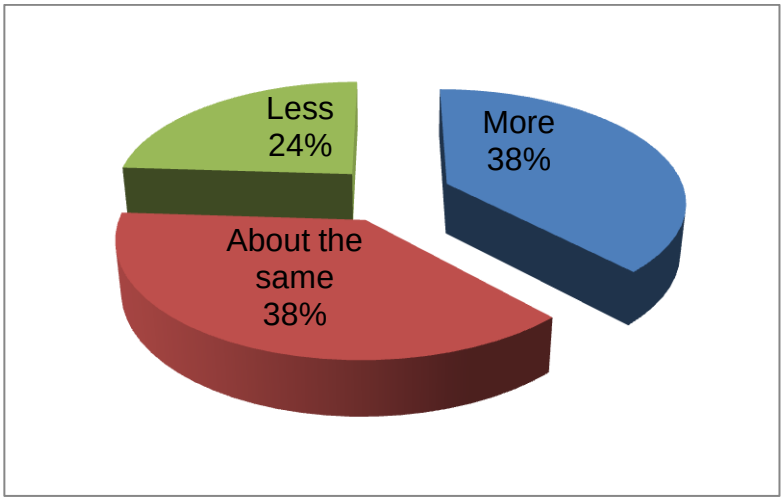
Those who consumed less fruit and vegetables than before explained it as a financial problem (affordability). Other reasons given are: Don't like it, back home I eat fresh fruit, no appetite, expensive, financial reasons, not affordable, I don't value it, not used to it.

4.2.5 Do you eat the same mixture of different foods?

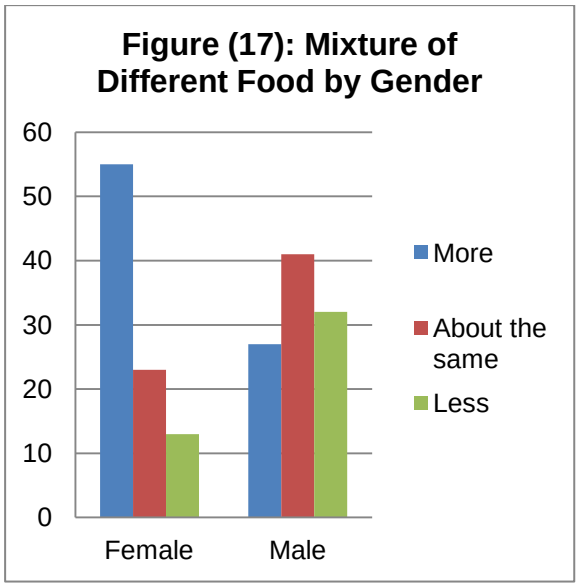
Earlier we explored whether respondents ate the same kind and amount of food, and fruit and vegetables they used to consume before moving to the UK. In this section we are going to study whether they change the mixture of fruit and vegetables they used to eat in their home countries.

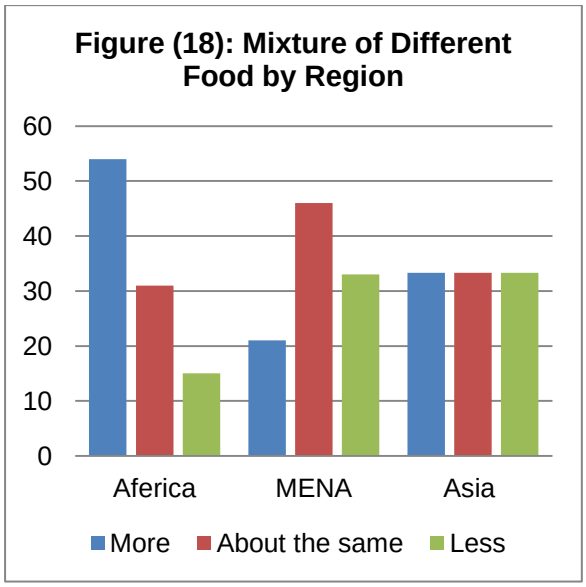
The answer to this question highlights whether people's diets had changed significantly since their arrival and whether they were accessing a diverse range of different foodstuffs. The overall result (Figure 16), shows that 24 percent of the respondents said they consume 'less mixture' of different kinds of food, while the rest of the sample divided equally between 'same' and 'more' mixture.

Figure (16): Do you eat a different mixture of foods?



As shown in Figure (17), more females (56%) said they consume 'more' mixture of different kinds of food than they were used to in their home countries, compared to males (27%). In contrast, more males (31%) said they consume 'less' mixture of food than what they were used to in their home countries compare to women (12%). This indicates that men and women have slightly different approaches to eating and health, and that female respondents demonstrated that they had more control over their eating habits than males.





Considering cultural backgrounds, as shown in Figure (18), we found that only Africans ate 'more' mixtures of different kinds of food (56%) than they used to in their home countries. While a high proportion (45%) of people from MENA ate the 'same' mixture of different kinds of food they used to in their home countries, people from Asia divided equally between the three options.

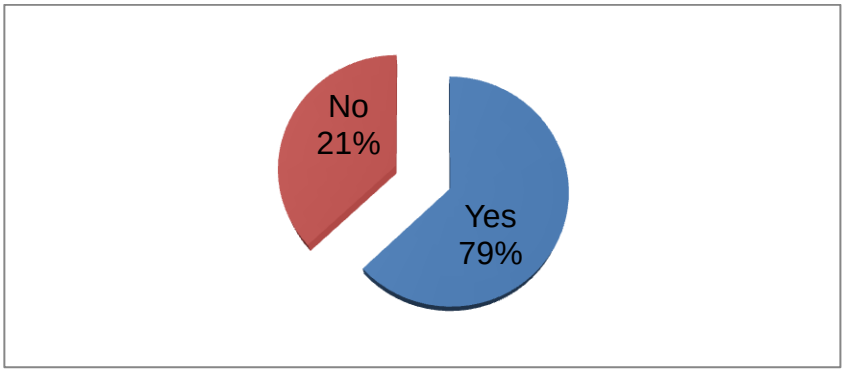
4.3 Access to health services

To assess the respondents' ability to access health services, two main questions were posed, followed by three follow up questions to find more detailed information. The main questions asked whether respondents were registered with a family doctor (General Practitioner or GP) and a dentist. Below we will explore the findings.

4.3.1 Are you registered with a doctor?

The first question was answered by all the respondents, and 21 percent of them had not registered with a GP.

Figure (19): Are you registered with a doctor?



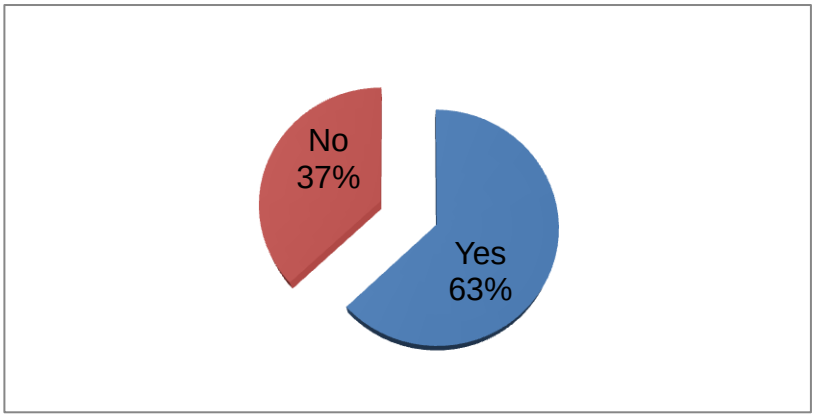
Of those who had registered at a GP, 49 percent had managed to do it in less than a month, 42 percent within three months and the rest after more than six months. The last group cited 'lack of information' as their reason for taking so long time.

