

# Health across borders

Recent migrants' experience of managing their health and wellbeing in the UK and the implications for health policy and practice.

4/1/2016

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## **Acknowledgements**

The project was funded by a British Academy/Leverhulme Small Grant – we wish to thank the funders for their support. Thanks also to the community researchers and to all the interviewees who participated. Without their time and thoughts this project would not have been possible.

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## **1. Introduction**

The arrival of migrants from many countries to many urban areas of the UK, combined with established minority populations, has led to the emergence of superdiversity<sup>1</sup>. Migrants come from an unprecedented variety of cultures, with hugely varied identities, faiths, languages, and immigration statuses. This heterogeneity has added complexity to existing challenges about how we identify and respond to the health needs of all members of society. We currently lack knowledge about the beliefs, experiences and health-seeking behaviours of recently arrived migrants and how these shape the ways they seek help with their health and wellbeing. Further, we know little about how individuals who have experienced other health systems bring this knowledge to bear upon their health-seeking behaviour once resident in the UK.

This study of the health histories of 23 recently arrived migrants in Birmingham and the Black Country aims to improve our understanding of how migrants perceive and manage their health and wellbeing needs. It identifies the different health resources that they use to be healthy and address health problems and the main barriers experienced when seeking to address health problems while living in the UK.

There has been limited research on migrants' access to National Health Service (NHS) care in the UK. Most studies over the past 10 years have focused in particular on the experience of asylum seekers or refugees in accessing General Practitioner (GP)<sup>2 3 4 5</sup>, mental health<sup>6 7</sup> or maternity services<sup>8 9 10</sup>. Within the West Midlands, as in other parts of the UK, difficulty in registering with a GP and access to primary health care has remained a live issue since the formal asylum seeker dispersal programme started in 2000<sup>11</sup>. With increased migration from Central and Eastern Europe post-2004, problems registering with a GP have been experienced by a wider group of migrants<sup>12</sup>.

Previous studies highlight the effect of socio-economic factors<sup>13 14</sup>, length of residence in the UK and the asylum system on individuals' health<sup>15</sup>. Some studies suggest that problems with GP registration are an important factor leading to greater use of Accident & Emergency (A&E) services by these new migrants<sup>3 16</sup>. Absence of interpreting services<sup>17</sup>, lack of knowledge of NHS services available<sup>18 19</sup>, confusion about entitlement to NHS services<sup>16</sup> and poor experiences of care<sup>20</sup> are also considered to affect migrants' health and the way they utilise the NHS.

### **1.1 Health services in England**

The NHS Constitution sets out the principles and values on which the National Health Service is based. NHS services are designed to 'improve, prevent, diagnose and treat both physical and mental health problems with equal rights'<sup>21</sup>. Central within the Constitution is the principle that access to health services is provided on the basis of clinical need and not on the ability to pay for care. This remains the case for the migrant population, although since 6 April 2015 the position has become more complex for overseas visitors and migrants wishing to come to the UK from outside of the European Economic Area (EEA): only. Those

with permanent residency (Indefinite Leave to Remain in the UK) are able to access NHS treatment without charge. Those applying to come to the UK or to extend their stay in the country who are non-EEA nationals are required to pay the immigration health surcharge<sup>22</sup>.

The immigration health surcharge, introduced under the Immigration Act (2014), is intended to reflect a contribution to possible health costs that an individual may incur during their time in this country. The changes in NHS charging regulations for overseas visitors in 2015 were also introduced to address so-called health tourism and further remove incentives for undocumented migrants to continue to remain<sup>23</sup>. Additional work has been undertaken with hospital trusts to improve identification and recording of EEA nationals who make use of accident and emergency and other secondary care services and are covered by the European Health Insurance Card scheme. Improved recording and recovery of health costs incurred by non-EEA visitors is another avenue the Government has pursued to help with the funding pressures on the NHS<sup>24</sup>.

The renewed emphasis on enforcing these regulations and the current consultation<sup>25</sup> on the extension of charges into primary care and accident and emergency services create further challenges for the principle of universalism within the NHS Constitution. These changes, and the rhetoric around migrants' use of the *National Health Service*, may cause confusion in the minds of health providers and migrants about migrants' entitlements to free UK health care, particularly in the primary care sector<sup>26</sup>. The NHS continues to face unprecedented demand for its services whilst operating in an environment of increasing financial pressure. Pressures on waiting times and demand on A&E and urgent care services have resulted in moves at a national and local level to change health-seeking behaviour of the local population. The promotion of Choose Well or Stay Well has been one attempt to encourage individuals to move away from attendance at A&E as a mechanism to be seen by a doctor in a non-urgent situation<sup>27 28</sup>.

Clinical commissioning groups (CCGs), NHS England and Local Authorities responsible for commissioning health services should take account of the particular health needs within the local populations served by these organisations. The unprecedented increase and diversity of migration since 2000 necessitates a deeper comprehension of how migration affects local health needs and how migrants' understanding, experience and expectation of health services might be significant in their interaction with these services. A number of studies in the West Midlands have sought to identify the effect of migration on health; they highlight the impact on primary care, maternity services, communicable disease and mental health, where data is available<sup>20 29 30 31 32</sup>. These studies consistently highlight the limits of available data sets with regard to understanding outcomes for migrants with particular conditions and the factors underpinning health inequalities which are evident for some migrant groups.

Reducing health inequalities for migrants should be a priority: the Health and Social Care Act (2012)<sup>33</sup> places a duty on the Secretary of State to ensure health inequalities related to access and health outcomes are reduced, and Public Health England is tasked with the reduction of health inequalities as one of its core functions. Accordingly, NHS England and CCGs are required to produce commissioning plans that set out proposals to reduce health inequalities; at a local authority level, Health and Wellbeing Boards are legally responsible

for producing a strategy that aims to improve health and wellbeing in their area. Obviously this requires an understanding of the current state of health, wellbeing and health inequalities within their local population. We suggest that this includes the role that super-diversity and migration might play in their locality.

The Marmot Review *Fair society, healthy lives* (2010)<sup>34</sup> reinforced the connection between poor health and an individual's socio-economic status and position in society. In public health, the work of Dahlgren and Whitehead<sup>35</sup> on the wider determinants of health also highlights the range of factors which come into play and can affect an individual's health outcomes. Migration is increasingly being seen as a determinant of health; Davis et al (2009) state that '*social determinants of migrant health relate to factors that influence the migration process, reasons for migrating, modes of travel, length of stay, the migrants' language skills, race and legal status.*'<sup>36</sup> The findings about the health of migrants are quite patchy, with some studies identifying a healthy migrant effect – underuse of health services by migrants because they tend to be youthful – and others greater usage<sup>37</sup>. Our study highlights different experiences and understandings of health and the challenges that migrants face in seeking to manage their health and wellbeing, and indicates some possible distinctions between migrant populations.

Work to reduce health inequalities and improve access to health care for socially excluded groups was taken forward by the National Inclusion Health Board during the period 2010–2014. One specific focus was upon asylum seekers and vulnerable migrants. Evidence on the issues faced by this group, examples of good practice and proposals to support commissioning and delivery of health services for this and the three other priority groups, were published during 2013–2014<sup>38 39</sup>. Public Health England identified the following priorities for its work in 2014/15<sup>40</sup>:

- Tackling obesity
- Reducing smoking
- Reducing harmful drinking
- Ensuring every child has the best start to life
- Reducing the risks of dementia in the 65-75 year olds
- Tackling growth in antimicrobial resilience
- Year on year reduction in TB incidence

Locally, several CCGs in Birmingham and the Black Country have set targets to improve the health and wellbeing of children and vulnerable adults, access and outcomes in primary care, mental health and maternity care provision and to prevent avoidable mortality. Delivery of these will require a greater understanding of these inequalities, their impact and the outcomes for migrants within these priority areas. Our research connects recent migrants' understanding of health and wellbeing and their experience and use of health services with the priorities of the commissioners and providers of health services. The research project aimed to elicit recent migrants' beliefs, values and experiences around health and to explore how these may be shaped by the migration journey and experiences after they settle in the UK.

## 1.2 Health and wellbeing

Before seeking to understand migrants' perceptions of health and wellbeing we outline definitions of these terms. The World Health Organisation define health as follows:

*'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* <sup>41</sup>

The Department of Health (UK) define wellbeing as follows:

*'Wellbeing is about feeling good and functioning well and comprises an individual's experience of their life; and a comparison of life circumstances with social norms and values.'* <sup>42</sup>

The Department of Health definition considers both subjective and objective measures of wellbeing. However, wellbeing is a difficult concept to define. Dodge et al. (2012) provide a detailed analysis of the concept of wellbeing, highlighting a focus on either subjective feeling or a means to describe how an individual's mood interplays with satisfaction with their life at a particular moment in time. They offer a new definition of wellbeing focusing on the balancing of the resources an individual has to draw on and the challenges they face. Wellbeing is constructed in their model as the mid-point of a see-saw which is constantly rebalancing in response to changes at either end. Wellbeing is achieved

*'when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge.'* <sup>43</sup>

Such a model may be particularly useful in considering the context of migration, identifying some of the challenges which migrants face as they manage their own health and wellbeing.

## 2. Methodology

The method adopted for this study was designed to collect narrative 'health history' data from recently arrived migrants residing across Birmingham and the Black Country; two urban areas which have experienced rapid increases in superdiversity in recent years (Phillimore 2013)<sup>44</sup>. The focus was on recent migrants, as previous work has demonstrated that newness is often a key factor in shaping the ways that migrants engage with health providers<sup>45</sup>. We sought to understand the ways that moving between differing health systems impacted on health beliefs and health-seeking behaviours. We also considered the implications which such changes in cultural contexts had for the quality of health care interactions for newly arrived migrants.

We interviewed 23 migrants who had resided in the UK for longer than one year, but less than five years, at the time of interview, reasoning that they would have had enough time to settle down and engage with health services but be sufficiently new to recall the transition between health systems experienced after arrival. We used a maximum variation sampling approach, looking for variation according to region of origin, immigration status, age, and gender. This approach was designed to elicit a range of perspectives, working on the basis that where respondents are dissimilar it would be possible to identify commonalities and differences between groups. Interviews were conducted in the respondents' preferred language by trained community researchers with the relevant language and cultural competence. Community researchers transcribed and translated the interviews and contributed to the analysis.

The interviews sought to examine participants' narratives about the role of health and wellbeing in their lives, from their memories of learning about health as children through to their lives in the UK. We examined the resources they utilised to maintain health, and to seek help when they had concerns. We focused upon the following questions:

- What health and illness histories, including beliefs, behaviour, determinants and influences impact upon health and wellbeing in superdiverse communities?
- How are experiences and understandings of these imported from countries of origin into countries of settlement?
- How does the process of migration influence such factors?
- How do processes of post-migration settlement socialisation and change impact upon health and wellbeing?
- How do ongoing and continuing transnational relationships both with country of origin and with friends and family in other countries continue to influence health behaviours?

