



Experiences of asylum seeking women on housing and health care services in Bradford



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EXPERIENCES OF ASYLUM SEEKING WOMEN ON HOUSING
AND HEALTH CARE SERVICES IN BRADFORD

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The purpose of this study was to look at housing and health care services provided for asylum seeking women in Bradford, and whether service delivery meets their needs and expectations.

This study used a qualitative research approach; the method of data collection was focused group interviews. The participants were selected from the Bradford Ecumenical Asylum Concern (BEACON) project. 10 women seeking asylum were interviewed and the interview data was analysed through the method of content analysis to search answers to the questions: What are the experiences of women seeking asylum in using housing and health care services designed to cater for their needs in Bradford? Do housing and health care services in Bradford meet the needs and expectations of asylum seeking women?

The main findings in this study were that participants have access to health care services, and there are continues housing support services. The findings reflected that health care services are culturally inappropriate, the accommodation allocation system leads to social isolation and a feeling of loneliness, and insufficient information on healthcare and housing services due to lack adequate English language skills.

On the basis of the findings, this study concluded that although there is a wide-range of housing and health care services for women seeking asylum in Bradford, most services do not meet their needs and expectations; as provider-led approaches to running services were used.

Key words: Asylum Seeking Women, Housing, Health Care, Anti-oppressive Practice

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1 Introduction

People seeking asylum may have suffered torture and persecution; they may have seen some or all of their family murdered before their eyes and are literally fleeing for their lives. Asylum seekers are frequently jailed for months, and even years, with little contact with the outside world. They become indistinguishable from the criminal inmates with whom they often share space. In the process, some of these people seeking for protection lose hope and sometimes abandon their asylum claims to risk the return to their home countries (Winchester 2001, 18).

Policies introduced in the United Kingdom (UK) require all asylum applicants to claim as soon as is reasonably practicable after their arrival in the country or else be denied all state support. A record number of people seeking asylum in the UK has therefore become one of the most contentious social issues for the government and for organisations set up to support them. As a result of the dispersal policy introduced in UK by the government, asylum seekers have been separated and scattered around the country - leading to new services being set up (Home Office, 2008) Government institutions alongside some community and voluntary support groups such as the Bradford City of Sanctuary Organisation, Student Action for Refugees (STAR) and Bradford Ecumenical Asylum Concern (BEACON) aimed at supporting asylum seekers have emerged around the country. These support networks have found a place providing links with other vital services that help in the search for survival in the UK, though like many other organisations some are undoubtedly better than others.

Women's voices often go unheard in the process of shaping and implementing policies designed to support them (Dumper 2002, 12). Women seeking asylum may move away from violent and oppressive regimes, and arrive in the UK after having lost everything they know and value. Many of these women have fled gender-based persecution, including gang rape by military forces, forced marriage, or female genital mutilation. They may well have lost families, partners and children and there is likelihood that they have lost their jobs, homes and all of their possessions. In their quest for safety, they are faced with a number of problems in the UK. They are likely to be traumatised and suffer anxiety about their ability to support themselves or their family, they may not be able to communicate and face language barriers not to mention the difference in culture and the prejudiced attitude of the general public towards them.

Previous research has not adequately addressed the services in Bradford for asylum seekers, particularly women. This study seeks to uncover the provisions of health care and housing services for asylum women in Bradford. It also aims to examine whether asylum services in

Bradford meets female asylum seekers' needs and expectations. As health is both a medically and a culturally constructed concept, every culture perceives health differently and therefore has different needs and expectations of care. Equally, like any new migrant, secure housing is probably the most basic need for an asylum seeker. This study seeks to consider explanations to difference and diversity, and how to develop a social work practice that is both reflective and anti-oppressive. The main goal of this thesis is to highlight the female asylum seekers' experiences in the areas of health care services and that of housing. As the UK is a receiving country of asylum seekers, issues related to the welfare of these asylum seekers is of maximum importance. In order to safeguard these services, there is a great need for government officials and policy planners to understand how the needs of clients are met by the services they provide.

This study answers the questions: What are the experiences of asylum seeking women in using housing and health care services designed to cater for their needs in Bradford? Do housing and health care services in Bradford meet the needs and expectations of women seeking asylum?. Aimed to empower asylum seeking women for their voices to be aired and heard, this thesis uses a qualitative method through semi-structured interviews to understand the participants' experiences. Two focus group interviews are to be conducted to collect data for this study. The aim of using this method is to make the interviews flexible for participants to comment when they needed, and also for the interviewer to probe with follow-up questions when expected. This study interviews 10 participants from BEACON. BEACON is a voluntary organisation in Bradford which provides welfare support services for asylum seekers. Being more vulnerable, women seeking asylum need to be empowered for their voices to be aired and heard, and it begins with considering the standpoint and experiences of women themselves (Brayton 1997, 12)

2 Theoretical concepts

Each year thousands of asylum seekers, fleeing persecution in their own countries, come as strangers to seek refuge in the United Kingdom (Home Office, 2008). Upon discovering the real hardships that asylum seekers face, the local churches in Bradford founded the Bradford Ecumenical Asylum Concern (BEACON) project in 2005. BEACON was set up out of a shared concern to address the practical needs of the many asylum seekers and refugees who live in the Bradford district. Depending on the need of a client, BEACON provides housing support, health care support, financial support, legal support and other social supports. The goal of the project is to empower asylum seekers and refugees, and to support their integration process. It is an ecumenical (inter-church) response to fulfil the Biblical injunction to welcome the stranger, but seeks to work with other faith groups and secular agencies to offer care and support to asylum seekers and refugees. In providing support, BEACON collaborates with other local and national agencies such as the Bradford Immigration and Asylum Support and Advice Network (BIASAN), National Asylum Support Service (NASS), British Red Cross, and Amnesty International.

2.1 Asylum Seeking Women

Protection from persecution, as defined by the 1951 United Nations convention on refugees, must be provided to anyone unable to receive security from his or her own government; anyone seeking this protection is known as an asylum seeker. Asylum seekers refer to persons who have left their countries of origin and made a claim for a refugee status in another country, but whose applications are not yet decided. In the UK, this is the definition applied when deciding whether someone is entitled to housing or welfare support by the National Asylum Support Service. Presently in the UK, the countries most asylum seekers come from are Afghanistan, Iraq, Zimbabwe, Iran and Eritrea (Home Office 2008)

Women's asylum claims are usually complex and often based on more than one ground under the 1951 Refugee Convention. In most cases, their experiences in the UK of seeking asylum, are often overlooked, or are framed in terms of their dependence on their husband; and their voices often go unheard. The decision to refuse protection for female asylum seekers is often made on the basis of a gender-blind approach to their claim. Intimate and sensitive issues such as rape, abortion, abuse and medical conditions often have to be discussed with male interpreters and because most are unaware of their rights to have a female interpreter and interviewer. Some facts therefore may not be disclosed thereby putting their claim in serious jeopardy (Dumper 2002, 4).

Refugee and asylum seeking women are persecuted; suffer deprivation and hardship similarly to their male counterparts. For forms of political activism however, there are some signifi-

cant differences in the forms of persecution that women may endure. Women may be persecuted for not confronting to moral and ethical standards, or for standing up for their rights; they may be targeted because they appear more vulnerable; and forms of sexual and domestic violence are often used to degrade and humiliate them (Crawley 2001, 2-3). For these reasons, 'women's needs are different to men's and ought to be recognised as such' (Valios 2001, 32)

Asylum seeking women's experiences in their countries of origin often differ from that of men. For example women's involvement in political protest and action is not as widely publicised as that of men and their inability to produce evidence, both oral and documentary may alter their asylum claim.

Violence against women is a common occurrence but is not recognised when asylum applications are made. Domestic violence is often seen as a cultural norm. In many African traditional cultures for instance, a man is permitted to discipline his wife by physical means - beating is viewed as a husband's prerogative. A Kenyan woman, who was a teacher by profession, had her eyes plucked out by her husband who suspected her of having a relationship with another man. Also, a woman in Kenya was beaten almost to death by her husband for casting her vote for a different candidate to that one of her husband; whilst another woman was thoroughly beaten for attending a meeting without the prior approval of her partner (Mbugua 2003)

Because of fear and unfamiliarity of protection structures, incidents of domestic violence often go unreported. If however, incidents are reported the proof required by the Home Office is beyond reasonable doubt, which is often impossible to prove. Without this proof, funds from NASS for emergency accommodation will not be released leaving women with violent partners to suffer (Southall 2002, 2). While the media and press portray the distress, the anxiety, the fear and the human costs of war and displacement through the images of women and their double responsibility of caring and protecting the children, policy makers have been slow to recognise that women are also asylum seekers, candidates for refugee status in their own right (Hellen 2008).