Those who had not registered at a GP at the time of the interview cited different reasons, such as: 'my health is good', ' I am fit', 'I am not educated so I could not understand', 'I am still in the asylum process', 'I didn't receive any paper about it', 'I don't know where GP could be found'. These reasons could be summed up in one reason: 'lack of knowledge'.

4.3.2 Are you registered with a dentist?

98 of the respondents answered the second question: Are you registered with a dentist? As shown in Figure (20) 37 percent were not registered with a dentist at the time of the interview.

Figure (20): Are registered with a dentist?



Of those who had registered with a dentist, 39 percent took less than a month to register, 45 percent between one and three months, five percent three to six months, and three percent more than six months.

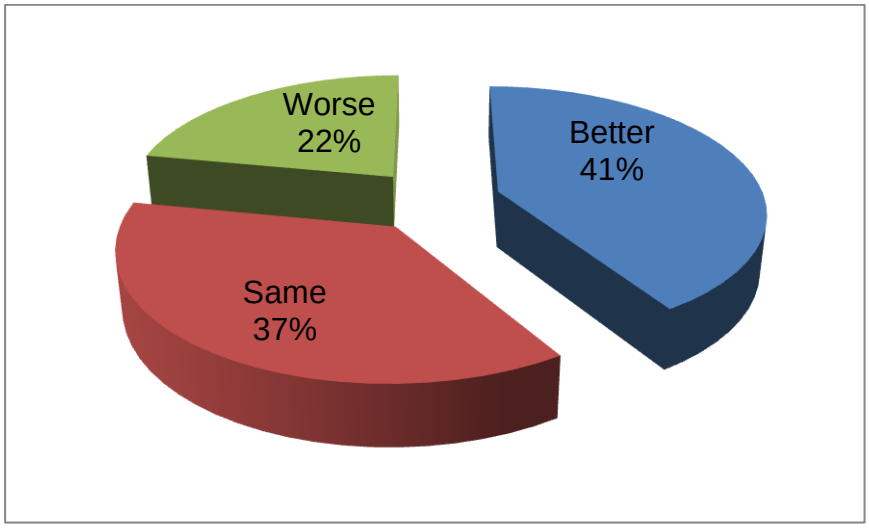
Those who took more than three months to get a dentist gave reasons such as: not needed, didn't know how, a long waiting process, shortage of time, don't like dentistry, still in the asylum process, have no problem with my teeth, I don't know how and where to go a dentist, I don't like doctors, I lost an appointment, I need very much to go to dentist, but I don't know how, waiting for GP, paper.

This study shows that lack of knowledge of the way the health system operates is the main reason for delaying registration with a GP or a dentist. Many people have come from countries where access to health services is different from the system in the UK. Despite the fact that some organisations provide written information on how to access the health services, a considerable number could not access the services at suitable times due to their lack of information / knowledge. Therefore, we argue that it would be useful either to review or to change the method by which the information is provided.

4.3.3 How has your health been since you have come to UK?

The third question addressed to the respondents concerned their subjective feelings about their health since their arrival in the UK compared to what they experienced in their home countries. 41 percent of the respondents said their health had improved since their arrival in the UK, while 22 percent felt the opposite.

Figure (21): How has your health been compared to in your country?



Two types of examples of the statements made by respondents follow:-

From respondents who felt better:

- *Back home I used to suffer from depression and had no money to pay for my treatment,*
- *Because I am very happy, and I don`t have problem of killing, punishment and capital punishment.*
- *So I feel freedom, because in the U.K I have more freedom, but in Iran I have not any freedom, and I don`t have any problem like my country in social life and political,*
- *Because I do some exercises,*
- *Because I feel safe, eating is better.*
- *The air is better and the life is more comfortable,*
- *Warm people in Glasgow, and*
- *Fewer problems, good freedom and the human equality in this country.*

From respondents who felt worse:

- *stressed about my on-going immigration case, which had taken too long, Bad weather and housing,*
- *because for being foreign and stressed,*
- *Because I miss my family and I have problem with different culture and language.*
- *Also I have problem with my case,*

- *Because still I did not get a paper so it is affecting me and affects my mental health,*
- *During my journey I was faced the more health problem then in there I have many problem with my case. So that my mental situation was changed to bad,*
- *I am very worried and I have mental problem,*
- *I have not work, and I miss my family,*
- *I find it very difficult to cope with the weather and also, No sunshine and too dark,*
- *So much stress, spending most of the time at home without doing anything that effected lot on my health, and*
- *Suffering depression because still not got papers.*