The research team collectively conducted a thematic analysis of the translated transcripts, focusing on health beliefs, interactions with health services, fairness and justice, and the use of health resources from abroad and the UK.

The 23 participants came from 13 different countries: Cameroon (2), China (2), Democratic Republic of Congo, India (2), Iran (4), Iraq, Ivory Coast, Pakistan (2), Poland (4), Somalia, Sudan, Uganda and Zimbabwe. Eight were male and 15 were female. The most common



reason for migration to the UK was to seek asylum (Figure 1); current migration status ranged from seeking asylum to recognition as refugee or British/ EEA citizen (Figure 2). Individuals were predominantly Christian (10) or Muslim (8). Eleven of the sample indicated they had no or little English language. Appendix 1 provides further information on participants' age, year of arrival and religion.

Figure 1. Reasons for coming to the UK

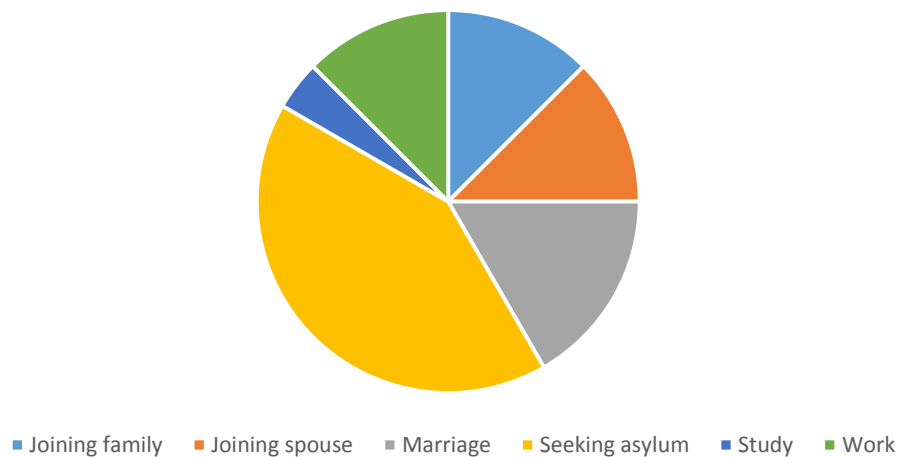
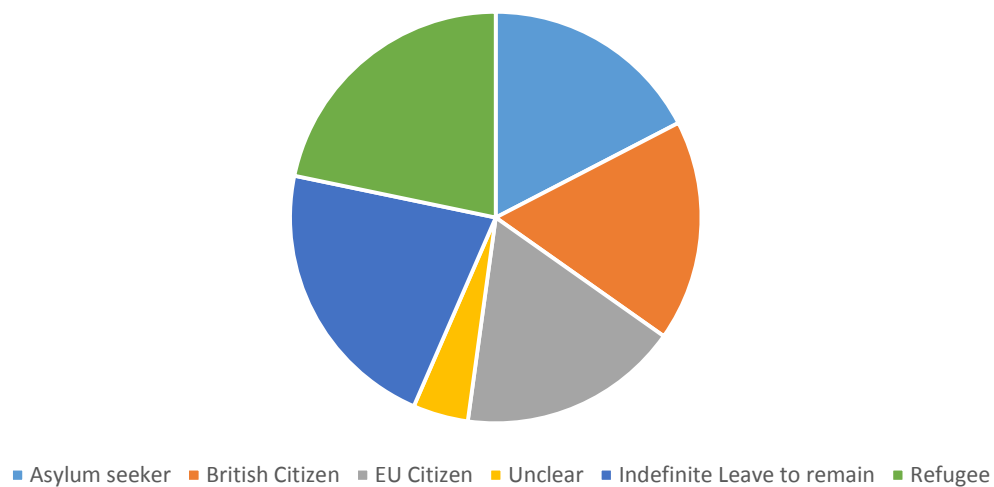


Figure 2. Current immigration status of participants



### 3. Findings

#### 3.1 Meanings of health and wellbeing

Migrants' beliefs about health and wellbeing may have an effect on their health-seeking behaviour, while their reasons for migration and their social and economic position in the UK may affect their ability to maintain 'good' standards of health and wellbeing. Beliefs about the cause of good or bad health may influence people's willingness to make use of health services in the UK.

Respondents considered health and wellbeing to be associated with individuals' perceptions about their state of health, or health linked to a good quality of life.

*When you feel good, you are strong, no pain in your body or mentally, you can say you are healthy.* (Chinese woman, aged 38)

Several migrants had little or no understanding of the term 'wellbeing'. The Chinese interviewer noted that in a Chinese context health refers exclusively to physical health with wellbeing closer to the term 'happiness'; being mentally happy included having a good quality of life and being physically healthy.

Many respondents were not familiar with the term 'wellbeing'. Individuals from Iran, Poland and Rwanda had not heard the term until they came to the UK:

*It's only recently when everyone is obsessing about their wellbeing, how unhappy people are. In the past we didn't know the word stress, not to mention wellbeing.* (Polish man, aged 36)

Some received more information on health and wellbeing after arrival. Information provided at the asylum centre was one source, for others it was college courses, particularly those linked to health and social care.

*I have to admit that my understanding of health and wellbeing has been changed over the years but it has been clearer from the time I arrived in the UK.* (Congolese woman, aged 30)

Understandings of wellbeing appeared most commonly shaped by the family, particularly mothers, and in some countries by school and the media. In some communities, religion appeared to be important in shaping health beliefs and the causes and solutions to ill-health for some, as was evident in interviews with Indians, Pakistanis, several Africans and one Polish individual.

The wider social and economic conditions which individuals grew up in also appeared to have a role in shaping understandings of health and wellbeing. Family, school and college also provided support and information about how to sustain health and wellbeing.

Respondents described wellbeing in subjective ways, talking about feeling good, mood, mental or psychological health and the quality of life experienced. Several individuals associated wellbeing with an absence of stress or illness:

*Wellbeing is more subjective, maybe more psychological, again it's about feeling good, but it's more about mood. (Polish woman, aged 36)*

*To be free from any sickness/ illness be it psychologically, physically, emotionally etc. (Somali man, aged 29)*

*Lack of peace of mind is the number one thing. If you don't have peace of mind, you'll have illness and your health will suffer a lot. (Sudanese woman, aged 29)*

### **3.2 Health and wellbeing - enablers and barriers**

A number of factors were seen as contributing to good health and wellbeing. Connections were made between poor physical health and poor wellbeing, as well as with the physical and social environment.

#### **3.2.1 Physical environment**

Respondents identified a number of environmental factors that affected health and wellbeing in their country of origin:

- Levels of air pollution (China, Iran)
- Water born infection (India)
- Climate (Pakistan, Iraq)
- Working conditions (Poland)

A Chinese woman spoke of the impact of 'poison air' in one factory where a friend worked that ultimately led to his death. Hygiene and cleanliness were seen as important factors in promoting good health. The physical environment in which respondents lived was seen as shaping their ability to exercise and access particular types of foodstuffs viewed as healthy or unhealthy.

Some respondents said they noticed that the climate had a negative effect on their health after their arrival in the UK. One individual suffered frostbite leading to infection which subsequently affected her employment prospects. Another commented,

*Since I arrived here, I have had constant headache, unable to do any exercise, and also as a result of the cold wintry weather, I would remain indoors for hours on end. It is a contrast, because I come from extremely arid, desert and hot environment to a cold and wintry weather (Sudanese woman, aged 29).*

#### **3.2.2 Social environment**

Stress and conflict in relationships within the wider community and within the home were seen to have a negative effect on health and wellbeing. After migration, stress was linked to negotiating life in the UK, with hardships around engaging with state institutions such as education and health identified as particularly problematic. Stress was also experienced in response to financial pressures. Iranian respondents highlighted how worries about social and political pressures in Iran affected individuals' health after migration, while asylum seekers spoke of stress created by waiting for a decision on their asylum claim.

The positive effect of home life on health and wellbeing was described by several individuals. The role of mothers in enhancing health and wellbeing was noted by Iranian respondents. For one Chinese respondent, a home without conflict in the parents' relationship was seen as the most important factor in maintaining good health and wellbeing:

*... family members get along with each other nicely, that is most important. My son grows up healthy and he can have good development, not too much pressure for him. Between husband and wife, [relationships] must be good, they need to be together, no arguments in front of the child* (Chinese woman, aged 25)

### **3.2.3 Factors affecting physical health**

Diet, exercise and the absence of illness and sickness or long-term health conditions were considered by the majority of respondents to promote good physical health and wellbeing. Respondents identified healthy eating as the most important contributor to good health. Specific comments about avoiding cholesterol (Polish female, aged 35), avoiding 'street food' (Indian male, aged 34), the importance of fresh fruit and vegetables (Pakistani female, aged 26) and avoiding foods with preservatives (Indian male, aged 34) were made in the interviews. One of the Polish females indicated that she had changed her diet following migration, having noticed the high levels of obesity in the UK.

The role of exercise in contributing to good health was recognised in both home country and UK contexts. Regular exercise, increased walking and sporting activity were highlighted particularly by African and Asian migrants. The physical environment in the UK, such as access to local parks, was said to positively enable physical activity. However, the lack of opportunity to exercise was noted by two individuals. Inability to keep busy and active was described by one Pakistani female as likely to lead to depression:

*In this country, it isn't as easy to exercise within the home; houses are small, and housework is completed rather quickly, and you can sit down.* (Pakistani female, aged 28)

Polish respondents saw the increase in more sedentary forms of work both in Poland and the UK as negatively affecting health:

*People didn't have that many conditions in the past; maybe it's the polluted environment, modern life also means less activities, people drive everywhere or sit in front of the TV all day. In the past everyone would be out all the time, active. Now life is more comfortable, but with so many health problems.* (Polish woman, aged 52)

One Polish individual also spoke about avoiding cigarettes, alcohol and too much coffee while an Iranian woman contrasted the prevalence of the use of alcohol and smoking in the UK population with the stress her father-in-law was under in Iran, which she considered to have caused his early death, believing that stress was more harmful than other lifestyle factors. Pakistani, Indian and Zimbabwean respondents also highlighted that lack of money restricted individuals' capacity to buy food or medication or pay for health treatment, with

knock-on effects on individual health. One Chinese respondent discussed the connection between stable employment and good health.