Women are viewed as men's property in many cultures. The practice of paying bride price to a woman's family during marriage reinforces wife controlling, discipline and. In recent times women from many African countries, for instance, have been learning about their rights. As a result, more than ever before they desire greater independence. They are more educated and have greater confidence than past generations. They want to assert their rights and freedom. However coming from male dominated cultures women have encountered serious opposition and abuse as they try to earn their basic rights as individual women. Many women become the

target of punishment and have received death threats for merely speaking their minds (Mbugua, 2003)

The UK has received many asylum seeking applications in the last decade (Home Office, 2008) Many women, mostly parenting alone have made long journeys to arrive in the hope of safety and security. Recently, however, women in the asylum system have been made to feel like criminals and constantly feel under threat and insecure. As well as the abuse that many have carried with them, their psychological well being is under attack (Southall, 2002)

In the overall context of poor quality decision-making of asylum claims in the UK, three quarters of women are refused at initial decision stage. However, over half of cases determined do obtain refugee status or Exceptional Leave to Remain after appealing against the initial decision (Southall, 2002)

The needs of women seeking asylum are universal, and the displacement of women outside their country complicates meeting the most basic needs such as obtaining food, shelter, clothing etc. Their ability to carry out responsibilities to themselves and to society becomes challenging and can cause immense problems for their wellbeing. It is true to say that women do not readily uproot themselves from everything they have and everyone they know unless in severe danger (Hellen, cited in Valios 2001, 32)

Across the UK, women are particularly badly affected by recent changes in legislation on refugees, such as the 'dispersal system' and new support arrangements. Isolation, poverty and lack of support in the UK add to the pressures women are already experiencing, and many private housing providers and landlords are letting accommodation that is generally unfit for cohabitation (Dumper 2002, 12).

Although relatively little research has been done with regards to women and their overall experiences in the UK, 'Mothers In Exile' examines views of pregnant women and the health care they received; whereas 'Is It Safe Here?' examines views on accommodation, quality of life and future aspirations of women asylum seekers (Mcleish, 2002)

In West Yorkshire, a research into the effects of the UK asylum 'dispersal' policy proved that whilst the UK Home Office insists that the 'dispersal' system is working well, the refugee council has serious concerns and stated that the government needs to develop proper ongoing support service for asylum seekers in order for the dispersal system to work (Pollock 2002). The quality of accommodation offered through the dispersal system is varied, and in West Yorkshire research revealed the need for Kirklees private housing providers to increase their social support and facilitation function for asylum seekers to match that of the local authority, as people have often been left with little or no support (Wilson 2001).

'Mothers in Exile' is a qualitative study of women and their maternity experiences in the UK during their asylum process. This report reinforces findings from 'Dispersal' in that adequate housing and ongoing support was needed; and that mixed hostels were unsuitable, because women were prone to harassment whilst sharing kitchen and bathroom facilities. This report also highlights the fact that a number of women were not aware of relevant information about services and support that was available to them (McLeish 2002).

Asylum seekers are often viewed with a disproportionate level of suspicion and distrust by their host country. There are misconceptions that asylum seekers have a burden on public services, get preferential benefits and are responsible for unemployment. Research indicates that these misconceptions often arise from an imbalanced media and weak political leadership. The fact is that in many countries across the world, the life of an asylum seeker is harsh and often unfair. In the UK, asylum seekers are barred from working for an independent income during the asylum application process; rather a single adult presently has to survive on £37.77 a week, which is 70% of regular income support. They are therefore forced to live 30% below the poverty line (Kirklees Council, 2007). The UK gives less financial support than other European countries including Ireland, Denmark and Belgium. Asylum seekers are placed in accommodation on a no choice basis; normally provided by private landlords and Registered Social Landlords. Often these are the hard to let properties that nobody else wants (Dumper, 2002).

A study by the Refugee Action found that 83% of women interviewed feel so unsafe in the UK that they live under self-imposed curfew, locking them indoors after 19:00. One in two feels so depressed and anxious they can not sleep at night. On the whole, asylum seekers are ill served by the statutory social services (Mahmoud & Gray 1999).

As part of the development of a Common European Asylum System, European Union member states have set minimum standards for asylum procedures. However, they include little related to gender apart from a general principle of considering specific situation of vulnerable persons such as pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence. The reception directive on asylum seeking proposes that the individual EU member states should establish procedures in their national legislation to better identify such vulnerable persons and ensure that their needs are supported and monitored throughout the asylum procedure (UKBA, 2008-2009). In response to this, the UK Home Office introduced guidance on gender issues in March 2004, which was updated in October 2006, for asylum caseworkers. The aim of the guidance is to ensure caseworkers are aware of additional issues when considering claims from women. It identifies examples of gender violence that can be persecutory, recognises that decision-makers should be aware of the impact gender-based violence may have on how a woman responds during an interview, and the importance of gender-sensitive

procedures such as providing female interpreters and interviewers (Home Office 2006). The UK is one of the few countries in Europe to have such gender guidelines (Crawley & Lester, 2004).

In 2008, the UK Border Agency (UKBA), the Home Office executive agency responsible for determining asylum claims, released an updated Race, Disability, and Gender Equality Scheme, which aims to ensure that asylum seekers with gender-specific care needs can disclose such needs, obtain the necessary treatment, and not be prevented from presenting their case to its best advantage. Recently, the UK Border Agency regional office in Glasgow introduced childcare provision during asylum interviews, allowing women to discuss their claim for asylum without their children present in the room. This provision, however, is currently only available at UKBA regional offices in Wales and Scotland (UKBA, 2008-2009).

While these are indications of an improvement to the policies on the reception of asylum seekers in UK, there is still much room for improvement. Unfortunately, the limited data on women in the UK asylum process, especially in account of their experiences, present an obstacle for policy-makers, and service providers, in addressing the needs of female asylum-seekers.

In a transnational study in France, Hungary and England about asylum women's experiences in European host countries, the International Organisation for Migration (IOM) reported that most European hosting countries uses gender-neutrality of the legal instruments for defining refugee status and that the failure to ascribe equal status to gender-based persecution experienced by women reinforces a gender bias against women in the asylum process. The procedures adopted for dealing with women as asylum applicants vary widely across Europe, and in many countries female applicants are not necessarily interviewed by women, making it more difficult for them to communicate their gender-specific experiences. Women's exposure to danger does not necessarily cease when they reach a country of asylum. For this reason, it is important that the option of resettlement to a third country is equally available to them as to men. Yet women face special obstacles in access to resettlement programs, as they do in accessing services during the asylum process (Newland 2003, 6)

Women are less likely to be interviewed as principal applicants than men, even in cases where they have a stronger case. Asylum procedures are found to increase women's dependency on men, as their refugee status more often than not derives from a male relative. This then places women in a vulnerable position as changes in gender roles can place strain on marital relations. Further, if divorce means loss of refugee status, women can be trapped in unhappy relationships (Havinga 1997).

In the USA, the Immigration and Naturalisation Service (INS) imprisons thousands of asylum seekers, including hundreds of women, in detention centres and prisons across the United States. A recent study of the experiences of women seeking asylum in the USA showed that women asylum seekers faces physical and verbal abuse in prisons used by the INS and frequently endure prolonged detention. Their physical and psycho-social needs are not often addressed. In most cases, basic provisions such as childcare and female interpreters or interviewers are often not available. These conditions fail to meet international principles of refugee protection and basic standards of decency and compassion. Most disturbing are reports of abuse of asylum seeking women at the hands of the officers charged with their care. This abusive treatment eerily reminiscent of the abuses the women fled in their own countries (Young 1997)

2.2 Housing

It is necessary to emphasise the value of secure housing as probably the most basic need for everyone, but in the case of asylum seekers it is particularly important for a number of reasons: First, it is a chance to obtain some security after, perhaps, weeks of travelling, of separation from family and friends, and - often - real personal danger. Second, housing may be the first step to building a new life for asylum seekers and refugees. Fourth, it provides an address - allowing benefits to be claimed and jobs to be applied for. Finally, it gives access to wider services such as schools and health care (Carey-Wood, 1997) Housing is the key to the door of integration. Only by making housing equally accessible to asylum seekers, refugees, migrants and national citizens, as well as stimulating multicultural living environments will integration succeed (Hact, 2003)

In most European Union (EU) member states, many actors, governmental (national, regional and local authorities) and non-governmental, are involved in organising and managing housing facilities, as well as providing accommodation for asylum seekers. The cooperation of these different stakeholders in providing accommodation for asylum seekers in combination with social counselling and integration programmes is essential for the realisation of their future integration. Most asylum seekers are accommodated in reception centres, which are often not conveniently located and normally isolated from social and health services and facilities (Home Office, 2008).