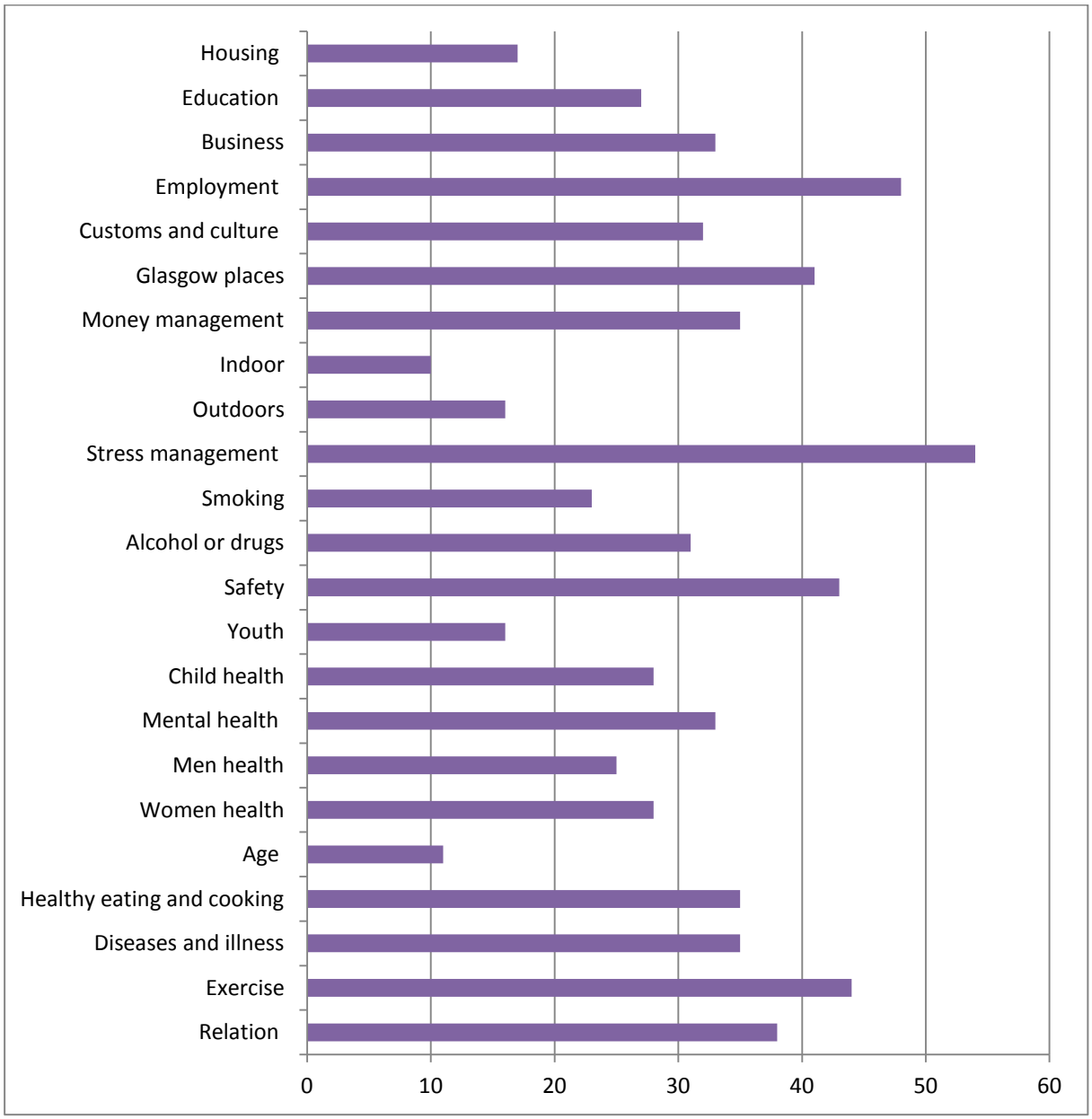
4.4 Activities

In order to assess the respondents' needs, that would improve their wellbeing in Glasgow, various training activities were listed and the respondents were asked to choose which one(s) people might be expected to attend. Each respondent could select more than one activity. Figure (22) summarises the answers.

For example, 88 percent said that people could be expected to attend workshops related to mental wellbeing (54% stress management activities and 34% mental health); this is a good indicator of the stress and mental health of the newcomers.

In addition to what the refugees and asylum seekers experienced in their home country, and the process of fleeing the situation there, they also suffer a lot during the process of establishing their lives in UK. 81 per cent would like to improve their access to the labour market (48 percent employment, and 33 percent for business establishment), 78 percent want to improve their health by doing exercises (44 per cent), and/ or by healthy eating and cooking (34 per cent) .

Figure (22): Do you think people are interested in attending workshops on..



Dedicated: Olivia volunteering, even with a broken ankle!

Chapter Five: Organisation survey results

5.1 Aims and Objectives

The main aims and objectives of this part of the research project were to:

- Ask organisations what type of support they currently provide for refugees and asylum seekers.
- Find out what organisations think new refugees and asylum seekers need in order to live healthily in Glasgow
- Find out what organisations think are the best ways of presenting information to people who do not have English as their first language.

Sample

Twenty organisations which work closely with refugees and are based in Glasgow were approached and asked to participate in the survey. It was thought they could provide additional information and insights.

5.2 Findings

Question 1.
Background Information

Please see spread sheet of organisations and the contact person there (Appendix Four).

Question 2.
What support does your organisation provide to refugees and asylum seekers?

Please see spread sheet for responses (Appendix Five).

Question 3.
Please tell me about your role in the organisation.

The roles were all individual – they are briefly summarised on the spread sheet for Question 1 (Appendix Four) and listed here for information.

- I am the Project Coordinator and am responsible for the day-to-day running of the organisation and service delivery (Unity Centre).
- I am a religious sister, I am also a local superior; I live a simple life as any poor person would live (Missionaries of Charity).
- I am manager of the Scotland Centre. I work strategically across 5 locations of the organisation. I am also a therapist and work with individuals (Freedom from Torture).
- I signpost and pass on information. I run and organise the group. I listen to people's stories, help them with any problems I can, help them build relationships and share their experiences as single mothers. I help them build their confidence and independence (Umoja).
- I am the Female Outreach Worker. I work with awareness raising over HIV testing, condom use and condom distribution. To provide information about access to information to these issues. I am involved in running workshops. I also signpost to other organisations who can help with their needs should issues like housing arise (Waverley Care).
- Provision of emotional support, advice and information on services available to asylum and refugee women (Ethnic Minorities Law Centre).
- I am one of the founding members of the organisation and ex-chair person and acting chair for around three years. Due to this I assist the current management when I am required to and contribute towards the improvement of the organisation's functions. I do also address some queries from other organisations and funders who use to contact me every now and then and signpost them accordingly (Ypeople Residents' Association).
- The Health Service: 1. knows and understands the inequalities & discrimination faced by its patients and population; 2. engages with those experiencing inequality & discrimination; 3. knows that people's experience of inequality affects the health choices they make; 4. removes obstacles to services and health information

caused by inequality; 5. uses an understanding of inequality and discrimination when devising treatment and care; 6. uses its core budget and staff resources differently to tackle inequality (NHS).

- My role is development of people and projects in Glasgow Edinburgh, Stirling, Fife, Newcastle and Inverness (Destiny Angels).
- A member of the Management Committee: at one time I was chair of the organisation (Karibu Scotland).
- I help run the drop-in and support volunteers and work with the community flat (G&CIN).
- I help run all the above activities as a volunteer support worker (Ycommunity).
- I manage housing advice and the destitution project. There are 2 teams. One provides housing advice, the other money skills advice and runs the drop-in (Positive Action in Housing).
- Office Manager (Bridges Programmes).
- I am the campaign coordinator (NCADC).
- Development worker, general manager (Unity in Community).
- Life Skill Programme Manager (British Red Cross Refugee Service).
- Women`s policy development officer (Scottish Refugee Council).

Question 4.
What field does your organisation provide support in?

See spread sheet for a tabular summary of the different fields of support (Appendix Five)

The support was mostly in providing general information (15 organisations) and training (11).

Many organisations offer general advice (9), clothing (9), employability help (8) and food (8).

Less common are organisations that offer immigration information (4), legal support (3), money (3), stress management (3) and accommodation (3).

Support was provided for cultural issues by 7 organisations and issues of violence (5), minority ethnic issues (6) and mental health support (6).

Question 5.
How do you provide that support?

Some organisations provide a drop-in service: Ycommunity, Unity Women's Project, GCIN, Karibu and Destiny Angels.

Destiny Angels also run a helpline and mobile food banks.

Freedom from Torture provides therapy, which is open-ended. Clients have to be referred.
Emotional support is also provided by Umoja and Waverley Care.

Waverley Care also direct people to relevant organisations for their needs.

Ypeople runs a weekly surgery to have first-hand knowledge of the problems and needs of the residents and liaise with the appropriate department.

Positive Action in Housing and Unity also sign post people to other organisations.

Karibu, Destiny Angels and EMLC run one to one support sessions.

Bridges Programme and NCADC provide training.

Question 6.
What do you think people need to live a healthy life?

Fifteen respondents answered this question.

Most respondents (12) stated that people need healthy food/a healthy diet in order to live a healthy life.

Five respondents replied that (a) information about healthy living was important and (b) information about exercise and sport was important.

Three respondents named housing/shelter, medical services/healthcare, community support and social activities and good mental health as important factors.

Two respondents named hope or having a meaning in life as important.

Safety and security, money, and advice about entitlements were considered necessary by one respondent.

Question 7.
What do you think refugees and asylum seekers need to know to live healthily in Glasgow?

The responses of organisations to this question can be divided into seven sections.