Two individuals identified good health as their own responsibility, stressing the importance of taking control of their own health care:

*I have to take care of my body, I'm aware I will be getting older now, and my physical health and psychological may require different actions from me. I know it's my responsibility to stay healthy and therefore, to live a longer life.* (Polish woman, aged 52)

Age and genetic propensity to health were also seen as factors affecting health; e.g. one Polish man (39) stated that *good health is something that you are born with*. However, the impact of stress and poor mental health on physical health was identified as a factor by several respondents. One individual said their psoriasis was brought on by stress; financial circumstances were also outlined as important:

*and even financial, because if your financial situation/ status is poor it will lead to poor health because you will be worried and thinking a lot, and that can affect your health.* (Zimbabwean woman, aged 60)

At the level of the health system and what it might do to improve health, participants identified:

- the provision of regular health checks (Polish woman, aged 36)
- education about health and wellbeing (Congolese man, aged 30)
- screening programmes (Polish woman, aged 30; Iraqi man, aged 37)
- vaccination programmes (Iraqi man, aged 37)

The inability to access health services, early diagnosis and good medication (either due to an underdeveloped health system or the need to pay for health care) in respondents' countries of origin, and barriers to accessing NHS services in the UK were both considered as contributing to ill-health. Only two individuals commented on viruses or communicable disease as factors leading to ill health.

### **3.2.4 Factors affecting psychological health**

Similar to physical health, many individuals connected good mental health and an absence of stress. This is variously described as a need to feel you are healthy, having a 'happy heart', peace of mind and the absence of conflict. Good psychological and mental health was identified as important by a cross-section of nationalities (Polish, Chinese, Indian, Cameroonian, Pakistani, and Iranian). Delays in accessing the UK health system were discussed by one individual as having a negative effect on their mental health. Asylum seekers noted receiving a positive decision on their asylum claim as one of the most important factors that would enable them to have good health in the UK, while anxiety caused by delays in asylum decision making was mentioned by several individuals:

*The number one thing that will lead to good health and wellbeing to me is peace of mind and grant of refugee status or indefinite leave to remain in this country. These*

*are the things that are constantly ringing in my mind and affecting my health and wellbeing. Any time I receive a letter from the Home Office or my solicitor, I always feel sick and worried that I would be deported or denied the status in this country.*  
(Sudanese woman, aged 29)

The negative perception of mental health difficulties in Poland was mentioned by Polish respondents, while one Polish individual commented on the availability of psychological support in the UK, in contrast to their home country:

*We are more aware of it, for example so many people suffer from depression nowadays, and people do talk about it more. Not long ago when Robin Williams committed suicide, people talked about it as more normal illness. There is also more awareness of PTSD, people get their traumas. Personally, I know quite a few people who go to psychologists or therapists.* (Polish woman, aged 36)

### **3.3 How individuals' experience and cultural understandings shape responses to health and wellbeing**

This section considers the experience of illness, mainly in the country of origin, and factors which were perceived as leading to good or poor health. Cultural understandings of health in the context of the home country, the role of home remedies and the impact of the migration journey on individual health are also discussed.

#### **3.3.1 Remembering illness in the country of origin**

There was some evidence that the family's perspective, especially those of parents, on health and illness determined how seriously conditions were taken and the willingness to seek medical help or use traditional remedies. The range of parental perspectives spanned a continuum between anxious parents seeking immediate medical care and blood tests for every condition, pragmatic users of a doctor if needed and reluctant users of healthcare as a last resort, where medical attention was sought only at the point of an emergency:

*My mother would always take me to the doctor, father didn't trust doctors.* (Iranian woman, aged 20)

Most of the health conditions individuals mentioned were childhood illnesses, such as measles, mumps, chicken pox, tonsillitis or common colds with one reference to the experience of poor mental health and depression brought on by relationship problems.

Consideration was given to the experience of family members' health or illness and bereavement that individuals had in their home country and how this might contribute to their health seeking behaviour in the UK. Some individuals had not experienced any health problems within their family. Several African respondents commented on how they believed the lack of accessible or affordable health care in their countries had contributed to the early death of family members. The most common issue described was the experience of dealing with cancer and the resultant death of a family member. The fear of cancer, as a result of this experience, was particularly evident in two responses.

*My grandfather had cancer. I remember this very well, I was 18; it was a horrible, horrible illness and experience for the whole family. Later on, another uncle, from my father side had cancer too, but we were not very close, I didn't visit him then, plus, they didn't really tell the rest of the family until at a very late stage. Then my mother, her sister and brother after that. They all had a different type of cancer, I asked about that because I worry a lot it's genetic. But my doctor said if it's a different type of cancer it's not genetic. I think it's quite strange so many of my family members had cancer. (Polish woman, aged 35)*

Most respondents raising this issue identified delays in diagnosis or, in the African context, the lack of local specialist health services as a contributory factor to early death.

Concerns were also raised about the perceived lack of recognition which was given to migrants' previous family history of health conditions in their experience of NHS care. One Iranian woman was particularly distressed that her GP appeared uninterested in her family history of breast cancer. Her grandmother had died of breast cancer and her mother had a mastectomy. She had been experiencing problems with her breast since arriving in the UK and felt doctors in the UK were not taking her family history into account; she wanted a referral for a mammogram but the GP had refused her request.

A number of individuals spoke of how religious beliefs had shaped views of health and illness. The Muslim individuals from India and Pakistan described health both as something that was their responsibility and as something in God's hands:

*In our religion, we are told to take care of our own health and to do what is good for our health. However, life and death is in God's hands. (Pakistani woman, aged 28)*

*Illness and good health are both from God. But even though illness and good health are in God's hands, it should not be the case that we don't look after ourselves. (Indian man, aged 34)*

*I think that illness comes from God, but sometimes you have to be careful as well. (Indian woman, aged 34)*

A view of illness as punishment from God and of prayer as a response to illness in her family was described by a Polish individual. She noted that these views are changing now as people are becoming more rational and less religious:

*I remember a story. I was too little to remember it myself, but I was told this story so many times; apparently when my cousin was just a few weeks old she had her appendix complication after operation, it was very serious, it didn't look like she was recovering and she wasn't given much chances to survive, then the whole family would give money to the church to have the whole mass to pray for her health and then she was OK. My family believed it was a miracle. This is one of those things some people in Poland would do; give money to the church to dedicate a whole mass to pray for someone, they also do that after someone died. (Polish woman, aged 35)*

Finally, the experience of bereavement in the context of war and persecution was identified by one African asylum seeker. She spoke of the murder, torture and rape of family members and friends. The impact of these experiences on the current health and wellbeing of individuals should not be under-estimated.

### **3.3.2 Cultural beliefs about health**

Understanding what lies behind beliefs about health in countries of origin may benefit GPs and other health professionals in the diagnosis and explanation of treatment options for specific conditions. It may also provide some explanation for a reluctance to seek medical care for certain conditions in some communities or expectations that some conditions should be treated in certain ways. Some respondents talked about health beliefs and behaviours that they learned in their country of birth.

Individuals from Iran, India and Pakistan all describe foods as being either 'hot or cold' and the need to have certain foods in specific situations. For example:

*in Pakistan I love to have lemon juice; it also is just very good, with a bit of salt and sugar – perfect to cool the body in hot conditions. (Pakistan woman, aged 26)*

*when you eat something that is cold and has cooling properties, then your body finds it hard to accept and as a result you may get a cough or a cold. (Indian man, aged 34)*

Mangoes, kebabs and pakoras were seen as having warming properties in Pakistan and one individual reports being discouraged from eating them in the hot season.

*I eat pakoras here (in the UK) but I don't eat them much in Pakistan due to the warming characteristics and properties of pakoras and the effect that this has in a hot climate. (Pakistani woman 26)*

The concept of light and heavy foods was mentioned by another Pakistani respondent:

*If we were ill, we would eat light food, such as chicken soup and not heavy food, such as chapattis, or curries. (Pakistani woman 28)*

### **3.3.3 Home remedies or 'traditional' medicine**

Use of home remedies, herbal medicine and herbal drinks was discussed by some respondents. Sometimes this approach was influenced by the costs of medicines – one Pakistani woman also suggested that traditional medicine was seen as a cheaper alternative to expensive doctors in her country.

Consulting traditional healers, practitioners of witchcraft or Muslim Hakims was identified as a response to illness by some African, Indian and Pakistani respondents. In the African context this was seen as one of few options available where there was a lack of clinical health services:

*First you speak to family members for advice while you are waiting for your illness to heal itself; and then go to the street shop where you describe how you are feeling and your illness, the shopkeeper will give you the advice about the tablets or*



*medicine they have that you can take for your illness. If it doesn't get any better, you go to traditional herbal doctors who can give medication from their herbs. If you don't get any better then you go to the hospital where you have to pay for treatment but also, you have to bribe the nurse or doctor so that you will be treated well. (Cameroonian man 26)*

*Sometimes people used to go to see the traditional healer or witchcraft practitioner and use the herbs or roots taken from some trees or plants for treating major illnesses or diseases. Especially, for example malaria and headache are very common illnesses, and we sometimes use herbs or roots taken from some trees or plants for treating malaria, diabetes, headache or stomach pain or diarrhoea. (Somali man, aged 29)*

The use of garlic or onion juice to fight colds in Poland was mentioned several times. Others discussed herbs and spices, such as turmeric, cardamom, ginger, tulsi, linseed, carom seeds, as well as lemon juice or lime juice as beneficial for coughs and colds. The use of herbal drinks to improve wellbeing in China, and herbal medicine 'khak-e-shir' in Iran, were described; while a Somali individual highlighted the beneficial qualities of camel meat and milk for diabetes, heart disease and hepatitis. Overall, traditional home remedies were generally used to deal with minor illnesses; however, they were sometimes used for more serious conditions where clinical services were unaffordable or inaccessible.

### **3.3.4 The impact of migrants' journey to the UK on their health**

The migration journey was only raised as a health concern for asylum seekers. Three asylum seekers described their journey to the UK as long and arduous and outlined the impacts upon their health. For example, one asylum seeker was taken to hospital in the UK on arrival and given antibiotics to combat health complications that resulted from having travelled to the UK in a freezer lorry. Another individual described a lengthy and traumatic journey, during which she was raped by traffickers, as having an ongoing effect on her physical and mental health. The experience of her journey to the UK compounded the trauma associated with events witnessed in her home country.

## **3.4 Access to Information, support and informal networks**

### **3.4.1 The role of informal friends-and-family networks**

Family were normally the primary reference point for information and advice about health matters in the home country. Mothers often acted as the first point of contact and they would decide if an individual needed to go to a doctor. One Pakistani woman indicated that normally her father's decision should be sought on when to access medical care.

Some individuals had family members who were medical professionals and were consulted when individuals were unwell. Elderly relatives were also seen as a source of advice on health (Iran, Pakistan); often this linked to more traditional remedies to illness.