Though measures are daily in place to address the housing needs of asylum seekers in the UK, it also argues that asylum housing providers could go further to be well-placed to establish the necessary links between different agencies, thus helping people sustain their tenancies and providing or co-ordinating other kinds of support to people seeking asylum. Securing accommodation and support services for asylum seekers and refugees, and aiding their integration through community-based initiatives, are key elements of the UK Government's refugee

integration strategy. Yet in cities like Bradford, many local authorities are not engaged with this area of need, and housing associations have also been criticised for the limited contribution which many are making. Housing agencies across the UK are under increasing pressure to support and help integrate new migrants, of whom asylum women are key groups. Yet until now there has been little practical guidance aimed at housing practitioners on how to do this (Pollock 2002).

In the UK, housing agencies have a mixed track record in dealing with asylum seekers. Many local authorities respond to the dispersal demand from the Home Office, but this is done with varying degree of sensitivity. There are some notable examples of housing associations working with asylum seekers, but equally many examples of poor co-operation. There are inconsistency practices across different areas on how asylum seekers and refugees are treated under homelessness legislation, and to what extent their housing needs are considered in local policies on race and equality. The UK Border Agency (UKBA) places single adults and families in temporary accommodation, and most are living in shared housing provided by private landlords. The private rented sector is used directly by the National Asylum Support Service (NASS), leading in a minority of cases to problems of exploitation, poor conditions and little attention to the wider support that service users often require. NASS sometimes award block contracts to the private sector at rent levels in excess of the average; this has caused problems in the private letting market where landlords expect higher rents, in return for poor quality accommodation (Home Office, 2008)

People seeking asylum in Finland are normally sent to the reception centre closest to their point of arrival by the border authorities. The allocation of accommodation also depends on the availability of places in the centres. Asylum seekers may either stay in a reception centre or find their own accommodation. The only free living accommodation is that provided in the reception centres. Unaccompanied minors are accommodated in special centres for children, called group homes. Asylum seekers are allowed to stay in the reception centres during the whole procedure, including the appeal process. After protection status is granted the authority responsible for the distribution of refugees, to the different municipalities in Finland, is the Ministry of Labour and, on a district level, the Employment and Economic Development Centres, all of which have a special employee responsible for migration and refugee matters. The municipalities are responsible for the settlement of refugees. They are free to decide whether or not to accept refugees, and the number of persons they will receive. The municipalities are obliged to provide accommodation, usually in the form of rented flats owned by the municipality, when accepting refugees. Government subsidies, lasting for a three-year period, are paid to the municipalities that receive refugees. Therefore if a refugee moves to a municipality, without an agreement with the Government, no subsidy is paid to that municipality. Refugees may choose the municipality where they want to settle provided they find accommodation by themselves. In practice, because they often have difficulties in find-

ing apartments on their own, they tend to live in the municipality in which they were allocated. However, many of them move to larger cities after an initial period spent in the (smaller) municipality where they had been allocated (Työministeriö, 2008).

Also, in Italy the Sistema di Protezione per Richiedenti Asilo e Rifugiati (SPRAR) is the national programme for the reception of asylum seekers and refugees. The provision of housing services for asylum seekers in Italy is subject to much criticism. It is criticised for its slowness - asylum seekers wait for between 12 and 24 months for a response from the Central Commission working on asylum seekers' reception. Apart from the small proportion of those who are lucky enough to be accommodated under the National Reception Plan (PNA), estimated to be under 10%, most are left to their own devices and without resources once the 45 days during which they receive an allocation have expired. They have no access to health care and no opportunity for safe shelter. It is very complicated for an asylum seeker to have his or her application transferred from one region to another, since it can take over six months for changes of address to be registered. Some prefer to keep an address going even when it is far away from the place they actually live, rather than requesting a transfer. Because of this they are forced to make long and expensive journeys in order to carry out simple procedures, sometimes returning from the north of Italy to Sicily, which is for many their first point of arrival in the country (FIDH, 2005).

In Austria, there is no compulsory accommodation for asylum seekers on arrival. Federal accommodation, if granted, is the only possibility available after the interview has been carried out by the Federal Asylum Office. In such cases, this provisional accommodation is made available in refugee camps, or hostels. Asylum seekers under federal care are provided with accommodation but, in practice, conditions often depend on the local and regional context. Accommodation is also provided in hotels, private hostels and hostels run by Non Governmental Organisations (NGOs). However, those who abandon designated accommodation for more than three days will no longer be eligible for federal care. Adults can also be arbitrarily transferred to accommodation facilities in other regions, often with little prior notice. Asylum seekers without federal care have to rely on the subsidiary social benefits of the federal provinces or the assistance provided by NGOs, charitable organisations or churches, and may be accommodated in private inns, hostels or even rooms in parish buildings. Presently, the Refugee Integration Fund administers housing services, of which vulnerable groups such as women are given priority. The Fund also provides them with grants for housing (renovation, payment of rent and housing loans). However, these services are only available to those who have been granted refugees status (Jack and Andrzej, 2008)

In a study, McLeish noted that adequate housing and ongoing support was needed for women seeking asylum; and that mixed hostels were unsuitable, because women were prone to harassment whilst sharing kitchen and bathroom facilities. Also, it was highlighted that a number

of women were not aware of relevant information about services and support that was available to them in the United Kingdom. Accommodation for asylum seekers continues to be of very poor quality. A report commissioned by the Mayor of London found that asylum seekers' accommodation is at best sub-standard and at worst unfit for human habitation, often being infested, with poor heating and ventilation, a lack of adequate washing facilities, little privacy or security, and lacking in play spaces for children; and these exacerbates the problems asylum seeking women face in securing good quality maternity care (McLeish 2002)

2.3 Health care

It appears women globally are healthier than men since women have higher life expectancy. Life expectancy, however, does not take into account the differences in health status and needs between men and women such as women's menstruation, reproductive abilities and breastfeeding. This difference is often neglected as women's health is defined in male terms, thereby creating a system that is unable to respond appropriately to women's needs (Puentes-Markides, 1992)

Within the broader issue of advancing access to services in general, enhanced access to health care services plays a significant role in improving the situation of people seeking asylum. Most countries provide a significant good level of healthcare coverage for immigrants who have acquired a residency status, normally under the same cost-sharing regulations that apply to others in the population. In some cases, however, this happens only after they have stayed for a minimum period in the country, which can severely limit their access to health-care. Generally, asylum seekers are entitled to basic treatment for acute diseases at no cost in most countries. However, current regulations in some countries limit the entitlement of asylum seekers to health care services under public programmes. In many countries, people seeking asylum have the right to the provision of emergency and medically necessary health-care only. However, the decision of what constitutes a medical emergency is usually left to the provider. This is particularly problematic for important but non-urgent cases such as diabetes and childhood immunisations, which frequently pose a dilemma for providers if service users cannot afford to pay (Huber et al, 2008)

Asylum seekers have lost their social cornerstones: their language, attitudes, values and social structures have all been suddenly uprooted. They often lack friendship groups or know people who have similar backgrounds and experiences. They find themselves disempowered and disenfranchised. Fathers can no longer provide effectively for their families while often poorly educated women and children must now adapt to the values of an alien culture. When this is compounded by traumatic personal stories and an immigration system that denies an independent income and permits arbitrary detention, it is perhaps not surprising that asylum

seekers are therefore a population with medical risks and health problems. These health problems are often compounded by the fact that asylum seekers are poor users of health care services.

Asylum seeking women's backgrounds of forced migration have a profound impact on their overall health, including their sexual and reproductive health. This can be further complicated by specific issues, such as physical after-effects of war and torture, which may induce stress-related mental health problems, depression, high blood pressure, digestive problems, headaches and more importantly reproductive health problems in women. Studies have shown poor antenatal care and pregnancy outcomes amongst refugees and asylum seekers. Uptake rates for cervical and breast cancer screening are typically very poor amongst asylum women in the UK (Stewart, 1997) Asylum women alleging torture need information about how to contact an experienced medical expert. Improved access to general health care, including also health promotion and prevention strategies, is essential to minimising disadvantage for asylum women.