Section 1: Food

- Where to get cheap, healthy food
- Awareness of what is healthy and unhealthy food
- Cookery lessons/demonstrations

Section 2: Exercise

- Where to go for free/cheap exercise e.g. parks, exercise groups, football groups

Section 3: Healthcare

- How the NHS and the GP system work
- Reproductive health
- Children's health

Section 4: Mental health

- Assistance in dealing with past trauma
- Assistance in dealing with present and future uncertainty

- Orientation to work through and accept cultural and life style differences

Section 5: Financial

- Help with travel costs
- How to survive on very little money
- Budgeting advice

Section 6: Networking

- Access to community activities
- Informal support structures
- Help to integrate
- More English classes
- Information about drop-ins
- Information about women's groups

Section 7: Rights

- Knowledge of rights and entitlements regarding asylum
- Knowledge of benefits/rights to work
- How organisations are structured

Question 8.
From your experience do you have any suggestions about how health information can be shared with people whose first language is not English?

There were a variety of responses to this question, with some disagreement about the most effective approaches. All respondents except one answered this question (19 out of 20).

The most popular solutions to sharing health information with people whose first language is not English were (**a) using multi-media methods** (9 respondents) and (**b) using people-oriented events** (9 respondents).

(a) Visual and audio methods were recommended as effective ways of presenting health issues; for example, picture cards, photographs, videos, posters, documentaries.

(b) The importance of people-centred events for passing on information was also highlighted e.g. having a mixture of one-to-one sessions and group discussions, demonstrations or workshops; involving key people from the community; having a system of befriending/mentoring in the community.

Examples given were of one-to-one help with using the internet and groups for cookery classes and First Aid.

Two respondents recommended offering women-only groups: one to explore issues such as sexual and domestic violence and the other to provide an opportunity to speak to an expert e.g. a midwife about women's specific health issues.

Several respondents recommended using **interpreters** (8 respondents) although one respondent disagreed and warned that using an interpreter can 'skew the relationships and the transfer of knowledge.' However another respondent stated that 'the only way is to have translators'.

Another suggestion was **translating leaflets into different languages** (5 respondents). One respondent suggested providing information leaflets at drop-in centres used by asylum seekers and another suggestion was to provide information in packs when people first arrive from their induction.

However, two respondents did not consider this effective due to literacy issues, expense and the difficulty of keeping information up to date. It was suggested that having material available on-line would be cheaper.

Other suggestions were to make recipe books combining recipes from different countries, and to use sporting activities as a way of getting people together and sharing information.

Question 9.

Do you know any organisations or groups who could provide Healthy Living workshops for us?

There were many suggestions of suitable organisations and groups:

- Wise Women: http://www.wisewomen.org.uk/
- Sure Start: http://www.direct.gov.uk/en/Parents/Preschooldevelopmentandlearning/NurseriesPlaygroupsReceptionClasses/DG_173054

- North West Women's Centre: http://www.maryhillwomenscentreglasgow.org.uk/
- Karibu Scotland: http://www.karibuscotland.org.uk
- Lifelink: http://www.lifelink.org.uk/
- Nutritionists from the NHS
- We (Freedom from Torture) can do psycho-educational programs. We look specifically at post-traumatic symptoms. In groups people can get help and advice and it doesn't have to be personal.
- Unity Centre
- Scottish Refugee Council
- Refugee Women's Strategy Group (RWSG)
- We (Waverley) provide sexual health workshops but we focus on HIV.
- Asda Community Events: http://your.asda.com/community
- Health and Well-being centre in Kingsway; there is also a centre in a Royston.
- Govan and Craigton Integration Network developed a book which included healthy recipes from all different countries.
- NHS also had a project last year where they gave information.
- EMLC Leisure classes for women
- Ethnic Enable- befriending and Workshops: www.ethnicenable.org.uk
- Glasgow women's library-courses and workshops: http://womenslibrary.org.uk/
- Bridging the Gap: http://www.educationscotland.gov.uk/Images/Bridging_The_Gap_tcm4-552837.pdf
- Ankur -0141 248 8889 - workshops
- Food for Thought - healthy eating and cooking- not free
- Simple Pleasures - access to green space – free: http://www.snh.gov.uk/enjoying-the-outdoors/simple-pleasures/
- BTCV: Conservation volunteering http://www2.tcv.org.uk/display/btcv_scotland
- Glasgow Life -taster session for all of their services: http://www.glasgowlife.org.uk/Pages/default.aspx
- Compass- mental health awareness sessions (capacity issues): http://www.nhsggc.org.uk/content/default.asp?page=home_compass
- Health Team (Dr Anne Douglas).

- integration networks and YMCA
- Hidden Gardens , Red Cross,
- Freedom from Torture
- Work Glasgow Community Food Interactive: http://www.communityfoodandhealth.org.uk/
- Work Glasgow Healthy Living Community: http://www.healthynorthglasgow.co.uk/nghlc/work-areas

Question 10.
Do you know any asylum seekers or refugees who may have skills or information about healthy living?
Most respondents did not know anyone with appropriate skills or information about healthy living.

Other respondents suggested that the following agencies could help:

- Barnardos has a group that works with refugees over HIV
- Waverley Care
- Scottish Refugee Council (SRC)
- British Red Cross
- Refugee Women's Strategy Group (RWSG)

Question 11.
Do you have any other comments you would like to make about healthy living in Glasgow?

Comments from the organisations centred around the difficulties of accessing information:

> Life Skill Programme only works with the most vulnerable young people (30 each year) with information about healthy living: [it is] also valuable for the vast majority of young asylum seekers that we do not have capacity to support e.g. information on access to sexual /mental health services and support to access education.
>
> I do think there is a gap in information and services provided.

I think that it is worthwhile explaining this. It would be effective if the balance between what people knew and needed to have the confidence to do things themselves could be bridged. Walking, being taken to different clinics and services to show people would help. Being encouraged to role play and dialogue with other mental professionals would help. People are often too embarrassed to say if they don't understand (Umoja).

You can't force people to change but you can give them the information to help themselves. There can be great benefits to awareness raising. I would like to be invited to any workshops and events (Waverley Care).

Need to encourage/ educate asylum seekers and refuges about the benefit of physical activity to health e.g. walks, running, swimming etc.

Other comments dealt with the political aspects of support:

Many of the women we support have major difficulties accessing basic and specialist services because of their vulnerabilities and the discrimination they experience. This coupled with the stress of an ongoing asylum case creates huge barriers to women asylum seekers having healthy lifestyles (Unity).

Are you going to use any information featured from your sessions to explain to politicians how hard it is to live a healthy life when you are under the stress, both financial and emotional of going through the asylum process?

I think it is a good idea, if there is some focussed work in this area, it will have an impact on the mental health of asylum seekers. Especially for destitute people as they need advice on how they can buy and prepare food healthily on limited budget and not eat things like fish and chips all the time

Living in real poverty, sometimes with no money at all, is a big issue. As is living under threat of detention/deportation/removal.

Stress. Losing your GP when refused asylum and having to move and became homeless.

The biggest health effect for asylum seekers in Glasgow would be to give them their papers.

Sharing food after one of the Healthy Eating & Cooking Workshops
(This one delivered by Soghra from Woodlands Community Garden)

Chapter 6: Conclusions

This study is pioneering action research carried out by Living Well in Glasgow with the support of Community InfoSource. The research was a baseline study which aimed to provide information needed to develop activities for the refugees in order to improve their living standard, health and wellbeing in Glasgow. The research was designed and implemented by refugees. They used mainly quantitative and some qualitative research methods to collect the data, the bulk of which was analysed by SPSS statistical software.

Respondents were 100 refugees from Africa, Middle East and North Africa (MENA) and South and East Asia. In addition supplementary data was collected from 20 key informants from organisations that provide services to the target group. Questions addressed to the refugees were clustered into three groups: access to healthy food and change in their food intake; access to health services and change in their health status; and their subjective gap of knowledge that prevented them from having good health and wellbeing in Glasgow.