*We would consult the doctor if we were very poorly. Otherwise my mum would try and manage it herself if it was just a simple cold. (Iranian woman, aged 35)*

For those migrating to join family members or for marriage, the family played a significant role in providing advice and support around health issues and accessing health services:

*About 15-20 days after I had come to this country as a migrant, my family told me to register with a GP. (Indian woman, aged 34)*

Spousal migrants tended to discuss health issues with their husbands. One Pakistani and one Indian woman indicated they would only discuss health issues with a sister or wider family. Finally, both Pakistani and two Polish individuals indicated that they still referred back to family in their home country for health advice when feeling unwell. African, Iranian, Polish and Chinese respondents reported sharing their experiences of health with friends, discussing health concerns and health and wellbeing issues or of receiving assistance to navigate the UK health system:

*We speak about this quite often with my friends in Poland, about how to exercise, and about food, how it affects our bodies, we discuss different diets. I think these days a lot of people are aware of that and there are different approaches to healthy lifestyle. But actually we never talk about mental health. (Polish woman, aged 30)*

One Iranian individual noted how friends in the UK tended to have the same issues and experiences of health services:

*Most of my friends have the same issues. When I speak with them they too have had the same issues such as the reception they get from the doctor and the difficulty in having medication prescribed (Iranian woman, aged 35).*

One individual was a trained health professional and she described how she functioned as a source of information and advice and support to individuals in her community. She provided an example of how she helped to explain to a friend the dosage regime for a prescribed medication when they went to the chemist.

### **3.4.2 The role of the internet and media**

The internet was the most commonly used source of health information, although its use was highest amongst the Iranian, Polish and Pakistani respondents. Individuals reported using internet sites in their own language to help understand health and symptoms, e.g. an Iranian website or Polish internet forums, whilst others used English health sites to self-diagnose or get information on children's health. Such information was important in helping them to manage their health in the UK or to learn about the new system.

*You get a lot of information, you learn a lot and become really informed. So yes I do that a lot. Actually I had a pain in my big toe, I did go to the GP and then he referred for some tests. But before the tests I looked it up in the internet and checked the symptoms and realised it was gout. So too much red meat had caused my uric acid to be high. So I told the GP what it was. He asked me how do you - where did you get this information and I told him. It was that in the end. (Iranian man, aged 39)*

The use of foreign language websites created expectations about the treatment a GP or hospital should offer in their country of origin, but this often contradicted what they were

offered in the UK – potentially causing respondents to believe that GPs were not offering the right treatments. Not all migrants had access or the skills to make use of the internet, while some expressed distrust in internet based information and a preference for seeing a doctor face to face.

Magazines, TV and college were identified by a small number of individuals as sources of health information. Television in Iran was described a source of health advice and information; one participant described how certain medical professionals appeared on the state TV to talk about specific medical conditions and provide their contact details at the end of programmes. This was not an option now these individuals were in the UK.

### **3.4.3 The role of community and voluntary organisations**

For some of those who came to the UK via the asylum system, the community or trusted voluntary sector organisations or health professionals were used to provide information and support access to health services. It also appeared for this group that the pool of health information and knowledge amongst friends and their wider community appeared more significant in the UK than back home. Some individuals accessed health care and information in detention or reception centres, while support workers or accommodation providers told people where and how to register with a GP:

*NASS<sup>i</sup> staff gave us information about the nearest GPs and they advised us to register with any of them who were receiving new people. (Ivorian man, aged 35)*

The beneficial role of the Refugee and Migrant Centre and Freedom from Torture was noted. The Chinese community centre also played a significant role, providing access to a wide range of information for the Chinese respondents and supported access to health information and services for those with limited English.

## **3.5 Language and interpreting**

### **3.5.1 The effect of language on access to health care**

Migrants commented on the lack of information available in languages they could understand. Thus language was a barrier to accessing health care or self-management of their health. Secondly, some found health jargon hard to comprehend. One individual made a connection between their inability to speak English and their poor experience of NHS care, with another respondent suggesting that poor quality or lack of interpreting provision was likely to result in misdiagnosis of health problems.

Understanding the way that the NHS functioned was also problematic. A Chinese woman identified the need to find someone she trusted, to speak to the doctor and arrange health appointments for her. Another illustrated the challenges non-English speakers faced in understanding and accessing health information and services:

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<sup>i</sup> NASS – The National Asylum Support Service created in 2000 – is no longer in operation. Asylum support is now delivered through the UK Visas and Immigration department of the Home Office.

*Because of my limited English I am just like a deaf person. I couldn't watch the TV because it is all in English and the only place I became aware of health and wellbeing was when I went to the community centre. (Sudanese woman, aged 29)*

Some had asked friends, family members or a community organisation to make appointments or attend the appointment with them. One Pakistani woman highlighted that although interpreting could be provided she preferred to be supported by a family member. Another individual described how a family member called NHS 111 on her behalf and explained the symptoms for her:

*I can understand English perfectly, but I can't speak it so well so I wouldn't phone them, even if a number was given. (Pakistani woman, aged 26)*

This comment highlights the important distinction between being able to understand English and the confidence needed to interact with health services. Individuals appeared to make their own decision as to when they could 'cope' without interpreting. They wanted an interpreter for serious issues but were prepared to 'get by' with limited English in routine GP appointments. Some individuals described experiences of being provided with an interpreter who did not speak their language:

*The GP had booked someone from Afghanistan unfortunately not Iranian. He didn't understand me, but I didn't want to cancel my appointment! (Iranian man, aged 39)*

### **3.6 Formal health systems at home and in the UK**

Health systems outside the UK were frequently very different from the NHS so individuals had to learn a whole new way of accessing services. Participants from Africa, China, India and Pakistan also highlighted how access to health in their country of origin varied between rural and urban settings.

Distinguishing features of other health services included:

- Heavy reliance on NGOs in Africa
- Parallel public and private systems in Iraq
- Free services for members of the armed forces and their families in Iran
- The need to pay for health insurance to access free state treatment
- Easy access to private doctors in Iran and Poland
- Lengthy waiting times when using the Polish state system
- Location of most health services in hospitals in India and China

These features differed quite extensively from those of the NHS.

The overall perception of the NHS appeared to be influenced in part by the experience and availability of health care in the country of origin, and also by a view of what the NHS should be like given that it is located in a highly developed country. Respondents from countries where health systems are under-developed, under-resourced and costly tended to view the NHS in a positive light. They commented that NHS service was better and more accessible than health care in their country of origin:

*I see life in another perspective because I have access to a GP, I can book an appointment any time I am not feeling well. There is a human right here. I have right to medication and treatment according to my illness which was not the case back home. (Congolese woman, aged 30)*

*Also, the medical facilities here are great in quality and quantity. Many hospitals, many doctors and nurses. Basically, people who are not well in every case in the UK are well looked after which is not the case in Africa. (Ivorian man, aged 35)*

In contrast, the Iranian respondents thought the NHS would be better than Iranian health care and were disappointed to find it was inferior. One individual found she could not simply telephone or turn up for an appointment; paying to have private treatment immediately was not an option. The UK NHS culture of watchful waiting was perceived as unreasonable delay:

*I went to the GP and again he has given me more painkillers. He said if you are not better then we will refer you to the hospital. These stages... I mean if you are not at death's door by the time your turn comes up you may be dead (Iranian woman, aged 30).*

There was a difference in levels of understanding about the way the NHS worked which formed a barrier to health care for some individuals. As outlined above, individuals in the asylum support system received information and support to access NHS services and reported they were told by support workers or accommodation providers to register with a GP. Other asylum seekers were able to access health care whilst in detention or initial accommodation centres. Other migrants lacked any information on the NHS, relying heavily on friends or acquaintances for advice about how to use it. Whilst some liked the GP acting as a gatekeeper for all services, others felt GPs prevented them accessing the specialists they knew they needed to see – and who they had accessed directly in their country of origin. Pharmacies were used for self-care, advice and prescriptions, with Chinese, Indian, Pakistani and Polish respondents viewing pharmacy services positively. One of the Chinese women preferred to use her pharmacy as the first point of contact because she was helped by a Chinese speaker working there.

Table 1 shows the range of UK health services migrants in this study had discussed or used by country of origin.

**Table 1 Knowledge or use of UK health services by migrants' country of origin**

UK health services individuals discussed or had used	Identified by individuals (by country of origin)
A & E / 999	DRC, Iran, Poland
Dentists	Iran, Ivory coast, Poland, Uganda
GPs	China, DRC, India, Iran, Iraq, Ivory Coast, Pakistan, Poland, Rwanda, Somalia, Sudan, Zimbabwe
Health visitors	Uganda
Home remedies/ self-care	Iran, India, Poland, Uganda

Mental health services	Poland, Sudan
Midwives	DRC
NHS 111	Pakistan, Poland
Online health resources (English and own languages websites)	Iran, Poland, Uganda
Pharmacy	Cameroon, China, India, Pakistan, Poland
Physiotherapy	DRC, Poland
Walk-in centre	India, Pakistan, Poland

## GP services

Contrary to some of the stereotypes of migrants' use of the NHS, GP services were the first point of contact for many migrants. Experiences were mixed: some celebrated being able to access a local doctor and receive treatment or appreciated GPs and practice staff who were from the same ethnic group or spoke the same first language. On the other hand, Iranian respondents often spoke of the effect of poor quality interpreting, feeling misunderstood or made to feel that they were a burden, and being given insufficient time to explain their health problem:

*I mean when you go to the doctor it is as if you are a burden. The doctors here, when I go, there are three of them. Two are from Pakistan and one from India originally. Two of them are wonderful, but one of them is so bad that when my appointment is with him I almost mourn. With their own people their interaction is great you know, but not with us (Iranian woman, aged 35).*

*His (the GP) behaviour is so bad, he blocks you in saying anything (Iranian man, aged 39)*

Some respondents expected a GP to do more regular check-ups on their health and prescribe medication more readily. Polish individuals discussed alternative routes for medication, even antibiotics, when GPs wouldn't prescribe. The problems in getting through to the GP surgery and making appointments are also highlighted by several migrants.

*It is hard to get an appointment at a GP, therefore better to use the pharmacy first scheme (Indian woman, aged 34)*

One asylum seeker, herself a nurse, highlighted the differences between her experience of health delivery in her own country and in the UK. She expected to have more of a say over her own health and the treatment options, but found that the GP made all the decisions.

Several respondents questioned the level of medical knowledge held by health professionals. The over reliance on paracetamol was interpreted as a lack of medical knowledge by GPs:

*They can't understand at all, I have killed myself (a Persian expression to indicate you have done everything you can) to ask for physiotherapy, but still have not been referred (Iranian woman, aged 35)*

Several individuals commented on the time taken to get a referral into secondary care. An Iranian stated how she felt you need to, *'big everything up until they care'*, inflating illnesses so GPs won't just advise them to take paracetamol:

*You see here in my opinion is that you really have to inflate how ill you are for them to care, if you just go and say, I have pain here from start to finish you just get paracetamol. (Iranian woman, aged 40)*

In general, migrants did not understand why GPs appeared to be slow to diagnose conditions and reluctant to prescribe antibiotics or to refer individuals through to other services e.g. mental health services:

*If you ask them to prescribe you antibiotics, they will not give it to you and say it will not be good for your health. (Somali man, aged 29)*

### **Hospital care**

The experience of hospital care appeared much more positive, with migrants highlighting high levels of care, thorough tests, well organised and hygienic services. With caring staff,

*Compassionate approaches can half make you feel better. (Indian man, aged 34)*

A Congolese woman asylum seeker was pregnant on her arrival in the UK and described a positive experience of care from a range of health professionals.