A study carried out in twenty-five European Union (EU) countries found some restrictions on the access of asylum-seekers to health care in ten of them, in spite of their being 'documented' migrants. National Health Systems (NHS) often discriminates against asylum seekers in spite of several international treaties and commitments protecting their rights. Asylum seekers tend to experience poorer access to health care compared to the rest of the population. Poor mental health is commonly due to social isolation, poverty, loss of status and hostility from the local population. For those already suffering from distress caused by persecution, torture and violence, these exacerbating factors can result in serious mental illness and suicide (Norredam et al. 2006)

In the UK, the Department of Health's Asylum Seeker Co-ordination Team (ASCT) co-ordinates healthcare policy for asylum seekers and refugees. The team works across the Department of Health and other Government departments, and with health workers and service planners in the field. In particular, ASCT liaises with the Home Office to ensure that health and social care requirements are met at all stages of the asylum process and taken into account in policy planning. Although asylum seekers are entitled to use the services of the National Health Service (NHS) without charge, they are often unsure of their rights. Some asylum seekers actively avoid using health care services for fear that it might negatively impact upon their asylum application. Asylum seekers are often from very different cultures, may not understand the principles behind the UK health care system, may not speak English, and may have complex health care requirements. They may experience health problems associated with travelling long distances during the UK dispersal system, particularly for certain groups of asylum seekers, particularly the women (Home Office, 2008)

Access to healthcare according to needs is important for asylum seekers' health. General health policies determine access to healthcare for the population, but other agendas are influential when health policy towards asylum seekers is defined. Government policy to redistribute asylum seekers away from the London area mean that they may be placed in the care of people without any specialist knowledge of their problems, including people working in healthcare. Access to local health authority outreach services and special refugee community groups becomes difficult for asylum seekers, which increases their feelings of isolation. Although all asylum seekers are eligible for free NHS treatment and have the right to register with a general practitioner, general practitioners are often confused about these people's entitlements. They have been registered on a temporary rather than a permanent basis, thereby being excluded from a full package of checks and advice. Additionally, various forms of identification are being requested before registration. Because of the redistribution of asylum seekers throughout Britain, many general practitioners find themselves faced with new issues of care. In the absence of any national guidelines, each health authority must provide guidance for primary care groups for the integration of asylum seekers into general practices. This should emphasise that practices are not required to ask for passports or immigration documents as proof of status and should encourage general practitioners to offer permanent rather than temporary registration. These guidelines could be incorporated into a general information package, which could also provide information about social services, education, and interpreting services and a directory of telephone numbers of both local and national helplines (Montgomery and Feuvre, 2000)

Epidemiological evidence from Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain and the United Kingdom confirm that the health status of large population of asylum seekers is poorer than that of natives. In general, health problems often overlap with deprivation and poor living conditions, highlighting the relationship between poverty, poor health and lack of access to health care. To vulnerable asylum seekers such as women, this can be further complicated by specific issues, such as physical after-effects of war and torture, which may induce stress-related mental health problems, depression, high blood pressure, digestive problems, headaches and back pains. Depending on their living conditions, they may also be at higher risk of infectious diseases (Huber et al, 2008)

Also in Italy, the Italian Constitution guarantees everyone's right to health and access to healthcare services free of charge for indigent people. The whole population, regardless of individual or social status, is entitled to access the basic benefit package within the National Health Service (NHS). Italian nationals and authorised residents have to register with the NHS at the local health administration that will provide them with a health card. Asylum seekers have the right to freely register in the Italian National Health System and receive healthcare on equal grounds as nationals and upon the same conditions. However, asylum seekers who do not reside in an asylum centre encounter problems to receive care from a general practitio-

ner. They also face administrative barriers. To gain full access to health care, they need to prove that they regularly live in a house by showing an official lease or an official statement of the owner of the house. The effect of these conditions is that many houseless asylum seekers access health care on same conditions as undocumented migrants. Also in Italian reception centres for asylum seekers, there is a lack of standardization of patient management. Pregnant women and inmates with diseases do not receive well-structured professional medical care, provided by specifically trained professionals. The care received in the centres appeared to be strongly dependent on the attitude and willingness of the medical staff working in each centre (HUMA Network, 2008)

2.4 Anti-oppressive Practice

Women seeking asylum are being prevented from presenting their cases adequately, because they face barriers in terms of accessing the asylum seeking process, in the course of the 'fact-finding' process in relation to their claims for asylum. They are particularly at risk of neglect and abuse. Inadequate translation assistance results in women being held in prison, unable to voice their needs or draw attention to any abuse they experience. The diet provided to women asylum seekers is often insufficient and almost never culturally appropriate. Recent studies indicates that the delivery of Services and interventions into the lives of people seeking asylum, especially the women asylum seekers, do not take their views into consideration. In most cases, women asylum seekers are discriminated upon and socially excluded. They therefore become weak, powerless and oppressed (Southall 2002)

Oppression, according to Thompson, is the 'hardship and injustice brought about by the dominance of one group by another; the negative and demeaning exercise of power' (1997, 34) Oppression results in negative self-image and an inability to play a pro-active role in society. These in turn generate experiences of powerlessness, such as exclusion, rejection or being treated like an inferior, which leads to feelings of inadequacy, helplessness and dependability. Anti-oppressive practice brings about changes which lead service users from a state of feeling powerless to powerful (Dalrymple & Burke 1995, 15)

Working from a perspective that is informed by anti-oppressive principles provides an approach that begins to match the complex issues of power, oppression and powerlessness that determine the lives of the people who are recipients of social care services. Anti-oppressive practice brings with it a fundamental transformation in the relationship that exists between the assessment of a situation and the nature of the action that is required to change the existing state of affairs. The driving force of anti-oppressive practice is the act of challenging inequalities. Opportunities for change are created by the process of the challenge. Challenges are not always successful and are often not met with delight by the person or group being challenged or challenging. In providing appropriate and sensitive services that are needs-led

rather than resource-driven, anti-oppressive practice **embody** a person centred philosophy; and egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives; a methodology focusing on both process and outcome; and a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of social hierarchies on their interaction and the work they do together (Dominelli 1994, 3)

Anti-oppressive practice is built on the principle that social differences arise because of disparities of power between the dominant and dominated social groups. The major divisions are described in terms of race, gender, class, sexual preference, disability and age. Other differences, such as those of religion, region, mental health and single parenthood, exist and interact with the major divisions, making the understanding and experience of oppression a complex matter. Also, anti-oppressive practice recognises that personal biographies are placed within a wider social context and the individual's life situation is viewed in relation to social systems such as the family, peer groups, organisations and communities. Power, by principle of anti-oppressive practice, is a social concept which can be used to explore the public and private spheres of life. In practice, power can be seen to operate at the personal and structural levels. It is influenced by social, cultural, economic and psychological factors. All these factors need to be taken into account in any analysis of how individuals or groups gain differential access to resources and positions of power. Individual life experiences and events are placed within a specific time and place, so that these experiences are given meaning within the context of prevailing ideas, social facts and cultural differences. In practice, these principles of anti-oppressive practice relate to each other, interconnecting and overlapping at all times (Clifford, 1995)

The concept of anti-oppressive practice addresses social divisions and structural inequalities in working with clients or service users, and it is a way of structuring relationships between service providers and users. It empowers service users by reducing the negative effects of hierarchy in their immediate interaction with service providers. The critical components of an anti-oppressive framework of practice are anti-racism, anti-sexism, anti-heterosexism, anti-ablism, anti-ageism, and an understanding of class oppression.

One of the most visible ways that discrimination occurs is through the use of colour to group people together. Racial classification is the groupings of people rather than biological differences. White is the dominant colour in the UK and most western countries. It is also believed that the dominant class also represent the truth in society. Therefore, everyone who does not fit this colour pattern is not dominant and does not represent the truth, and thus, is oppressed. The UK prides itself on being a multicultural community where diversity, equality, and harmony are valued. Despite attempts in the British society to address inequalities related to race, ethnicity, and culture, many people have been and continue to be oppressed,

marginalized, and excluded from full meaningful participation in the British society; and this includes asylum seekers (Hepworth & Larsen, 1993)

Sexism is another form of oppression. Sexism is the practice of male privilege or the acting out of male power. This is based on and supported by the beliefs and stereotypes of male theory. The clearest way that this is portrayed is through the differentiation of gender in society – male and female. Gender, however, is not defined as biological sex differences, but the ascribing of patriarchal social significance to the sex and biological differences and allocating of roles accordingly. Biological sex differences are used to justify and legitimate the inequalities that are inherent in sex differences and gender. Many roles have been delegated to society and family members based on gender. Each person in the gender group carries numerous roles that are integrated into the structure and represent certain expected, permitted, and forbidden behaviours. Children are socialized with these roles from birth in the way that they are dressed, the colours they wear, the toys they play with, the friends that they associate with, and the style of their play. Males are stereotyped to become doctors, managers and bread winners of their families; whilst females are expected to become nurses, secretaries, and housewives (Hepworth & Larsen, 1993)

Though there has been a trend toward the dismantling of these stereotypes, societies have internalized oppression: the oppression that we put on ourselves due to social norms. The oppression is internalized from the dominant society's message through the media, schools, religious institutions, and other forms of socialization. An example of this oppression is the consideration given to a husband as the principal asylum seeker in the case of a family seeking asylum together, whilst the wife as a dependant.