The first part of the individual surveys explored cooking skills and access to nutritious food. It became clear that almost one third of interviewees needed to improve their cooking skills and to have their awareness raised of healthy eating. The group in most need of these were males from MENA.

We also explored the extent to which people had changed the food that they ate, and if they continued to eat healthily with an appropriate intake of fruit and vegetables. Results appeared rather complex and contradictory and there were no clear trends. Where changes had taken place, sometimes this seemed to lead to improvements in diet and sometimes the opposite. Improvements were attributed to security, better standards of living and better access to health services, while those whose diet had not improved spoke of the stress they had felt during the asylum and settlement process, together with feelings of longing and loneliness. They stated that they used to eat better in their home country.

Regarding access to services, the majority of interviewees were registered with a GP and a dentist, but a significant minority were not registered and, in some cases, there had been a considerable delay in registering. The most cited reason for this was a lack of information.

There was a relatively even split between those interviewees who felt that their health had improved since coming to the UK and those whose health remained the same. In 22% of cases, their health was felt to be worse. Those who felt better attributed this to freedom from persecution and threat, to safety and a more comfortable existence. Those who felt worse highlighted the stress of getting used to a different culture and language, as well as being separated from family.

Finally, in relation to activities, it was clear that interviewees were keen to improve their employability and access to the labour market, and were also concerned to improve their health. This could be achieved by exercise and leisure activity as well as by healthy eating and cooking.

The organisations interviewed offered a wide range of support – both emotional and practical. Some offered advice sessions and had drop-in services; others had ‘helplines’. Practical support included advice on housing and employment, training mobile food banks.

All organisations stressed the importance of healthy eating, of exercise and sport, and of safety and security in helping refugees to ‘live well’. This echoes many of the findings of other studies elsewhere and which are described in Chapter Two. There was general agreement that refugees needed to know about food, exercise and sport, healthcare provision and the availability of community activities. In addition, for long-term safety and security, refugees need information on their rights and entitlements, and financial advice.

In terms of advising refugees on these matters, organisations suggested a wide range of methods, including the use of visual and audio material, for those needing support with English language, and group sessions, possibly with interpreters. These suggestions echo some of the refugee toolkits developed by outreach workers in America and Australia, and described in Chapter Two.

Recommendations

In accordance with the Scottish Government's strategy paper of 2013: "New Scots: Integrating Refugees in Scotland's Communities 2014 to 2017", we make the following 10 recommendations:

- Partnership working should be arranged to support the development of workshops on all key topics requested by refugees

- Refugees must be involved as key partners in any new workshops being developed

- Putting funding in place to provide more mental wellbeing workshops as developed by Living Well in Glasgow, these being the highest priority identified in the research. Current provision in Glasgow is extremely stretched and tends to only reach those who are in an emergency situation

- Putting funding in place to provide additional employability support

- Dissemination of good practice and audio-visual learning methods of delivering information for refugees

- Investment in development of multi media types of information provision and person centred events for refugees

- Provision of a 'Training for Trainers' specialised package to support good practice in delivering information to refugees

- Provision of information in improved and accessible formats for newly arrived asylum seekers

- Provision of orientation support for new asylum seekers to learn about Glasgow and the types and locations of services in it

- Provision of culturally sensitive and inexpensive physical activities in the city

Bibliography

Chapter One Introduction

Netto, G. (2011), 'Identity negotiation, pathways to housing and "place : the experience of refugees in Glasgow', Housing Theory and Society 28.2, pp.123-143

Mulvey, G. (2013), *In search of normality: refugee integration in Scotland,* Glasgow: Scottish Refugee Council

Chapter Two Background and literature review

Ager, A. and Strang, A. (2008), 'Understanding integration: a conceptual framework', *Journal of Refugee Studies* 21.2, pp.166-191

Barnes, D. and Almasy, N. (2005), 'Refugees' perceptions of healthy behaviors', *Journal of Immigrant Health* 7.3, pp.185-193

Bunting, R. (2009), *Asylum seeker and refugee health needs assessment,* Nottingham: NHS

Burnett, A. and Peel, M. (2001), 'Health needs of asylum seekers and refugees', *British Medical Journal* 322, pp.544-547

Cardiff Health Alliance (2011), *Cardiff health, social care and well being operational plan 2011-2014,* Cardiff: CHA

Connelly, N., Forsythe, L., Njike, G. and Rudiger, A. (2006), *Older refugees in the UK: a literature review,* London: Age Concern England and Refugee Council.

Johnson, M. (2006), 'Integration of new migrants: health' in Spencer, S. (ed.), *Refugees and other new migrants: a review of the evidence on successful approaches to integration,* Oxford: COMPAS, pp.57-72

Lewis, H. (2009), *Food, gender and 'refugee community' moments,* Unpublished paper, SOAS Food and Migration Workshop, https://www.soas.ac.uk/migrationdiaspora/seminarsevents/food_migration_abstracts/file49328.pdf

Manandhar, M., Share, M., Friel, S., Walsh, O. and hardy, F. (2006), *Food, nutrition and poverty among asylum-seekers in north-west Ireland,* Galway: Health Service Executive

McCarthy, R. and Haith-Cooper, M. (2013), 'Evaluating the impact of befriending for pregnant asylum-seeking and refugee women', *British Journal of Midwifery* 21.6, pp.404-409

Milosevic, D. (2002), *Refugee young people and mental health,* Sydney: NSW Youth Action and Policy Association

Mulvey, G. (2013), *In search of normality: refugee integration in Scotland,* Glasgow: Scottish Refugee Council

New Zealand Red Cross (2013), *The Refugee Health and Wellbeing Project: changes in knowledge, attitude and practice of participants in the health and wellbeing programme,* Wellington: NZRC

O'Donnell, C., Higgins, M., Chauhan, R. and Mullen, K. (2007), '"They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK', *BMC Health Services Research* 7.75

Palinkas, L., Pickwell, S., Brandstein, K., Clark, T., Hill, L., Moser, R. and Osman, A. (2003), 'The journey to wellness: stages of refugee health promotion and disease prevention', *Journal of Immigrant Health* 5.1, pp.19-28

Papadopoulos, I., Lees, S., Lay, M. and Gebrehiwot, A. (2004), 'Ethiopian refugees in the UK: migration, adaptation and settlement experiences and their relevance to health', *Ethncity and Health* 9.1, pp.55-73

Refugee Health Consortium (1998), *Promoting the health of refugees,* London: RHC

Rondinelli, A., Morris, M., Rodwell, T., Moser, K., Paida, P., Popper, S. and Brouwer, K. (2011), 'Under- and over-nutrition among refugees in San Diego County, California', *Journal of Immigrant Minority Health* 13, pp.161-168

Roshan, N. (2005), *Supporting new communities: a qualitative study of health needs among asylum seekers and refugee communities in north Glasgow,* Glasgow: NHS

Scottish Executive (2004), *Providing information to refugees: a good practice checklist,* Edinburgh: Scottish Executive

Scottish Refugee Council (2011), *How to access health care in Scotland,* Glasgow: SRC

Scottish Refugee Council (2013), *Health rights and entitlements of refugees and asylum seekers in Scotland,* Glasgow: SRC Health Information Briefing

Sellen, D. and Tedstone, A. (2000), 'Nutritional needs of refugee children in the UK', *Journal of the Royal Society of Medicine* 93, pp.360-364