*I was helped by the nurse (in the hostel), the GP and medical staff in hospital. The nurse looked after me while I was in hospital, and she wrote me a letter in form of a report to take to my GP. I visited the GP on a regular basis to make sure the baby was doing well. The hospital staff helped when I had my baby as I had a caesarean section. I was looked after very well throughout my pregnancy, even after having my baby. (Congolese woman, aged 30)*

The only complaints were linked to waiting times, one case of misdiagnosis and another where a patient experienced poor treatment they perceived as linked to their lack of English.

## **3.7 Comparing health systems**

Respondents were asked to compare their experiences of health services and managing their health in their country of origin with their experience now in the UK.

### **3.7.1 Quality of medical care**

Views on the quality of medical care in the UK were mixed. One Pakistani female stated that GPs and doctors are much better in the UK than in Pakistan:

*My husband always says he doesn't like Pakistani doctors. He likes doctors in the UK because they check you thoroughly and it's free and not expensive. (Pakistani woman, aged 28)*

The Polish and Iranian respondents considered the level of expertise and medical knowledge in primary care to be higher in their countries. They perceived doctors in their country to be more thorough, provide quicker access and onward referrals to hospital and deliver more routine health checks for individuals than the UK health service.

*When you come here you appreciate the doctors in Iran.* (Iranian woman, aged 30)

There were also comments on the GP–patient relationship, with some respondents expressing concerns about the way they were treated by doctors.

*Most of my friends have the same issues. When I speak to them they too have had the same issues, such as the reception they get from the doctor and the difficulty in having medication prescribed.* (Iranian woman, aged 35)

### **3.7.2 Cost of services**

The cost of health care in the country of origin was not necessarily viewed as a problem. Polish and Iranian respondents associated private provision with quicker access and better treatment. For African and Asian respondents, the UK system meant that all could access health care unlike in Africa and China:

*No money, no health check.* (Chinese woman, aged 25)

*The NHS is very good because it is free.* (Indian woman, aged 34)

*I think it is the health care system in China that needs improving. In the UK, if there is anything they can do to help, they will help, first is not to talk about money, first is to treat the patient.* (Chinese woman, aged 38)

A Chinese individual commented that in some cases parents in China would not seek medical help, due to the cost, preferring to use their money to ensure their children can go to school. In Iran, where social insurance covers part of the costs of health care, a private health insurance system has also developed. Although the annual fee for these schemes is very expensive, it was seen as cost effective as the quality of service it provides was considered superior.

### **3.7.3 Access to specialist services**

Several respondents described the opportunity to access specialist care on the same day in their countries of origin without having to go via a GP in their country. There was frustration expressed by one Iranian, about the inability to be able to pay for quicker private treatment in the UK, particularly in relation to the health experience they were having with their child's health. The confusion about what services were available and how they could be accessed was noted by a Polish woman:

*To be honest I cannot really say for sure what their (GP) role is. I know they are kind of first contact doctor but that's about it. They are the first person to contact when something is wrong, but I'm not sure where to go if I want new glasses or regular gynaecological checks, or when my bones are broken or something like that, or when*



*there is something wrong with my belly, I don't know how to access the specialist. I don't know how it works here. (Polish woman, aged 36)*

Polish respondents described direct access to some services, without referral. Doctors appeared to provide all services in Poland, while the UK often utilised specialist nurses to provide health care, particularly child health e.g. baby clinics and health visitors.

Referral from a GP to specialist services also appeared to be more common in most other countries, and there was an acceptance that you would go private for quicker treatment. The contrast between health in Poland and the UK was highlighted by Polish respondents:

*Generally, people complain here about how long they need to wait for a specialist, but I think in Poland they wait too, plus very often they end up paying to go private anyway. (Polish woman, aged 25)*

*I think Poland doctors give more attention and energy when seeing patients, and I think they do more thorough, more detailed check-ups, you can often get referred to a specialist, and here (in UK) you don't. (Polish man, aged 36)*

Delays in referral to specialist care in the NHS appeared to push Polish respondents to return to Poland for treatment or to access private Polish medical services in the UK.

*Here the GP needs to refer everywhere, but in theory only, because in practice you can't get any referrals from them. That is why so many people go to Poland for treatment or to Polish private doctors here. (Polish woman, aged 52)*

### **3.7.4 Access to medication**

Real contrasts were described between prescribing and accessing medication in other countries when compared to the UK. Respondents spoke routinely of reluctance by GPs to prescribe any medication except paracetamol. On the plus side prescriptions were free, or low cost in comparison to the situation in respondents' country of origin.

African respondents were the only ones who stated medication was more widely available in the UK than their country. Greater availability of medication in the other countries did not necessarily lead to greater access. The level of payment required for medicines meant some individuals were unable to obtain them; those that could be accessed more cheaply from street traders were possibly unsafe. One Polish woman highlighted that in Poland GPs would routinely prescribe probiotics with antibiotics, especially for children.

Access to medication from abroad or from private providers appeared to be an option for some respondents:

*Luckily I can get all needed medication in the Polish shop; you can even find antibiotics there. ... All my mates go to private Polish doctors, because doctors here (NHS GPs) don't prescribe medication, just paracetamol for everything. (Polish man, aged 36)*

By utilizing these options individuals were able to enjoy similar levels of access to medication that they were used to in their home country.

*Since I came to England I am constantly ill because my body has become weak because they give me weak medicines. My body is not used to weak medicines. I constantly get medication from my family in Iran such as Amoxicillin. (Iranian woman, aged 30)*

Respondents joked that GPs prescribed paracetamol for everything. Some suggested that GPs should apply a different standard to those who are coming to the UK from countries where antibiotics are routinely prescribed. Others appeared to appreciate the benefits of a more cautious prescription of medication in the UK and an awareness that practice in the country of origin may not have been helpful long term. There were a few examples of GPs explaining why they would not prescribe medication:

*But here the doctor doesn't easily give you antibiotics. I will declare in all honesty that back home the moment I felt I had a cold I would go to the pharmacy and buy Amoxicillin and take it. Well this is totally wrong because your body becomes resistant to antibiotics and then when you really need antibiotics they won't really work, and this is my disadvantage. (Iranian man, aged 39)*

### **3.8 Managing health in the UK**

Respondents described the varying ways which they managed their health needs now in the UK. Most relied heavily on the UK health system and on home or traditional remedies. African respondents described their use of traditional herbs and foods when they could get hold of them to maintain health and wellbeing.

*Family send herbs and roots, a local wooden toothbrush, organic honey and dried camel milk and meat for wellbeing (Somali man 29)*

Polish respondents appeared to make use of GP and pharmacy provision within the NHS system, but had a much broader range of health options available to them. All the Polish women reported making use of private gynaecology services and some use of dentists, pharmacy and dermatologists in Poland. They also used home remedies for less serious health issues.

*When I think it is something serious I go to the appropriate Polish doctor. (Polish man, aged 36)*

*I access gynaecology services back in Poland. I'm confused about the NHS so would not know how to do this in the UK. (Polish woman, aged 36)*

Iranian respondents described a complex interplay of health information, advice and treatment from abroad and within the UK. This included advice from family members about home remedies, obtaining medication, ranging from traditional remedies for colds and flu to other forms of medication, including antibiotics, the use of Iranian language websites and occasional return to Iran for dental or other medical treatment.

One of the most striking examples of use of health services abroad was the use of arms-length treatment by a GP in Iran. One individual described the ease with which her relative

could make an appointment with a GP for her and then discuss her health issue over the phone:

*Yes, when my son was ill I took pictures of his face, because he had blisters all over his face and so on, they (her relative in Iran) would take them to the doctor in Iran and show him. So I treated my son through the doctor in Iran. The doctor in Iran advised me... he prescribed medicines and creams and said what to do and what not to do. (Iranian woman, aged 30)*

She took this action after taking the child to the GP and hospital in the UK and being told it was a virus and nothing could be done. She described using an Iranian health internet site to find out what to do when her son had chicken pox arguing:

*We have become doctors in our own right. (Iranian woman, aged 30)*

Respondents' management of their health was strikingly similar to the NHS 'Choose Well' model. This model encourages individuals to make use of the health service in a measured and appropriate fashion, choosing self-care for coughs and colds and A & E services for only the most serious conditions. A number of health episodes were described in the interviews and show the respondents as intelligent users of the UK (and other) health systems.

### 3.8.1 Options for managing health and wellbeing

Figures 3-5 (below) illustrate the different range of options for managing health and wellbeing discussed by respondents who were Iranian, Polish or African. While we recognise that these representations are drawn from the accounts of a small sample of respondents, they illustrate the differences between migrants, e.g. going home to access health services (Polish migrants) or enlisting the help of family (Iran).