An anti-oppressive theory challenges these myths and traditions. The main element in this fight for true equality comes from consciousness rising. This is done through the process of breaking through the theories that women's problems are strictly personal problems and are born from individual flaws. It is also aided through backing away from the idea that the professional knows best, even better than the client (Hepworth & Larsen, 1993)

Thompson's (1993) PCS model also explains how oppression is occurring to women asylum seekers, because this model is used to 'develop our understanding of discrimination and the oppression that arises from it' (Thompson 1998, 12) The P (personal level) is the thoughts and feelings. This level interacts with and is influenced by the C (cultural level), which operates within the S (structure of society level). In effect, each level is interlinked and interacts. This is a useful model to examine how discrimination against asylum seekers occurs not simply at a personal level, but that discrimination is institutionalised within our society.

In the UK, people seeking asylum are not permitted to work. Many asylum seekers bring with them useful work experience, skills and qualifications and many employers want to deploy their skills as paid employees if they have permission to work or as volunteers. Self determination is achieved by service users having and knowing they have real power and control over their own lives. There is therefore the need to empower asylum seekers to play an active role in their new communities, to support local businesses and to contribute to the local economy (Southall 2002)

Empowering asylum seekers (especially women) to gain control over their lives in their locality and the society at large will do much good to societies. It is firmly rooted in opposition to oppression. According to Stein (1997, 62) the perspective of empowering the woman asylum seeker is not characterised as achieving power to dominate others, but rather power to act with others to effect change in society. To successfully safeguard the needs of women asylum seekers, 'empowerment seems to be an effective strategy, but one that is not attracting men' (Stein 1997, 70).

3 Methodology

The methodology of this study has been discussed in three divisions. The informants' selection is discussed in the first division. In the second division the data collection method has been introduced and rationalised, and the data analysis procedure has been described in the third division.

3.1 Informants

The participants in this study were chosen from females seeking asylum in the Bradford Ecumenical Asylum Concern (BEACON) project. The BEACON project work with other network partners to provide support to asylum seekers and refugees; and also, raises awareness of refugees and asylum seekers by campaigning with and for their rights. I have been involved in working in the BEACON project throughout my one year studies in the UK, thereby developing an interest in the subject. Also with the level of motivation developed in working with asylum seekers, the possibility of getting beneficial and concrete information for this purpose was seen hence the choice of BEACON project. Focus group interviews were conducted on women seeking asylum in 'The Bradford Asylum District'. Women were chosen for this study because they are the dominant service users in BEACON, and appear to be more vulnerable in the asylum process (Crawley 2001, 2-3)

Because the student is a Health care and Social Services Degree student wanting to study the informants' experiences on health care and housing services, good level of experience and also the willingness to talk about such experiences was a basis for selecting participants for this study. Women interviewed in this study have been in the asylum seeking process between the durations of one year and three years. Attaining completeness should be targeted when selecting informants in qualitative research, which means choosing people who are knowledgeable about the subject and are willingly able to disclose their knowledge about questions asked them in an interview until what is heard gives an overall sense of the meaning of a concept or theme (Rubin, 1995). Two interviews were conducted with 10 informants on different days. The interviewees were from Zimbabwe, Iran and Eritrea; with the age ranges of 23 to 48 years.

3.2 Data Collection

As the purpose of this study was to understand real life experiences of asylum seeking women that are difficult to quantify, the data was gathered using a qualitative method on semi-structured focus group interview. Qualitative materials seek to uncover the meanings and understanding of experiences, give a clearer view of issue under study and also offers protection against ambiguous statements. This method of investigation places strong emphasis on

understanding the human experience of life; thereby documenting the world from the point of view of the people studied (Silverman 2000, 8)

The realities of people experiences is something that is constructed and interpreted by people but not something that exists objectively 'out there'; and that the use of qualitative methods in a research produces a more valid or truthful account of a situation or what it is like to be a member of a group than quantitative methods can (Webb and Westergaard 2004, 174-180). The subjective study of services provided for asylum seekers have no solid and material qualities that allow it to be measured and touched in some literal manner, hence the preference of qualitative method in this study.

Qualitative research is more interested in discovering and describing the complexity of phenomena and new perspectives in order to find meanings. Unlike static laws, this method of investigation do not search for principles that are true all the time and in all conditions, rather it is aimed to understand why and how certain things do happen in specific circumstances. Knowledge obtained in using a qualitative interview approach is therefore situational and conditional (Rubin 1995, 38)

The use of qualitative research method does not limit the researcher to existing theories but it rather gives room to new ideas and new theories. In-depth descriptions of participants' events are a concern to qualitative research, and qualitative data are collected through such methods as semi-structured interviews, participant observation, documents and texts, and the researcher's reactions (Myers 2009, 73)

To get respondents to voice out their own experiences, interview was seen as the appropriate measure to collect the data in this study. Interviews are particularly useful for getting the story behind a participant's experiences. With this technique, the interviewer can pursue in-depth information around the topic of investigation and this seeks to bring out both factual and meaning levels of the informants' experiences (McNamara, 1999). The interviews in this study were based on semi-structured procedure. However, the questions were open-ended thereby giving a flexible pattern of questioning according to how the discussion circulated. By using semi-structured interviews participants were given the possibility to make comments when they needed, and also helped the interviewer to gain more as new questions emerged and further clarification sought from the respondents. Also, the use of semi-structured interview technique gave a good opportunity to the interviewer to respond immediately to what participants say by tailoring subsequent questions to information the participant has provided (Brayton 1997)

Unlike structured questionnaire whereby an interviewer strictly follows detailed questions which are formulated in advance, semi-structured interviews start with more general ques-

tions. This is to say that the modus operandi of a successful interview often begin with a standard set of questions for the interviewee but allow for more in-depth follow-up questions at the discretion of the interviewer. Whilst applying interviews in this study, it was of great importance to ensure that all interview questions align with what is being looked for in the evaluation; this makes semi-structured interviews not to be as free as unstructured interviews (Myers, 2009)

As evidenced in this study, relevant study questions are initially identified in semi-structured interviews and any possible emerging themes or questions becomes the grounds for more specific questions which do not need to be prepared in advance. Participants were encouraged to thoroughly discuss issues or themes coming out of the interviews and this flow of discussions gave ways to more specific questions. Some of the questions in this study were created during the interview, thereby giving room for both the interviewer and the interviewee to flexibly probe for details or discuss issues (Nieswiadomy 1998, 150)

The general interview theme in this research was divided into two: Housing and health care. Interview questions were therefore carefully directed to get the participants' experiences on these issues. To get a true reflection of these experiences, interviews were carried out in a focus group. Focus group interview was chosen for gathering data in this study because it is illustrative, seen as a form of conversational interview session which makes the informants to be part of the study, and it yields a more diversified range of responses and afford more extended experiences of service users (Merton et al.1990, 135)

The use of focus group interviews for this study has helped to determine the perceptions, feelings, and manner of thinking of participants regarding their experiences. Focus group participants are able to empower one another to react to questions, which provides for a more natural environment. An informant goes beyond her own initial responses to give an additional experience after hearing the responses of others. The aim of conducting interviews in group was not for the group to reach any kind of agreement nor was it for the group to disagree on anything, but to get the participants' experiences in a defined area of interest in a permissive, non-threatening environment (Kreuger 1988, 18)

Two group interviews were held in this study, with the same participants. This called for a rich data as the participants turned to give a more detailed account of their experiences in the second interview. Repeating a study interview with the same participants gave the participants an opportunity to know the interview structure when appearing for the second interview, thereby making them comfortable to talk in the interview environment (McNamara, 1999). The repeated interview approach, in no small way, encouraged participants to be more open during the interviews, thereby helping the researcher in gaining as much information as possible from the respondents.