Simich, L., Este, D. and Hamilton, H. (2010), 'Meanings of home and mental well-being among Sudanese refugees in Canada', *Ethncity and Health* 15.2, pp.199-212

Southcombe, F. (2008), *Feeding the family in an unfamiliar environment: food insecurity among recently resettled refugees,* Sydney: NSW Refugee Health Service

Szczepura, A. (2005), 'Access to health care for ethnic minority populations', *Postgraduate Medical Journal* 81, pp.141-147

Victorian Refugee Health Network (2008), *Healthy eating resource kit for community workers,* Melbourne: VRHN

Victoria State Government Department of Health (2012), *Victorian refugee health and wellbeing action plan,* Melbourne

Wasp, D. with Noel, A., Farah, I. and Habib, D. (2004), *Mapping health access for Afghan, Iranian and Somali refugees and asylum seekers in Harrow,* London: Mind in Harrow

Chapter Three: Methodology

Dumper, H. (2002), *Missed opportunities: a skills audit of refugee women in London from the teaching, nursing and medical professions,* London: Mayor of London

Mestheneos, E. (2006), 'Refugees as researchers: experiences from the project "Bridges and fences: paths to refugee integration in the EU"' in Temple, B. and Moran, R. (eds.), *Doing research with refugees: issues and guidelines,* Bristol: Policy Press, pp. 21-36

Roshan, N. (2005)), *Supporting new communities: a qualitative study of health needs among asylum seekers and refugee communities in north Glasgow,* Glasgow: NHS

Appendices

Appendix One Timeline

January 2011
Ypeople Glasgow Residents' Association (now Scottish Asylum Seekers Residents' Association [SASRA]) and Community InfoSource CIC (CIS) agree to develop the Living Well in Glasgow project

April 2011

- Formal agreement in place between YGRA and CIS
- 1st Planning Group Meeting of Living Well in Glasgow (LWiG) takes place, agree to meet monthly
- Application made to Voluntary Action Fund's European Year of the Volunteer grant for the Administration side of the project in the office

May 2011
Grant application made to Scottish Community Foundation for the Research Project

June 2011
A Volunteer Co-ordinator takes up the voluntary position and we start working towards Volunteer Friendly Accreditation

August 2011

- Grants awarded for the two projects:
    - £995 from European Year of the Volunteer grant (Voluntary Action Fund)
    - £1,966 from the Hilden Charitable Trust and RND Community Cash Fund (through Scottish Community Foundation, now Foundation Scotland)
- Volunteer Policy agreed by the Planning Group

September 2011

- Planning Group agrees recruitment information and dates for volunteers for both projects

- Advertising takes place for the volunteer positions
- Shortlisting and interviewing takes place for both projects and volunteers are recruited

October 2011

- Introductory meeting for all volunteers takes place
- Administration volunteers start working in YGRA and CIS's office
- Research volunteers start training in Ycommunity in Springburn
- Steering Group Meeting 1 takes place with advisers to the project

November 2011

- A survey is developed by the researchers and piloting starts
- Financial accounting spreadsheets are set up by the Administration volunteers

December 2011

- A corporate image starts to be developed
- The pilot survey takes in 50 respondents and the analysis starts using Survey Monkey
- A Christmas night out takes place at the CCA with food and a poetry night

January 2012

- The Survey Monkey analysis method is completed and the 50 surveys are input
- The main survey is developed and individuals start to be interviewed
- A separate survey is developed for organisations

February 2012

- The main Survey Monkey method of analysis is finalised and surveys start to be input
- Interviews start with organisations and individual surveys continue
- Volunteers have a general meeting & support & supervision meetings are arranged
- LWiG emails are functioning

- The analysis of the pilot survey is completed and a report is compiled
- Method of analysing the organisations surveys is completed
- Steering Group Meeting 2 takes place to hear about the pilot survey and progress

March and April 2012

- Interviews continue with organisations and analysis is ongoing
- Individual surveys continue and analysis is ongoing
- Logo and website developed and live

June 2012

Refugee Week event to launch the research and carry out two pilot workshops for stress management

September 2012 to January 2013

- Volunteers developed and submitted funding applications for workshops based on survey & interview information.
- Grants awarded for the two projects:
    - £1,995 from Communities 2014 grant (Big Lottery Fund) for Zumba classes
    - £9,282 from Awards for All (Big Lottery Fund) for two sets of workshops plus the launch of the research and analysis once complete.
- A new volunteer supports the project by analysing the information gathered from organisations

March to September 2013

- Planning Group agrees recruitment information and dates for volunteers for the workshop development
- Advertising takes place for the volunteer positions
- Shortlisting and interviewing takes place and volunteers are recruited
- An additional volunteer is recruited to help with the analysis of the research data from individuals
- Volunteers start to develop the format and programme for workshops, based on the research findings

- Advice is sought from professionals with experience in our fields of interest
- Agreements are reached with support organisations for delivery of parts of workshops
- Advertising takes place to access participants

October 2013 to January 2014

Pilot workshops take place to help us decide what works best in practice:

1. Mental Wellbeing – separate sessions for men and women
2. Healthy Eating & Cooking – mixed sessions in the afternoons and women only in the mornings
3. Zumba – exercise classes, women only and mixed

These workshops were all very well received and there has been great demand from participants and other professionals, that they run again.

Celebration of current volunteers takes place followed by Christmas meal. See the results: www.lwig.org.uk

February to April 2014

- Research analysis completed and report written up
- Report on Zumba workshops completed
- Launch of research prepared for May 2014
- Projects for future decided on and starting to be developed
- Fundraising applications being prepared

Volunteer fundraisers urgently required!

April 2014

Appendix Two

Letter of Introduction and Individual Survey

Research project: Healthy Living Needs of Newcomers

Who We Are
Living Well in Glasgow is a partnership between Community InfoSource and Ypeople Glasgow Residents' Association which is developing this project.

The research
Living Well in Glasgow is a **Healthy Living Pilot** project being developed to provide health and well being information for people who have come to live in Britain from a different culture.

The research is being carried out by asylum seekers and refugees who have been trained for this project and who are volunteering.

You will be asked about how you live now compared to before you came here and about what would have been helpful for you to know when you arrived.

Your Role
Without you, this research would not be possible – we need you to talk to us about the information you felt you needed to live in a healthy way when you came to stay in Glasgow.

The interviews will be completely anonymous and you do not have to answer any question if you do not wish to do so. Each interview should last about half an hour.

Thank you very much for your support and help ☺

LWiG, C/o YGRA Mailbox, 33 Petershill Drive, Glasgow G21 4QQ;
YGRA phone: 0141 557 6112; CIS phone: 0141 946 6193;
Email: lwig@communityinfosource.org.uk

Tear off here and return to researcher

I have read the information sheet and understand the reasons for the research.

I understand that any comments that I make will be kept anonymous.

Name:

Signed: Date:

Living Well in Glasgow

Living Well *connecting people, improving lives*

Introduction

Thank you for meeting me today. *Check*: are you still happy to be involved with the research?

(*Give participant LWiG sheet). Suggest they put it in a safe and/or prominent place e.g. notice board, so they can see it easily if they need to contact LWiG at anytime*).