Figure 3. Visualising health use among Polish respondents

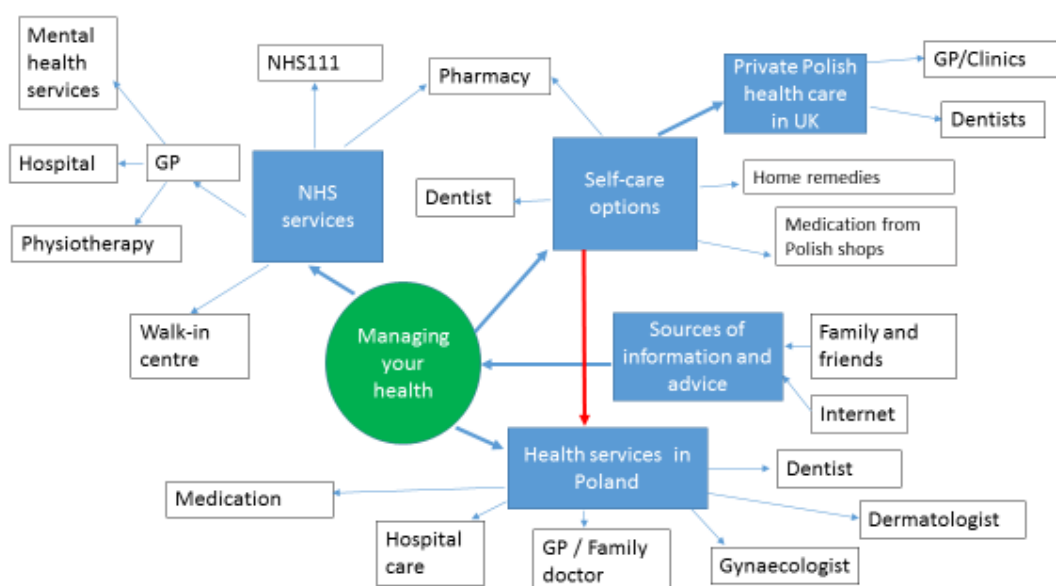


Figure 4. Visualising health use among Iranian respondents

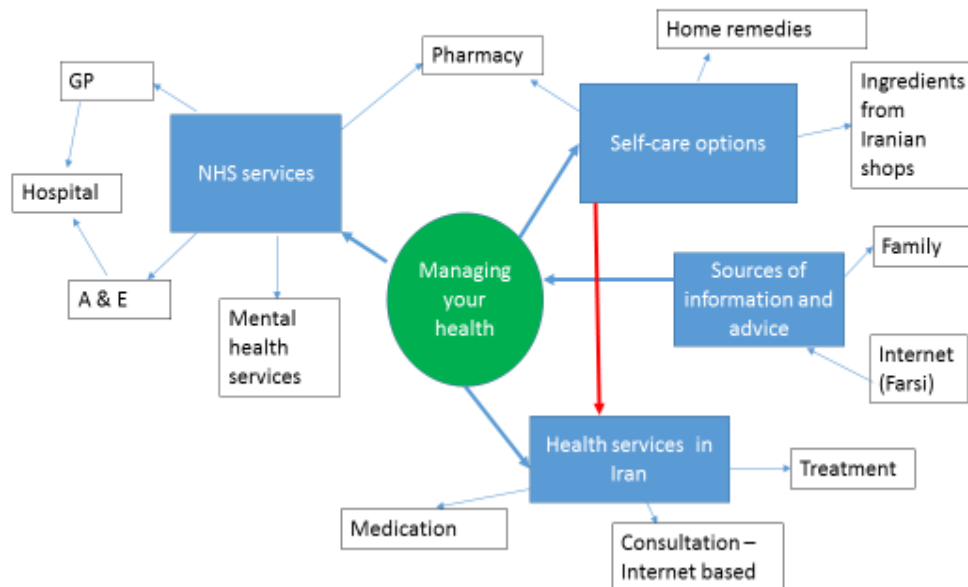
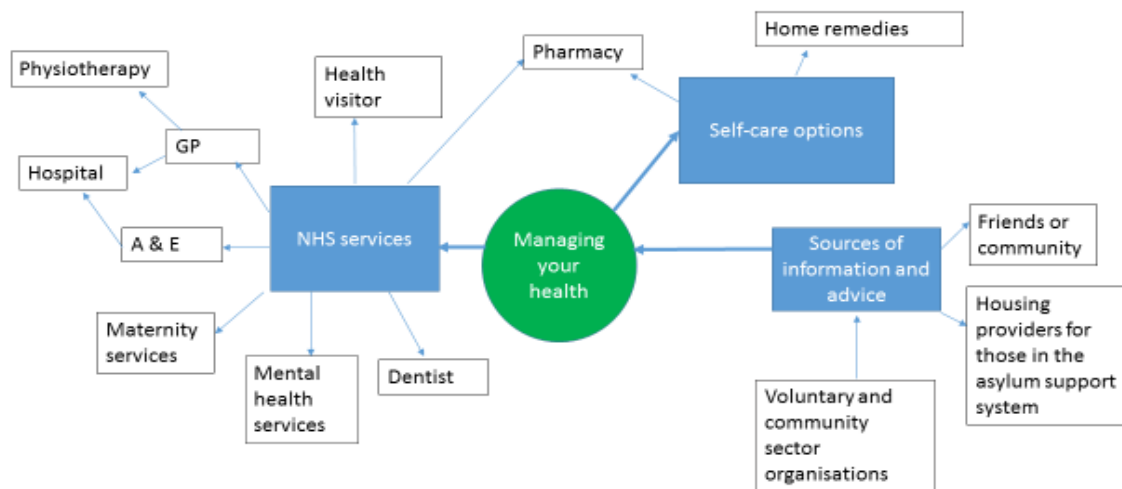


Figure 5. Visualising health use among African respondents



### 3.9 How could the UK system be improved?

Individuals were asked to comment on what or how the health system could improve in the UK. Respondents focused upon reducing waiting times and improved communication between health professionals and migrant patients.

*At least the time needed to see a doctor should be quicker, if I book for the GP today, I can see him tomorrow; that would be ideal. If it is an emergency, I will die before I can see a doctor in the UK. (Chinese woman, aged 38)*

Some individuals did not appear to understand what was happening or feel able to adequately communicate about their health conditions at times. Speaking English at a reasonable level does not necessarily mean that someone is confident in discussing a complex or sensitive health issue, nor should health professionals assume that individuals understand what they are being told. Migrants wanted to feel they have been understood. One Iranian woman expressed this in terms of feeling cared for or valued. Some suggested that doctors should have more time with patients. Those with limited English language skills would prefer test results or diagnosis to be provided in writing so they could check them after the consultation.

Finally, a number of individuals saw no need for changes in the UK system; one commented:

*I don't have much to say except thanking those who took care of me when I was pregnant and when I was in hospital. I will never have the words to express my thanks. (Congolese woman, aged 30)*

## **4. Discussion of findings**

The understanding and experience of recent migrants with regards to health and wellbeing and the management of their health in the UK has important implications for the commissioning and delivery of health services and for approaches aimed at influencing health behaviour.

The findings from this study highlight a number of central issues and suggest that the reasons for migration and the experience of health care provision in the country of origin may play an important role in determining how migrants manage their health and wellbeing. Respondents from Poland and Iran expressed higher levels of dissatisfaction with the NHS than other respondents and had higher levels of engagement with health services in their country of origin. African asylum seekers had a more limited range of health options, but accessed support to use the NHS on dispersal to the region and held a more favourable view of GP and other health services than other groups.

### **4.1 Health and wellbeing**

Our initial discussion highlighted the problems of defining and measuring wellbeing. It is apparent that the concept of wellbeing did not relate to some respondents' frame of reference. They characterised 'wellbeing' as something that you think about in the UK after your basic needs have been met, seeing it primarily as a western concept. The Chinese community researcher noted how wellbeing needed to be translated as happiness for her interviews, raising questions as to whether interviewing on this subject across different languages and cultures allows appropriate comparisons to be made. These points, as well as lower levels of English language proficiency amongst some migrants, may pose challenges to work to promote wellbeing. Several individuals considered wellbeing to be linked with both psychological and physical health. Of note in the wider discussion of health and wellbeing is migrants' identification of the physical and social factors that affected their health and wellbeing. They understood the role which the physical environment, access to support, advice and information and social circumstances in the UK could have.

Views on health and wellbeing as well as health-seeking behaviours were initially shaped by family and friends. For some, these influences continued even after migration, with individuals seeking advice, guidance and even treatment from their country of origin. This continued reliance on support 'back home' may present challenges and opportunities within some communities. Specific views on the causes of illness or treatment premised on different health systems can lead to unrealistic expectations of the NHS, while reliance on overseas systems means that many are not using the NHS, which would potentially reduce their costs.

### **4.2 Maintaining health and wellbeing**

Migrants showed clear understanding of the role of regular exercise and a good diet in achieving good health and wellbeing, with the vast majority making concerted efforts to stay healthy. The study highlights that ability to exercise may be more problematic for certain groups, with the UK climate described by some migrants as a limiting factor in terms

of their general health and ability to exercise. Some saw particular foods as having a positive, negative or restorative impact on health. Among the Iranian, Indian and Pakistani participants, this use of foods as part of the self-care management of health may be of particular interest to health professionals. The capacity to draw on traditional or home remedies using common herbs and plants was more limited for African respondents, reducing the range of health options available to them. It was not possible from the interviews to identify whether comments about the role of exercise or physical activity referred to peoples' belief or actual practice.

Good mental health and the absence of stress were frequently linked to health and wellbeing. Mental stress was seen as being associated with a range of social, economic and practical factors. Inability to realise these basic needs may have implications for individuals' health as highlighted in the social determinants of health. Respondents were often quite dependent on access to family and social networks and community or voluntary sector organisations for advice, information and support. Individuals described these resources as helping to broker access to services – without them they would have struggled because so little information was available in their own languages and no information was offered that explained how systems worked. Commissioners and providers should review delivery of health information and awareness to newer migrant communities.

In applying Dodge et al.'s (2012) model of wellbeing<sup>43</sup> to our findings one can see how many migrants are making use of family (Indian/Pakistani), voluntary sector organisations (Chinese, Sudanese), friends (Polish), the internet (Iranian), their experience of health (Pakistani) and healthcare in their country of origin (Polish, Iranian) as resources to help them address the new health challenges they face. Not all migrants arrive to an existing network; in particular, spousal migrants and asylum seekers had little social support to help them to access health services.

#### **4.3 The influence of health care in country of origin on migrants' experiences of the NHS**

Migrants' experiences of health services in their country of origin have been discussed in previous studies<sup>2 32 46</sup> as creating levels of expectation of treatment or medication which may not be realised by the NHS. Most respondents reported directly accessing secondary or specialist health services in their country, without going through a GP for a referral. Services and medication such as antibiotics were apparently much quicker and easier to access overseas<sup>2</sup>. We found that our Iranian and Polish respondents were frustrated by the differences in access to resources in the NHS.

The extent to which peoples' experience is affected by a lack of understanding of the NHS and of the role of GPs in particular is noted by several migrants and echoes findings in previous studies<sup>46 47</sup>. Lack of knowledge about the way the NHS worked was problematic for all except asylum seekers, who received some basic information on arrival in the UK. It is also apparent that this lack of information, particularly on the role of GPs, led to an unrealistic expectation of direct referrals into secondary healthcare. The lack of knowledge of NHS services was raised by some Polish individuals as the reason why they returned to Poland for health services.

Pakistani, African and Chinese individuals' experience of the NHS was generally more positive than other groups. They spoke of the effectiveness of treatment, ease of access and services that are free. The opportunity to see a GP who could refer you through to a specialist if required, was seen as a huge benefit in contrast to other systems where patients are responsible for locating and covering the costs of specialists. The benefits for Chinese, Indian and Pakistani individuals of encountering individuals working in health settings who speak their main language was perhaps also a factor that helped these individuals to have a positive experience of the NHS.

#### **4.4 Confidence in GP services**

An increasing range of services, including a number commissioned by public health departments, are now delivered via GP surgeries. Ensuring recent migrants have access and confidence in primary care is therefore essential in improving health outcomes and reducing health inequalities. Some respondents, especially Polish and Iranian individuals, and a small number of African individuals expressed low levels of confidence in GP services. Poor availability of GP appointments was a common complaint across all groups.

Lack of understanding of primary care and language barriers posed the greatest obstacles to accessing health care. There is currently no centralised source of information for migrants that explains how the system works and what the current guidelines for prescribing are. Further it appeared that some GPs lacked understanding that migrants may have experience of totally different systems and that these experiences shape expectations. This communication and understanding disconnect on both sides of primary care interactions is potentially problematic. Our respondents believed that GPs did not take their problems seriously while GPs may have found migrants' demands unreasonable.

Language created a barrier in making appointments and in the GP consultation, affecting the GP–patient relationship. Interpreting did not appear to be provided in all primary care settings, despite CCGs commissioning interpreting services for their member practices to use. Migrants in some communities were reliant on voluntary sector organisations to help access health care appointments. Bradby et al (2015) note how health services often function on the expectation that migrants have sufficient language and cultural understanding to use them appropriately<sup>48</sup>. Clearly language barriers interact with expectations and understandings to create considerable challenges in the GP–patient exchange. The extent to which such challenges can be overcome by GPs with greater experience of diversity might be explored in more detail in further research.