Interviews were conducted in June 2009. Desmond Tutu House (Bradford) was agreed with the participants as the place for the interviews. Desmond Tutu House is the venue where the participants attended BEACON's evening programmes, so they became much more at ease in talking freely and openly in that environment (McNamara, 1999). Before each of the interviews, the interviewer had coffee with the interviewee and talked about issues of feminism and a person's need for the love and care of a mother (woman), especially at the early stages of human development. With the echo of this off-topic discussion in participants' mind, they willingly talked about their experiences during the interviews. Consent letters were given to the informants and that marked the beginning of the interview session. A letter of consent is very important because it justifies the purpose of the study to the participants, explains the ethicality and confidentiality of the interviews, and also gives the participants a possibility of deciding as to whether or not to be part of the study (Merton and Kendall, 1990). The participants signed the consent letters and the interviews were conducted. The first group interview took 1 hour whilst the second took 1 hour and 35 minutes.

3.3 Data Analysis

In a qualitative study of this kind, data analysis is aimed to systematically and objectively analyse the gathered data in order to establish a clear reflection about what has been studied, without losing the content of the information collected. Data analysis is the process of bringing order, structure and meaning to the mass of collected data. Qualitative data analysis is a search for general statements about relationships among categories of data in "the ways in which the researcher moves from a description of what is the case to an explanation of why what is the case is the case" (Hitchcock and Hughes 1995, 295)

The informants' responses to the interview questions formed the data of this study. Irrespective of the number of informants, the amount of information obtained through focused group interview is usually abundant. Although this abundant data does not require complicated statistical techniques of quantitative analysis, it is nonetheless difficult to handle the usually large amounts of data in a thorough, systematic and relevant manner. Data analysis is seen as the suitable way of making a meaning out of texts, especially unstructured information. Analysis of data in this study was aimed to interpret, classify and combine the information gathered during the focus group interviews. Logical interpretation and conclusion has been followed in breaking the research data into smaller themes. Searching for theoretical hypothesis or proving theory is not the focus of data analysis in this study, but rather finding a way to illustrate data to reflect participants' experiences (Marshall and Rossman, 2006)

Tape-recorded group interviews were used to collect the data of this research. The tape-recorded interview data was transformed into written text and arranged for qualitative con-

tent analysis. According to Berelson (1952, 74) content analysis is a research tool focused on the actual content under study; it is used to determine the presence of certain words, concepts, themes, phrases, characters, or sentences within texts or interview records, and it is a good approach in determining the experiences of persons. Having the full transcript is essential to make sure that a researcher does not leave out anything of importance by only selecting material that fits her/his own ideas. Content analysis consists of reading and re-reading the transcripts looking for similarities and differences in order to find themes and to develop categories.

Transcriptions of the interview data was done to accurately serve the context of the participants' experiences. Listening to the recorded interviews was repeated severally in an attempt to discover any recurring feature of the organisation of talk which was not noted in the previous listening. Transcription of interviews involves a degree of interpretation and careful selection, but not to be assumed as a detail writing of recorded texts prior to the main business of analysis (Denzin and Lincoln 2003). In the text version, the data was thoroughly reviewed to make it familiarised and also to come out with a more clear understanding of respondents' responses. Thorough readings of the transcribed interview data was also very important because it made it easy in reducing the data into a form in which the irrelevant information is separated from the relevant ones (Hitchcock and Hughes, 1995)

Extraction of relevant interview data from the bulk of information was done by looking for repeated expressions or themes from responses that described respondents' healthcare and housing experiences. Original expressions in the data were carefully examined and then organised according to similarities or dissimilarities. This was to bring out common meanings in order to create simplified expressions and to categorise and name the content accordingly. The study data was grouped into sub-categories, which were created by interpreting the contents of those sentences. Informants' responses were compared with one another and then put in the appropriate sub-category. Two main categories were formed based on the sub-categories. Data was arranged under the themes of housing and health care.

4 Findings

4.1 Access to health care

In their stay in England in general and Bradford in particular, the respondents explained their experiences of getting basic health care, which they experience to be of good quality. Compared to that of their home countries, they are appreciative of the health care system in Bradford, in terms of quality. All the ten (10) women interviewed said they have accessed health care services, further describing their experiences that receiving and accessing health care services in England is possible, including people seeking asylum. The interviewees said their health care is functionally meaningful so they are glad to have access to basic health care services in their asylum years. Participants directly or indirectly compared their accessibility to health care services they are given in Bradford to that of their countries of origin, and wished for a similar level of health care delivery in their native countries. Most participants acknowledged that there are equally structures for good health care services in their home countries, but unlike in England getting access to such services in their country does not practically work well for everyone.

I was pregnant when I run to England for my dear life. As a pregnant woman, I had regular antenatal clinic appointments, the midwives paid much attention to me, and it was free (Irene)

I receive good medical treatment whenever I get sick, and it is free of charge. This is different because in my country you will not be treated if you don't have money (Kate)

However, the participants said language has a big role in their experiences of accessing health care in the UK. Those who can not speak English are neither able to describe their health problems nor are they able to understand health care consultation. According to the participants, service users do not often receive the best possible health care services due to insufficient communication between service providers and users.

When the Home Office brought me to Bradford, I was not feeling well. I didn't know what to do ... and couldn't also ask people because I did not speak any English by then (Amuzi)

4.2 Culture and gender

Most participants said they had not seen a female doctor or interpreter when they visited the hospital, though all the participants said they would have preferred to speak to a woman. They believe that the gender of health care professionals is important in the health care system. Nearly all participants felt that in times of sickness, the doctor's gender determines the degree of effective doctor-patient communication and satisfaction in medical consultation.

Paying attention to culture is significant when designing services for clients. The participants described the health care services they receive as asylum seekers as culturally inappropriate. Most participants stated that culture is an important factor in regard to access to health care services. When they arrive in the UK they need help to gain access to basic health care services because they come from countries with different systems of health care delivery. Although the participants stressed their appreciation for the quality of health care they receive in UK, most of them said having someone who can understand their culture helps a great deal in the matter of access to health care services. The participants expressed the view that mainstream health care services fail to provide for their needs when it comes to culturally sensitive services.

I have never been happy in going to meet my GP. All the GP's at my surgery are men ... and that is not helping me because there are some issues I don't feel easy to discuss with men, not even my husband (Rosalinda)

Here in Bradford I get good treatment whenever I go to the hospital. But I can not tell all my health problems because the doctors are of different sex (Vahid)

But you know as a woman you can't talk to a male doctor about the health problems of women (Lamisi)

I was by then a breast-feeding mother and the place where I went for [medical] consultation was not favourable to me ... at one time I had to breast-feed my child in the waiting room, filled mostly with men. I was very shy (Irene)

As women, we don't always have to explain everything when we visit the hospital, so it would have been good to have someone who can understand our culture (Vahid)

There is good treatment here but it is always difficult for the GPs to understand my own culture as a woman (Angela)

4.3 Effects of accommodation dispersal system

Participants discussed the UK dispersal system, new procedures for the accommodation of asylum seekers pending their claim for status determination, as separating them from their families and social networks. Most of the participants who applied for asylum together with their family members said they were sent to different dispersal regions - thereby denying them the love and support of a family. Fleeing to the UK, most of the interviewees explained to have already experienced severe loss of one's country, community, relatives and close ones. Therefore, they have expected to be housed in the same dispersal cities with the families they came with, or to be accommodated in a community where they could be socially connected to other people with their kind of cultural backgrounds. Most of the participants said that they find it very difficult to live in the accommodations provided in the dispersal system, because they have conflicting backgrounds and cultures from the people they meet in

their flats. They explained that living in accommodation blocks or flats where one does not probably know the next door neighbours was a new experience for them.

Also, most participants said they have experiences of huge inconsistencies in the time it takes to get housing support under the dispersal system. Respondents discussed how they are dispersed to Bradford and how it took such a long time to be offered a suitable accommodation. There is no priority housing list for asylum seekers dispersed to the Bradford district, not even to women with children.

I was surprised that the immigration people sent my husband to Cambridge and brought me to Bradford. How did they expect us to live together as married people? (Rosalinda)

The UK system works differently from that of Eritrea, and it's not easy to understand how it works until you have stayed in for years! ... so it would have been best if I was sent to the South, I mean London area; because there are many Eritrea people there and they can always help (Angela)

I was given a room in Great Horton Road. Though I like it, I have never found that place a good place to live because I didn't know anyone in that block, not even my next door neighbours ... so imagine, who will help me if something happens to me in my house? (Agatha)

But my brother was sent to Scotland, so I felt very lonely (Amuzi)

I had no choice though I would have wished to be in Huddersfield because I had two friends seeking asylum there, so I could have been happy with their presence (Vahid)

I had to remain in the Manchester detention centre for two months because the Home Office said they were still arranging with NASS to find me a house which will be big and conducive enough to contain me and my two children (Lamisi)

4.4 Health screening and specialist health care services

Most respondents believed that the initial health screening at the beginning of their asylum seeking process and subsequent check-ups during dispersal is a good way to identify those at risk. It was pointed out in the interviews that although most women were relatively healthy on arrival, they may experience health problems associated with travelling long distances during dispersal. However, three informants did say that the health screenings on women seeking asylum are not sufficient to determine those at risk, adding that those screenings are just questionnaires which try to discover the presence of communicable chronic diseases in them.