Points to discuss with participant before they give Consent:

- What we are going to discuss today is health and food. I am going to ask you some questions about healthy living and whether you feel your health or lifestyle has changed since you came to Glasgow. Also whether you would like to receive more information about health. The reason we are asking is that we want to set up some workshops where we can provide talks and information to new arrivals about health topics.
- There are some personal questions such as about age or nationality but these are only for our records and won't be shared. You do not have to answer anything you do not wish to share.
- If there is anything you don't want to talk about just say so. This interview is about me having the opportunity to understand what life is like for you and your family at this time - you are the expert, and I hope to be following your lead in what we talk about today. If however we do stray onto a subject that you don't want to discuss now or at any other time during the research, then please don't be afraid to tell me and we can talk about something else.
- We can stop whenever you like. If you want to take a break, feel upset or unwell; please just let me know and we can finish the session.
- You will not be named in anything I write about this research, it will be anonymous.
- So that I can protect your identity I will ask for your name and contact details at the end but will only if you are interested in future events that we are planning.

Signing Consent Form

You have a sheet to give the participant, with a tear-off sheet on the end of it.

Make sure the participant is giving his / her consent to take part in the research.

Does this all sound okay? Would you like to ask me to explain anything, or do you have any questions?

Begin interview

Living Well in Glasgow Research **First stage** **No. ___**

Circle or tick the correct answer

1. Food you are eating now, compared to before in your own country:

a. Are you eating the same foods? Yes / No

b. Do you mainly cook for yourself or do you buy more fast foods or take-away?

Mainly cook; Mainly buy fast food/take-away; Both

c. Are you eating the same mixture of different foods?

More of a mixture; About the same Less of a mixture

Less - why is that?

Too expensive; Not available; Takes too long to cook; No time; No cooking skills; No appetite; Life style changes;
Other / what:

_____

More - why is that?

Less expensive; More available; Easily available; More time; More appetite; More money to buy; Life style changes;
Other / what:

_____

d. Are you eating the same amount of fruit and vegetables?

More; About the same Less

Why is that (if different)?

_____

_____

e. Are you eating the same amount of food?

More; About the same Less

Why is that (if different)?

_____

_____

2. What country are you from?

_____

3. How long since you came to UK?

Under 1 month; Less than 6 months; Less than 1 year;
Less than 3 years; 3+ years

4. How long since you came to Glasgow?

Under 1 month; Less than 6 months; Less than 1 year;
Less than 3 years; 3+ years

5. What is your status?

Refugee; asylum seeker; asylum seeker on section 4 support;
asylum seeker on no support (destitute); other _____

6. Are you registered with a doctor? Yes / No

a. Yes: how long did it take you?

Under 1 month; 1 - 3 months; 4 – 6 months; Over 6 months

If over 3 months: why did it take so long?

_____

b. No: why is that?

_____

7. Are you registered with a dentist? Yes / No

a. Yes: how long did it take you?

Under 1 month; 1 - 3 months; 4 – 6 months; Over 6 months

If over 3 months: why did it take so long?

_____

b. No: why is that

8. Since you arrived in Glasgow, how has your health been?

a. How has your health been, compared to in your country?

Better Same Worse

b. Why do you think that is (only if better or worse)?

_____

_____

9. Do you think people would be interested to attend special events or workshops on the following issue

a. Relationships	b. Women's health	c. Smoking	d. Employment
e. Activities & exercise	f. Men's health	g. Stress management	h. Business
i. Diseases & illnesses	j. Mental health	k. Outdoors	l. Education
m. Healthy eating / cooking	n. Children's health	o. Indoors	p. Housing
q. Parenting	r. Youth	s. Money management	
t. Special needs	u. Safety	v. Glasgow places	
w. 50 +	x. Alcohol or drugs	y. Customs & culture	

Other: _____

_____

10. Is there anything you would like to know about health?

_____

_____

11. What would you need to be able to attend a workshop?

a. Would you need childcare?

Childcare: how many would need it? _____

What ages of children? _____

b. What gender are you?

Female Male Other

c. Would you like separate times for men and women?

Yes / No

d. What would be the best time of day for you?

10am – 2pm; 12 noon – 4pm; 2pm to 6pm; 4pm – 8pm

e. What would be the best day of the week?

Monday; Tuesday; Wednesday; Thursday; Friday; Saturday; Sunday; Any

If Saturday or Sunday, which times?

10am – 2pm; 12 noon – 4pm; 2pm to 6pm;

f. Interpreter?

Yes / No If yes, what languages?

_____

g. In which area of Glasgow would you like workshops to be held?

_____

h. Would you have any personal difficulties or support needs to be able to attend a workshop?

Yes / No If yes, what?

_____

i. Transport expenses?

Yes / No

j. What age are you?

Under 18; 18-24; 25-34; 35-59; 60+

12. How can health information be presented to people whose first language is not English?

_____

13. Do you, or anyone you know, who is an asylum seeker or refugee have skills or information about healthy living, to share?

Could you ask them to contact us? Or tell us their name?

_____

14. How did you find this discussion?

Interesting; useful; hard to understand the questions; good

Other? _____

15. Any other comment you would like to make?

_____

16. **When the Living Well project is starting, would you like us to invite you to it?** If yes:

Name: _____
Address: _____
Phone: _____
Email: _____

17. Could we talk to you again when we have developed the plans more?

Yes / Maybe / No / Don't know

Name of researcher:
Date of interview:
Researcher comments:

Appendix Three

Letter of introduction and organisational survey

Research project: Healthy Living Needs of Newcomers

Who We Are
Living Well in Glasgow is a partnership between Community InfoSource and Ypeople Glasgow Residents' Association which is developing this project.

The research
Living Well in Glasgow is a **Healthy Living Pilot** project being developed to provide health and well being information for people who have come to live in Glasgow from a different background.

The research is being carried out by asylum seekers and refugees who have been trained for this project and who are volunteering.

Your Role
We would like you to talk to us about the information you feel refugees and asylum seekers who are new to Glasgow need to know to live in a healthy way, especially when they have come from a different climatic or cultural background. Also how you think that information should be presented.

Thank you very much for your support and help ☺

LWiG, C/o YGRA Mailbox, 33 Petershill Drive, Glasgow G21 4QQ;
YGRA phone: 0141 557 6112; CIS phone: 0141 946 6193;
Email: info@lwig.org.uk

Tear off here and return to researcher

I have read the information sheet and understand the reasons for the research.

Name:

Signed: Date:

Living Well in Glasgow

Living Well *connecting people, improving lives*

Introduction First Stage Research for Organisations

Thank you for meeting me today. *Check*: are you still happy to be involved with this research? (*Give participant LWiG details).*

Points to discuss with participant from an organisation:

- What we are going to discuss today is what you think new refugees and asylum seekers need to know to live healthily in Glasgow
- We will also ask about methods of presenting information to people who do not have English as their first language
- You do not have to answer anything you do not wish to.
- We would like to quote you in our research report. If there are certain things you say that you would rather **NOT** be quoted then please just tell me.
- Let me reassure you, if you wish we can offer you pseudo-anonymity. This is when your name is changed in any reports or publications so no one can recognise you. You can even pick the name you wish to be called in our report!

Signing Consent Form

You have a sheet to give the participant, with a tear-off sheet on the end of it.
Ask the participant to give his / her consent to take part in the research.

Does this all sound okay? Would you like to ask me to explain anything, or do you have any questions?