The need for support for clinicians around cultural competency, working with interpreters, understanding common migrant health conditions and the effect of migration status has been identified in previous studies<sup>14 49</sup>. We also argue that GPs need support to understand the different contexts from which migrants come so they can explain why UK approaches are different but appropriate. Further, as other studies have also found, GPs need more information about the impact of the asylum experience including bereavement, torture and trauma so that they can better deal with their mental health needs<sup>50</sup>.



#### 4.5 How migrants manage their health

The perception that ‘migrants’ are responsible for increased demand on A & E services was not borne out in the experiences narrated by our respondents. The study highlights a range of approaches being used by different migrants to manage their health. In some ways these narratives mirror the kinds of health use that NHS organisations are encouraging via the Choose Well and Stay Well campaigns. Migrants see the connection between diet, nutrition and exercise in maintaining their own health and wellbeing. There was clear evidence of the use of self-care and home remedies for the treatment of coughs, colds and minor illnesses.

Many respondents could be characterised as reluctant or intelligent users of the NHS. Some groups made use of a much wider range of options to manage their health as illustrated in Figures 3-5 (section 3.8.1). Generally those in the asylum process, with the exception of Iranian respondents, appeared to have the most limited options. Whether this resulted from English language competency, lack of choice about where they are living, separation from individuals from their own community, recentness of arrival or the low levels of financial support they receive, requires a more detailed study. Their greater reliance on NHS services may also be connected to the information and support from asylum support organisations which encouraged them to register with health services. What is more difficult to identify is whether the health advantage gained by support to register is mirrored by improved health outcomes.

The Polish respondents displayed greater confidence in using multiple health resources to manage their health. The ease and cost of accessing health treatment either in Poland or via private medical providers in the West Midlands may be key factors in their use of these services and has been highlighted in previous studies on the use of health care by Polish migrants<sup>46</sup>. Lack of awareness of NHS services as well as problems in getting appointments or referrals may also underpin their use of alternatives. Treatment and medication received outside the NHS have implications for the delivery of primary care and other health. Most often the NHS has no knowledge of these treatments/medications which may well affect the efficacy of treatments received within the UK. The use of the internet for self-diagnosis and explanation of medical conditions and treatment in migrants’ own language again highlights one of the ongoing challenges faced by the health service when seeking to deal with a superdiverse population: most health and service information is only available in English or languages of long established ethnic minorities.

#### 4.6 Implications for current health priorities

Throughout the study migrants discussed their experiences of a number of specific health conditions. Findings about those conditions are outlined below:

**Cancer** was routinely mentioned when migrants talked of their experiences of illness or bereavement in their home country. Much of the information on cancer, signs and symptoms and what to do is available only in English. In cases where some migrant groups are infrequent visitors to their GP and language presents a barrier to communication and diagnosis, there are risks of later diagnosis and treatment. One of the respondents was particularly concerned about the risk of breast cancer because there was a strong family

history of the disease. She did not feel the NHS was taking effective action to address her concerns. Given that many migrants receive information about the NHS from friends or family, any perception that certain conditions are not taken seriously risks a loss of confidence in NHS treatment by some new migrants. Those responsible for cancer screening services should review uptake rates across migrant populations in their area and consider whether some focused engagement with specific communities is required to improve awareness and uptake of routine screening programmes. Further work might be undertaken with the Polish community to understand their expectations in relation to gynaecology services.

**Antibiotic use** is more prevalent outside of Western Europe and North America. The availability of antibiotics described by Polish and Iranian respondents, either from sources in the UK, accessed on trips back home or via the post, offers a challenge to the target of reducing antimicrobial resistance in the UK. Migrants lacked an understanding or explanation of the watch and wait approach GPs are encouraged to adopt in the UK in relation to viruses. Some migrants perceive a need for 'strong medication', and equate this with antibiotics; the lack of prescription is also interpreted by some respondents as GPs not taking their condition seriously, further undermining confidence in GP services. Public health authorities and CCGs need to consider the impact of migration in delivery of this PHE target. Future campaigns and work on the Antibiotic Guardians project to reduce antibiotic use need to engage migrant communities. Further study on the prevalence and accessibility of antibiotics amongst other Central and Eastern European communities with large populations in the West Midlands should also be considered.

**Mental health** perceptions vary within different countries of origin, and as we have already noted, the causes and experiences of migration can adversely affect the mental health and wellbeing particularly of some asylum seekers. It is encouraging to note that one of the positive statements about health care in the UK from a Polish individual was connected with the availability of mental health care here, in contrast to Poland.

Respondents in the asylum system described asylum seekers and refugees who had experienced mental health problems but struggled to access appropriate help, reflecting findings from earlier studies<sup>14 51</sup>. Other respondents identified stress as being linked to social factors<sup>52</sup> and resulting in poor mental health and wellbeing. Routes into mental health services are not always clear; language and cultural barriers may make achieving a diagnosis more complicated. Commissioners of mental health services need to consider which migrant groups might face particular challenges in accessing appropriate services.

## 5. Recommendations

The main recommendations from our findings are set out below, with more detailed actions proposed in Appendix 3. Some of these are in process in a number of areas in the West Midlands. We hope our findings and these recommendations will add further weight to such projects and encourage a wider sharing of practice that seeks to address the management of health and wellbeing by migrants at a local and sub regional level.

1. Work to understand the effect of migration and wider determinants of health on migrants' access to health services and their health outcomes.
2. Ensure new migrants are provided with clear information on NHS services and how to access them locally.
3. Take steps to ensure greater participation of recent migrants in patient and public engagement work.
4. Address migrants' confidence in primary care by explaining how the service works, with particular focus on Polish individuals.
5. Recognise that some migrants return home for treatment or medication and take this into account when treating new migrants.
6. Make interpreting services accessible for those who need them in health services.
7. Review the accessibility of health and wellbeing initiatives to migrants, especially those who have limited English language skills.
8. Review the provision of training and guidance for GPs and other health professionals on migration, migrant health issues and cultural competency.
9. Ensure asylum seekers are able to register with a GP on dispersal.
10. Review current uptake of cancer screening services by migrant communities and take action to improve awareness and uptake in underrepresented groups.
11. Develop actions to address reliance on antibiotics and their continued use by some migrant communities as part of the work to reduce antimicrobial resistance in the UK.
12. Improve understandings of mental health and awareness of mental health services in new migrant communities.

## 6. Conclusion

The study identified the ways in which recent migrants perceive and experience health and wellbeing and manage their health, collecting narratives on health from people's lives in their countries of origin to the current time. The evidence from this study indicates that language, reason for migration and experiences of health service delivery in the country of origin can play an important role in migrants' management of their health and wellbeing in the UK and can influence their experience and expectations of the NHS.

How successfully respondents could manage their health and wellbeing and make intelligent use of the NHS occurs depended on differing levels of resource available to them, depending on their reasons for migration or country of origin. Problems accessing health services and the perceived reluctance of GPs to prescribe medication, particularly antibiotics, emerged as factors which influence migrants' perceptions of UK health services and may encourage transnational use of health care.

Although reasons for migration were very different, Polish and Iranian individuals held comparable views of NHS provision and made use of alternative health services in the UK and their country of origin. The level and effect of such pluralism in these and other migrant communities needs to be understood as does its impact on immunisation rates, the uptake of cancer screening, access to primary care, and children and women's health. Migration is experienced differently across the West Midlands; however, the reduction of health inequalities and the delivery of current priorities in the health sector can only be achieved by ensuring a more detailed understanding of the health expectations and experiences of new migrants. This study highlights the need for more detailed evidence on the experience and health outcomes for differing migrant groups to inform Joint Strategic Needs Assessments and service reviews.

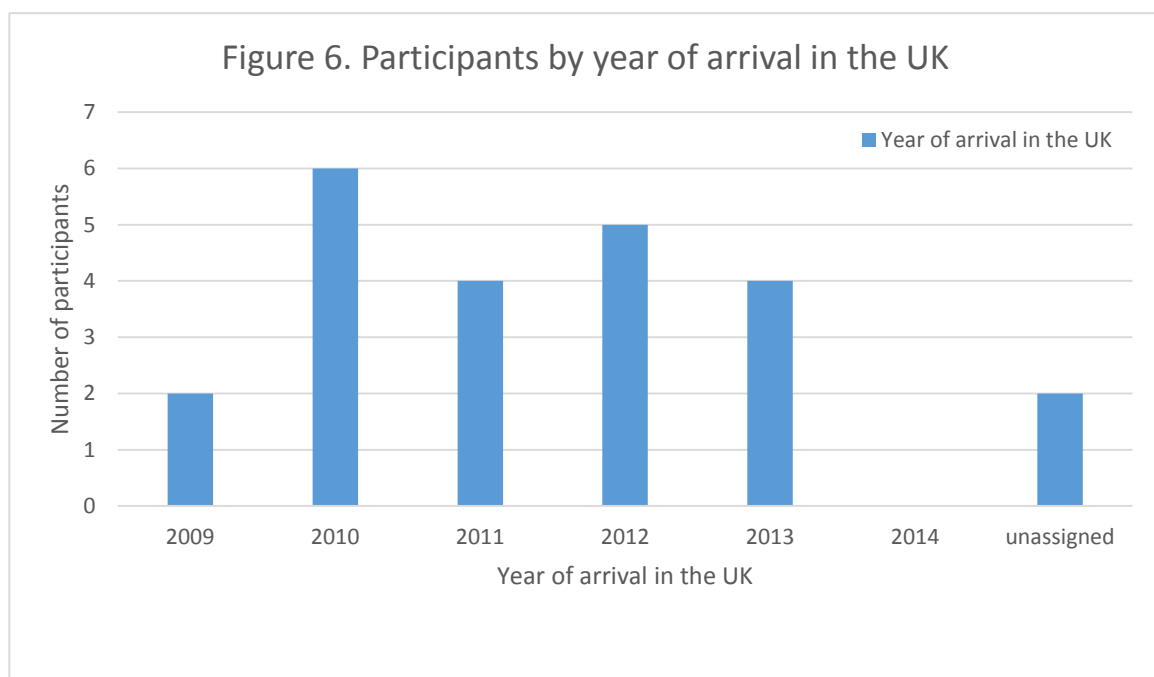
## Appendix 1 – Information on participants by age, gender, religion and length of time in the UK

### Participants by age and gender

Age range	Male	Female
25 – 30 years	3	8
31 – 35 years	2	2
36 – 40 years	3	3
41- 45 years		
46- 50 years		
51- 55 years		1
56- 60 years		1
Total	8	15

### Participants' religion

Religion	Number of participants
Christian	10
Muslim	8
None	5



## **Appendix 2 - Description of overseas health services, from respondents' accounts**

### **The Iranian health system**

Iranians described a mixed system where individuals could access state provided health care, which was usually seen to be of a lower standard, or could pay for private treatment if they had the means to do so. The state health service is funded by health insurance which covers 20–30% of the costs of treatment; individuals need to pay the remaining cost. Health insurance is paid by those who are working. Access to private health care is easy for those who can afford this option. The use of private GPs and hospital care appeared common and it was clear Iranian respondents saw private care as better.