Accommodation procedures make one to be sick (Agatha)

When I arrived here, my health status was checked. I think it is a good thing (Vahide)

You are only asked question whether you are sick or not, how can they know if there are some hidden sicknesses in the blood? (Lamisi)

Also, it was identified that specialist asylum support services in Bradford aimed at addressing the needs of female asylum seekers came in a number of ways, from individual casework support to signposting to relevant services. All respondents mentioned that basic counselling services were available in the Bradford Asylum District, and referrals are often made to other specialised services for victims of torture, post-traumatic stress disorders and other health care services.

Agreeing to the availability of specialist services, most participants pointed out that the cost of travelling to health centres can make it difficult for asylum seekers to access health care services, basic and specialist. They had expected to get services at their close proximity; or to be financially supported with the travelling expenses to service points.

But these referral services are located far distance away. One is based in London and another in Manchester. So imagine having to find your way to London or Manchester if you have no money (Angela)

You are monthly given a voucher for your feeding. I think it would have been a good thing if they give money for transportation whenever someone is referred to a different centre (Mary)

4.5 Violence and discrimination

The participants said it is difficult to be re-allocated to a new house in cases of domestic violence and/or general harassment. They discussed that in the experience of domestic violence or harassment, they are required to report to the police for an investigation to be carried out before an alternative house be allocated to them. The informants believe that asylum seeking women are often trapped in abusive situations in cases when domestic violence and harassment are reported. According to them, an investigation into reported violence suggests NASS would expect a woman to endure several incidents before she qualified for alternative housing.

Some informants explained of experiencing racism and/or discrimination from housing and health care officials in England; and that the words of an asylum seeker are not mostly trusted. The informants believed that most asylum-housing and health care officials tend to carry prejudiced attitudes and behaviour during service provisions. Agreeing that they had access to health care services and a number of good accommodation support services, they said racial discrimination is a barrier to these services.

I couldn't bear the violence any longer ... But when I reported it I was told it was going to take about two weeks to investigate it, before any support can be

given. I could have been seriously injured by the time they begin to help me, or even dead (Angela)

It is difficult for them to trust anything you tell them (Amuzi)

Sometimes you don't need anyone to tell you that the officers hate you. They don't receive you the same way as the British citizens. Some of them don't show interest in listening to you whenever you go to them for help (Angela)

They have negative thinking about asylum seekers so they don't believe you (Rosalinda)

4.6 Ongoing support

Most respondents said the local authority in Bradford provided ongoing support by way of visiting tenants in NASS accommodation, and ensuring that their needs are being taken care of. They have experiences of being visited in their accommodation. It was specified that they are being visited once a month but more regularly in the beginning and the option of dropping in to the service for advice on accommodation issues and that of health care services was available. Most participants have experiences of been visited by NASS officials outside their official duties. They explained to be very appreciative of that and that they developed strong trust in officers who frequently visited them in their accommodation.

You don't know anyone at the place you are given a house, so it is very good that people from NASS visit you (Rosalinda)

Sometimes NASS officials pay you a visit after work and that shows that they care about you (Hanh-Vo)

You begin to have deep trust in those who come to visit you (Vahid)

When I came to Bradford, people from NASS often visit me in my room ... and they ask if I am ok (Irene)

However, one respondent said she had been left alone in her accommodation. She has neither been visited in her accommodation nor being offered a support of any sort.

5 Discussion

Women come to the UK to seek protection from a range of human rights abuses abroad. Whilst some of their experiences, such as being detained for their political activities, are the same as men's, some of their experiences are gender specific. Asylum seeking women deserve to be treated in a way that recognizes their particular needs as women (Home Office, 2008). This study was carried out to examine the provision of housing and health care services for women seeking asylum in Bradford, from the experiences of women service users. It also aimed at examining whether housing and health care services in the Bradford district addresses the needs and expectations of female asylum seekers.

The findings of this study showed that health care services for asylum seeking women in Bradford, in particular on gender issues, are culturally inappropriate. Even though female asylum seekers have access to good health care services, their health care needs are identified from the view point of the service providers, with little attention being paid initially to culture, gender and religion. In many cultures, it is not considered normal practice for a female to deal with a male doctor or for a male client to deal with a female doctor. The lack of appropriate care has resulted in asylum women not approaching the health care authorities to seek their help, with the consequence that their health has suffered. In some cases applicants may be reluctant to engage in a discussion about their health with a care worker of the opposite sex, thus giving the impression that all is well when it is not (Dumper 2002, 6)

Had culture and gender been considered, men and women should have had separate surgery times or possibly separate waiting rooms. Changes have since occurred, however, in attempting to consider some of these needs from the experiences of the respondents. Valios (2001, 32) states that women are often left to discuss private and intimate details of their health problems to male professionals, thereby leaving facts often not disclosed and thus jeopardising their need for support.

The findings in this study contradict to some extent that of 'Mothers in Exile' which claimed that most of the women interviewed had had positive experiences of culturally appropriate health care services across England (McLeish, 2002); and also 'Is It Safe Here?' which stated that 72% of women claimed to have no problems in accessing housing and health care services in England (Dumper, 2002). This study showed that women face particular difficulties accessing health care services with lack of women doctors and child care facilities in some areas. However, due to the size of the sample this is not far from expectation. Had the sample size in this study been larger a different picture could well have emerged.

In the interviews, the informants discussed that language is a primary barrier that affects medical consultation and treatment, with few trained translators and interpretive services

available. It was stated that doctors using family members, such as children or spouses, as translators, create serious trust and confidentiality issues, both to the translator and the family unit, by exposing such translators to inappropriate information which can be psychologically damaging. Overall, there was a great deal of worry and confusion by respondents on the effect of language on their healthcare provisions.

This study showed that although there is a wide-range of health care services for women seeking asylum in the UK, those without good English language skills do not receive the best possible services. There are interpretation services but these services are not available for asylum seeking women at all times. A Home Office report states that nearly every general health care practitioner appears to have a different approach to dealing with interpretation and translation. In the UK, some health care practices gain access to language support via the Language Line telephone interpreting service while other practitioners are in dispute about who was responsible for the cost of language translations and support services for asylum seekers. This is a set-back to asylum service provisions (Home Office, 2008).

This thesis showed that the current UK government policy of dispersal and potentially long-term residence in communal accommodation centres do not support social network. The consequent social isolation can be made worse by the stress and anxiety that many experience, and consequently lead to ill health (Stewart, 1997). The accommodation dispersal policy affects women both psychologically and emotionally. It consolidates their social isolation and feeling of loneliness, as dispersed asylum seeking women are more likely to stay at home. By being dispersed, this study showed, women would be deprived from any social contacts in their communities.

Newly arrived asylum seekers look for the safety of close relations and friendly surroundings where other members of the community would be the bridge for their integration into their host community. Close relations and friendly social networks provide asylum seekers with the necessary support needed to settle in the new society. Being deprived of that support people seeking asylum have to live isolated in hostile environments without any suitable links to defuse their tension of uncertainty, fear and the sense of insecurity. The findings of this study showed that once they had arrived at the port of entry, asylum seekers are dispensed into local consortiums, and although they would have preferred to be accommodated in areas where they already have social relations or in communities where they could be connected to people of their type of background, they are sent to areas on a no choice basis. According to Asylum Aid's report, women seeking asylum in the UK are discriminated upon, socially excluded from being part of the larger community (Southall, 2002) and in most cases, their Welfare support services are structured in a way that makes them to become weak, powerless and oppressed (Thompson, 1995).

It was made clear from the experiences of the respondents that the Home Office officials initially decided the needs of asylum seekers. This meant that the consortium considered an area suitable to disperse clients. Therefore, the UK officials working for the welfare of women seeking asylum were identified in this study as using a provider-led approach. Housing policies in the UK therefore neglect the specific needs of female asylum seekers and put their personal safety at risk. This form of discrimination, from a perspective of anti-oppressive practice, results in negative self-image and an inability of asylum seeking women to play a pro-active role in society (Dalrymple & Burke 1995, 15). Oppression often involves disregarding the rights of individual or group to partake in making decisions affecting their lives, and thus a denial of citizenship (Thompson 1993, 33). Also, the report 'Is It Safe Here?' identified that women, through dispersal often end up in hostile and isolated environments (Dumper, 2002).