Begin interview

Living Well in Glasgow Research Organisation No. ___

Organisation's full name:

_____

Your name and position:

_____

Organisation's Email address:

_____

Organisation's Phone number:

_____

1. **What support does your organisation provide to refugees and asylum seekers?**

_____

_____

1a) Please tell me about your role in the organisation:

_____

_____

Circle or tick the correct answer

2. **What field does your organisation provide support in?**

a. Medical treatment
b. Information general
c. Advice general
d. Legal
e. Money
f. Food
g. Clothing
h. Training
i. Mental heath
j. Stress
k. Education
l. Employability skills
m. Accommodation
n. Immigration
o. Minority ethnic issues
p. Violence
q. Cultural

Other / what: _____

2a) How do you provide that support?

_____

_____

2b) What do you think people need to live a healthy life?

_____

_____

3. **What do you think refugees and asylum seekers need to know to live healthily in Glasgow?**

_____

_____

4. **From your experience, do you have any suggestions about how health information can be shared with people whose first language is not English?**

_____

_____

5. **Do you know any organisations or groups who could provide Healthy Living workshops for us?**

_____

_____

6. **Do you know any asylum seekers or refugees who may have skills or information about healthy living, to share?**

Could you tell us their name? Or ask them to contact us?

_____

_____

7. **Do you have any other comments you would like to make about healthy living in Glasgow?**

_____

8. **Do you wish a copy of our research findings?**

Yes ☐ No ☐

Name of researcher:
Date of interview:
Researcher comments:

Time interview took to conduct?

Appendix Four

Organisations Surveyed

Name of Organisation	Name of Contact and Position
North Glasgow Integration Network	Donald Lawrie Development Worker
Scottish Refugee Council	Nina Murray Women`s Policy Development Officer
British Red Cross Refugee Service	Megan Rothnie Life Skills Programme Manager
Unity Centre	Phill Jones Development Worker General Manager
National Coalition of Anti Deportation Campaigns	Michael Collins Campaign Coordinator
Bridges Programme	Fiona Colbron-Brown Office Manager
Positive Action in Housing	Sraboni Bhattacharya Project Manager
Ycommunity	Bechaela Walker Volunteer support worker
Govan & Craigton Information Network	Emma Zetterström Project development worker
Karibu Scotland	Twimukye Mushaka Management commitee
Destiny Angels	Susan Coupland
NHS Greater Glasgow & Clyde	Nuzhat Mirza Corporate Inequalities Practioners
Ypeople Glasgow Residents' Association	Hassan Darasi Member
Ethnic Minorities Law Centre	L. Zibi Female Support Worker
Waverley Care (African Health Project)	Margaret Lance Nat. Outreach & Developm'n tWorker
Glasgow Refugee, Asylum & Migration Network	Alan White Postgraduate Researcher/Intern
Umoja Inc	Vicky Grandon Saturday Group Organiser
Freedom From Torture Scotland	Norma McKinnon
Missionaries of Charity	Sr. H Vianita H.C Superior
The Unity Women's Project	Jane Pennington Project Coordinator

Appendix Five

Support Provided by Organisations Surveyed

Name	General Information	General Advice	Legal	Money	Food	Clothing	Training	Mental Health
North Glasgow Integration Network	Yes	Yes	-	-	Yes	Yes	Yes	Yes
Scottish Refugee Council	Yes	Yes	Yes	Yes	-	-	Yes	Yes
British Red Cross Refugee Service	Yes		Yes	Yes	-	Yes	-	-
Unity Centre	Yes	Yes	-	-	Yes	Yes	-	-
National Coalition of Anti Deportation Campaigns	Yes	Yes	-	-	-	-	Yes	-
Bridges Programmes	Yes		-	-	-	-	Yes	-
Positive action in Housing	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes
Ycommunity	Yes		-	-	Yes	Yes	(planned)	-
Govan & Craigton Information network	Yes	Yes	-	-	Yes	Yes	Yes	-
Karibu Scotland	Yes	Yes	-	-	Yes	Yes	Yes	-
Destiny Angels	Yes	-	-	-	Yes	Yes	Yes	-
NHS Greater Glasgow & Clyde	Yes	-	-	-	-	-	Yes	Yes
Ypeople Glasgow Residents' Association	-	-	-	-	-	-	-	-
Ethnic Minorities Law Centre	-	-	Yes	-	-	-	-	-
Waverley Care (African Health Project)	Yes	Yes	-	-	-	-	-	-
Glasgow Refugee, Asylum and Migration Network	Yes	-	-	-	-	-	Yes	-
Umoja Inc	-	-	-	-	-	-	-	
Freedom From Torture Scotland	-	-	-	-	-	-	-	Yes
Missionaries of Charity	-	-	-	-	Yes	Yes	-	-
The Unity Women's Project	Yes	Yes	-	-	-	-	-	Yes
Totals	**15**	**9**	**3**	**3**	**8**	**9**	**11**	**6**

Name	Stress	Education	Employ-ability	Accomm-odation	Immigration	Minority Ethnic Issues	Violence	Cultural
North Glasgow Integration Network	Yes	Yes	Yes	-	-	Yes	Yes	Yes
Scottish Refugee Council	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
British Red Cross Refugee Service	-	Yes	Yes	-	-	-	-	Yes
Unity Centre	-	-	-	-	-	-	-	-
National Coalition of Anti Deportation Campaigns	-	-	-	-	Yes	-	-	-
Bridges Programmes	-	-	Yes	-	-	-	-	-
Positive action in Housing	-	-	-	Yes	-	-	Yes	Yes
Ycommunity	-	Yes	-	-	-	-	-	-
Govan & Craigton Information network	-	-	Yes	-	-	-	-	-
Karibu Scotland	-	-	Yes	-	-	-	Yes	Yes
Destiny Angels	-	-	Yes	-	-	-	-	-
NHS Greater Glasgow & Clyde	-	-	Yes	-	-	Yes	-	Yes
Ypeople Glasgow Residents' Association	-	-	-	Yes	-	-	-	-
Ethnic Minorities Law Centre	-	-	-	-	Yes	Yes	-	-
Waverley Care (African Health Project)	-	Yes	-	-	-	-	-	-
Glasgow Refugee, Asylum and Migration Network	-	Yes	-	-	-	-	-	-
Umoja Inc	-	-	-	-	-	Yes (?)	-	Yes (?)
Freedom From Torture Scotland	-	-	-	-	-	-	-	-
Missionaries of Charity	-	-	-	-	-	-	-	-
The Unity Women's Project	Yes	-	-	-	Yes	Yes	Yes	-
Totals	**3**	**6**	**8**	**3**	**4**	**6**	**5**	**7**

Name	Other Comments
North Glasgow Integration Network	
Scottish Refugee Council	
British Red Cross Refugee Service	
Unity Centre	Volunteering opportunities
National Coalition of Anti Deportation Campaigns	Anti-deportation support
Bridges Programmes	
Positive action in Housing	
Ycommunity	
Govan & Craigton Information network	
Karibu Scotland	
Destiny Angels	Furniture
NHS Greater Glasgow & Clyde	Marginalised people
Ypeople Glasgow Residents' Association	
Ethnic Minorities Law Centre	
Waverley Care (African Health Project)	
Glasgow Refugee, Asylum and Migration Network	
Umoja Inc	None of these are really applicable
Freedom From Torture Scotland	Have a relief fund for people with problems. People are referred to us when they are in psychological treatment
Missionaries of Charity	
The Unity Women's Project	Violence against women including sexual and domestic violence, trafficking and torture

Voluntary Action Fund
Administration Volunteers

Mental Wellbeing Workshops

Healthy Eating & Cooking Workshops

Research Launch

Research funding

Communities 2014
Zumba workshops

www.lwig.org.uk

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