It is possible to see a GP on the same day, although in the state health system there are longer waiting times. Participants described having to find out for themselves which doctor or hospital was the best for a certain medical condition and then being able to access this directly without having to go via a GP. Ambulance services were described as a mix of public and private provision. Immunisations for children appeared to be delivered through schools overseen by the education department. Routine testing for hepatitis, HIV and diabetes took place in the Iranian health system.

### **The Polish health system**

Individuals from Poland described a mixed system of health care. There is a state health service, similar to the NHS; however, waiting times are an issue with this service. The system operated on a social insurance model, where treatment is free for those who pay their taxes and those who are registered as unemployed. Dentists, optometrists and gynaecology services were accessible directly for individuals without having to go via a GP.

There are GPs and state hospitals, there is also a wide range of private provision. In commenting on the delays in accessing treatment through the state health system Polish individuals stated,

*There is the same institution of family doctors which is called GP here (in UK). But, if you want to get very good care you need to go and see a private doctor, the same in Poland and here. (Polish woman, aged 36)*

*...but there is always the option of private care which we use very often. (Polish woman, aged 52)*

*With accessibility in practice, it's not always working great, so we use private care very often. I think everyone at some point uses private care. (Polish woman 36)*

### **African health systems**

Access to formal healthcare systems was dependent on the level of development of health infrastructure in the country concerned. In Zimbabwe and a number of the other countries there appeared to be no difficulties in accessing health care if you lived in a large city, but those in rural areas faced real difficulties in accessing care. Some spoke of having to rely on local healers and home remedies for treatment because of the absence of health services. In

one case a relative had died whilst the family had tried to take them to the only hospital in the nearest city. Health services suffered when the country's economy was in crisis:

*As time advanced, we were expecting that things will improve but now back home because of the economic situation the health facilities in general in Zimbabwe have remarkably deteriorated or gone down again. (Zimbabwean female, aged 60)*

Non-governmental health organisations (NGOs) were often the only point of access in Sudan. Health care could be accessed direct from a hospital in some countries but access was often dependant on an individual's financial circumstances. Medication costs often had to be covered in full and medicines were often only on sale in large cities. NGOs or hospitals were seen as the only communicators of public health messages:

*Although we do have some public health centres in Darfur and Nuba Mountains, however, they are poorly run with no medicines, no trained doctors and poorly trained health professionals. The only health facilities we have are the ones run by some NGOs. They are well stocked with medicines and run by foreign doctors and nurses; and that's where I became aware of health and wellbeing. (Sudanese female, aged 29)*

Most people accessed traditional herbal remedies first, going to hospital only if the problem was unresolved and they had sufficient resources to cover costs.

### **Pakistani health systems**

The health service in Pakistan provides access to local doctors, some of whom did home visits. Individuals with more serious conditions had to travel to a city to see more specialised doctors or access hospital care. One of the respondents spoke of the system in their village where there was a free hospital, free medication and the hospital in the nearest city also provided free treatment. Others used friends or family members:

*Well, we have a family friend who is a doctor; if we do feel ill, then we usually call them, and they come for a home visit. (Pakistani female 26)*

In other areas payment for medical services was required, even for emergency treatment.

### **Indian health systems**

Indian respondents described a mixed health system with government and private sector health provision. The government health service was described as poorly resourced in comparison to private doctors. The state also provided a range of health information to individuals. Those with choice would access private doctors. It was possible to buy a range of medication direct from pharmacists in India. Services varied according to region.

*In India there is better and greater healthcare access than in the UK. It is private and you'd have to pay, but there is no waiting time. (Indian female, aged 34)*

*In the village, the doctors that you'd find there are qualified, but are not as qualified as the doctors that you would find in the city hospitals. The hospitals are also*

*specialist hospitals and different hospitals have different facilities; depending on the specific illness you have, you visit a certain hospital. (Indian male, aged 34)*

### **Chinese health systems**

The two individuals from China provided limited information on the health system in their home country. The size of the population appeared to one to make the provision of primary care through a GP or family doctor model impractical in more rural parts of the country. Health services were located within hospitals or large towns or cities; however, individuals needed to pay to access healthcare. Doctors discussed by our respondents were all Western, rather than Chinese. A medical insurance scheme provided subsidised treatment for a range of conditions.



### Appendix 3 – Recommendations and suggested actions

	Recommendation	Responsibility and actions
1	Work to understand the effect of recent migration and wider determinants of health on migrants' access to health services and their health outcomes.	<p><b>Health and wellbeing boards and local authority Public Health Departments</b> need to understand the diversity of their local migrant population and consider what steps are required to ensure that health inequalities within these groups can be measured and addressed.</p> <p>Work to identify the impact of the wider determinants of health on particular migrant groups in the local population and understand how migration and restrictions linked to immigration legislation, e.g. NHS regulations for charging overseas visitors, may be affecting health outcomes in certain groups.</p>
2	Ensure new migrants are provided with clear information on NHS services and how to access them locally.	<p><b>NHSE / CCGs</b> in conjunction with local voluntary and community sector organisations should review how information on health services is made available to new arrivals.</p> <p>Opportunities for closer work with community and voluntary sector organisations, children's centres and schools and ESOL providers could be explored at a local level.</p> <p>The 'ESOL for health' course developed in Wolverhampton provides new migrants with an overview of NHS services and how to access GP registration, prescriptions etc. This model could be replicated in other areas.</p> <p>Choose Well / Stay Well is already being used in some areas with different migrant communities to promote understanding of NHS services and their appropriate use. (e.g. Sandwell &amp; West Birmingham, and Wolverhampton)</p> <p><b>Midlands and Lancashire CSU</b> are responsible for the Choose Well West Midlands information. Currently it is only available in English. Consideration should be given to develop this information for recent migrants.</p>

3	Take steps to ensure greater participation of recent migrants in patient and public engagement work.	<p><b>CCGs</b> should review the current level of engagement from new migrant communities in their existing public engagement processes and explore opportunities for more routine feedback from across the migrant population, specifically on the delivery of primary care, mental health and maternity services.</p> <p><b>CCGs/NHSE</b> – Monitoring of GP contracts linked to patient engagement should include seeking evidence of recent migrants’ engagement in patient forums.</p> <p><b>GPs</b> should consider what support local voluntary or community sector organisations could provide to improve representation on patient forums from new migrant communities.</p> <p><b>Local Healthwatch</b> – Review levels of awareness and engagement from new migrant communities in current Healthwatch activity.</p>
4	Address recent migrants’ confidence in primary care by explaining how the service works.	<p><b>CCGs/NHSE/ Local commissioning groups</b> should commission further work to explore and develop shared understandings of primary care between the recent migrants and GPs/ health professionals to address and improve confidence levels in primary care.</p> <p>Voluntary and community sector organisations working with new communities could play an important role in supporting this work.</p>
5	Recognise that some migrants return home for treatment or medication and take this into account when treating new migrants.	<p><b>CCGs/Public Health /NHSE</b> should determine who is best placed to undertake further research with migrant communities e.g. Central and Eastern European communities. This should identify the prevalence, reasons for return and types of treatment for which adults and children from identified countries are returning to the country of origin; and the implications for existing health priorities for Public Health and CCGs.</p>

6	Make interpreting services accessible for those who need them in health services.	<p><b>CCGs</b> should remind member practices of the availability and guidance governing the use of interpreting services for those who need them in light of current equalities duties.</p> <p>CCGs and other commissioners of interpreting services should develop and publicise processes to ensure migrant patients and clinicians have the opportunity, after a clinical consultation where interpreting has been used, to provide feedback on the quality of the interpreting service.</p>
7	Review the accessibility of health and wellbeing initiatives to migrants, especially those who have limited English language skills.	<p><b>Public Health Departments</b> commission a range of health protection and health improvement services. Contracts should ensure providers demonstrate the ability to engage with and improve access to their service by individuals from new migrant communities.</p> <p>Evidence of accessibility to non-English language speakers and evidence of use by recent migrants should form part of contract monitoring.</p> <p>This information is essential in ensuring priorities linked to reducing smoking, obesity, reducing harmful drinking engage those migrant communities where there may be greater prevalence.</p>
8	Review the provision of training and guidance for GPs and other health professionals on migration, migrant health issues and cultural competency.	<p><b>CCGs/Public Health Departments/ Hospital Trusts / Mental Health Trusts</b></p> <p>Organisations should review whether current training or professional development supports staff in understanding migration and migrant health issues and addresses cultural competency. Such training should be commissioned where required.</p>

9	Ensure asylum seekers are able to register with a GP on dispersal to an area.	<p><b>Public Health / CCGs</b></p> <p>Local protocols are in place in areas of asylum dispersal to ensure notification of new arrivals in the asylum support process.</p> <p><b>CCGs/Public Health Departments</b> should review current arrangements in their area and consider whether changes are required to ensure asylum seekers register with a local GP as soon as possible after arrival in the area.</p>
10	Review current uptake of cancer screening services by migrant communities and take action to improve awareness and uptake in underrepresented groups.	<p><b>PHE / CCGs</b></p> <p>Those responsible for cancer screening services should review uptake rates across migrant populations in their area and consider whether some focused engagement with specific communities is required to improve awareness and uptake of routine screening programmes.</p> <p>Public Health Departments and Public Health England should consider the possible impact of changes to migrants' entitlements to free primary care services on cancer screening programmes.</p>
11	Develop actions to address reliance on antibiotics and their continued use by some migrant communities as part of the work to reduce antimicrobial resistance in the UK.	<p><b>PHE/CCGs/ Public Health</b></p> <p>Targets on reducing the use of antibiotics are unlikely to be met if we do not reduce the use amongst some migrant communities. Future campaigns on 'antibiotic guardians' need to engage migrant communities.</p> <p>Commissioning of a further study on the prevalence of use and availability of antibiotics amongst Central and Eastern European communities with large populations in the West Midlands should also be considered.</p>

12	<p>Improve understandings of mental health and awareness of mental health services in new migrant communities.</p>	<p><b>CCG/ Public Health/ Mental Health Trusts and voluntary and community sector organisations</b></p> <p>Commissioners of mental health services need to consider which migrant groups/countries of origin face particular challenges in accessing local mental health services.</p> <p>Identify whether appropriate support for mental stress, trauma, experiences of torture and mental illness is available locally and whether services take account of the diversity of the local population.</p> <p>Work with new communities, with lower uptake of mental health services, to build a shared understanding of mental health and wellbeing and the kinds of services which are available locally.</p>
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