It is understood from this study that participants experienced racism and discrimination in receiving health care and housing support services. Barriers to asylum service provisions are partly as a result of harboured racism that leads to misconceptions against people seeking asylum. Service providers are sometimes not able to deliver services because of mistrust for users. Avoidance of prejudiced judgements on asylum seekers will go a long way to increase the quality and efficiency of service provisions. There is the need for officials to start acknowledging that racism is endemic in organisational structures in health and social care services, as in society more generally. It is only by an understanding of diversity and internalisation shall we make sense of the incredible fact that the prejudiced attitude we hold in our society goes a long way to affect our practices. Society does not only control our movements, but also shapes our identity, our thoughts and our emotions. The structures of society become the structure of our own consciousness. Society does not stop at the surface of our skins, but rather it penetrates us as much as it envelops us. In the provision of support services, the encounters between clients and the workers are shaped within the context of unequal power relations. It is therefore not surprising that the social welfare arena is a prolific ground for the emergence of oppressive practices (Pollack, 2004). In order to ensure that social support services are detached from expressions of oppression and bias, there is the need to adopt anti-oppressive practice in working with people of disadvantaged group, especially of different race.

Anti-oppressive practice clearly derives from a more critical, social model of difference. Anti-oppressive practice builds on a social constructionist model of racial and ethnic differences, as well as differences of other kinds, as produced within a context of unequal power relationships in society. Rather than having a sensitivity to apparent ethnic or cultural differences, anti-oppressive practice argues that what is needed urgently is the practice that challenges and changes structures of inequality at every level (MacPherson Report 1999, 34). Institutional racism has been a factor in the experiences of women on housing services, as well as in

health and social care services. Women in particular have experienced discrimination, particularly within the National Health Service (NHS) in England. The NHS, like many other organisations, reflects a history of discrimination in its employment practice (Baxter, 1997).

This study indicated that most asylum seeking women are satisfied with health care screenings and check-ups in their asylum process. According to some participants however, screenings are focused not on the general physical, psychological, and mental health of women, but solely on communicable diseases, which does not leave sufficient room for assessing the health of asylum seekers in the broad sense, nor engage them in a sense of their own well being. Also, it has been understood that asylum seeking women suffering from non-communicable chronic sicknesses are not generally facilitated, and they often must wait for a number of months to receive a medical card where they face considerable obstacles securing a general practitioner. Again, this study showed that participants have access to specialist professional clinical and counselling services, thereby offering a wide range of psychological support. However, these specialist and counselling services do not meet the needs of service users as a result of the cost involved in travelling to its access points.

Various factors influence how accessible health care services are for asylum seekers, such as whether information is made available. Earlier study by the Home Office indicates that some accommodation providers in the UK, and private providers in particular, were not meeting their responsibilities in helping asylum seekers to gain access to health care services by way of making them aware of local services and how to access them (Home Office, 2008). An attempt was made in this study to discover how the participants learned to register with a health care centre, and to discover where this support came from. The findings were that most participants claim they were not told about the UK health care system and/or how to register with a General Practitioner (GP) in order to receive health care services. Only few respondents described their experiences as good, explained the UK health care system and their rights to receive health care services during their asylum process. This finding is inline with a greater part of the literature in this study. Most of the literature highlighted that often, women were not given relevant information about services and support that is available to them. This indeed can jeopardise the asylum application process and/or their living conditions in the UK including their housing and health care service provisions. More women than men are illiterate; those who have some formal education have, on average, fewer years of schooling. It may therefore be harder for them to get information about how and where to apply for asylum, or even to learn what their options are. In some cultures, women are prohibited from interacting with strangers, including governmental authorities. This can be an obstacle not only to applying for asylum and gaining legal assistance in doing so, but also in getting information services available to them (UNHCR, 1991).

The findings of this study pointed out that women have experiences of difficulty in getting housing support from accommodation providers, in cases where they face domestic violence and harassment. Although the UK asylum accommodation support services lay out the guidelines for dealing with allegations of racial harassment, general harassment and domestic violence, the reality is that many asylum seeking women are trapped in abusive relationships because they cannot access appropriate safe and confidential housing. Policies set up on the provision of housing services for asylum seeking women state that caseworkers should consider the seriousness of domestic violence, the threats of such violence and the frequency of occurrence along with the likelihood of re-occurrence, before offering them alternative or emergency accommodations (Home Office 2008). The experiences of asylum seeking women in this study go alongside the literature from Asylum Aid's report by Southall Black Sisters, identifying that incidents of domestic violence often go unreported, and that even when they are reported it has to be proven beyond reasonable doubts before funds will be released to place these women in a place of safety (Southall 2002).

On the whole, this study concludes that although there are varieties of good housing and health care services for women seeking asylum in Bradford, most services do not meet the needs and expectations of the service users.

6 Ethical considerations and trustworthiness

A study of this kind can have a powerful impact on people's lives therefore ethical principles of beneficence, autonomy and justice were followed in planning and implementing this study. Ethics are moral rules and principles, virtues and values which are seen as a systematic attempt to understand moral conceptions. Ethical issues in qualitative study are often more delicate than issues in quantitative study, since qualitative study usually involves long-term and close personal contact. The benefits of this study to the participants were maximised. Justice principle of this study is ensured as this study maintained privacy and used fair procedures in the selection of informants. The procedures adopted in the implementation of this study therefore made the benefits to the participants outweigh the risks (McNeil 1990, 12-14).

In doing the interviews, this thesis made sure of the confidentiality of the people being interviewed. Participation for interviewing was on a voluntary basis. The participants were asked for their permission to be interviewed and to sign an informed consent form. The interview questions were formulated in a simple and understandable way. Although consent forms were signed by informants, it was made clear to them that it was possible to withdraw from the study. A contract of assurance was given to the informants that the information provided during the interviews would not be used against them in any way, and that the information obtained from interviewing them will be disposed of confidentially after the completion of this particular study. This assurance was particularly important as one of the respondents asked, prior to the interview date, whether the information they provide could have an impact on their asylum applications. In presenting the findings of this study, the real names of informants are not used. This is to ensure that the data given in this study stayed anonymous.

Respondents were approached with compassion and nurture during the interviews. This is because ethical standards in research relating to women go beyond merely avoiding harm, but also context and nurturing relationship. The interview session began after engaging participants in a chat concerning the need to treat women with respect, care and love. This off-topic conversation prior to the interviews, gave participants a positive idea about the ethicality of this study. Daily life dilemmas are shaped by social divisions of gender, class and ethnicity and the experiences of these generate different ethical perspectives. These dilemmas are not abstract but rooted in specific relationships that involve emotions, and which require respect, nurturance and care for their ethical conduct (Porter 1999)

Trustworthiness implies the information of a research is based on critical argument. Trustworthiness in a qualitative research implies a research report should reflect a factual accuracy of the data as reported by the qualitative researcher; the researcher's sincerity and accurate understanding and reporting of the participants' viewpoints, thoughts, intentions, and experi-

ences; and also the researcher's accurate use of theory or theoretical explanation developed from a research study should fit the data (McNeil 1990, 9). According to Patton (2001), the criteria for trustworthiness in qualitative study are dependent on the factors of its validity and reliability. These are two factors which any qualitative researcher should be concerned about while designing a study, analysing results and judging the quality of the study. The issue of validity and reliability is transformed into the question "how can a researcher persuade his or her audiences that the research findings are worth paying attention to?". In the following texts, the trustworthiness of this study has been examined in relation to these criteria.

Appropriate method has been used in this study in coming out with a valid data. The validity of this study is evidenced on the similarity of the theoretical framework of this study and existing social experiences in relation to the informants' responses to the questions presented to them during the interviews. Validity addresses the extent to which research methods and data are considered to be accurate, honest and on target. It examines whether a research explains or measures what it is intended to measure or explain; and also how truthful a research data is interpreted (McNeil 1990, 10). In an attempt to come out with a true reflection of the respondents' experiences, this Bachelor thesis used well planned measures to ensure that informants get sufficient and clear information about the research problem and questions. This study remained open and unambiguous throughout. The processes of this study were open to the participants and they had a voice in the entire study process. All the interviewees could speak English language so interviews were entirely in English. Maximum care was taken to ensure that the information given in this study was not misinterpreted. Transcription of the recorded interview data was soon after interviewing in order to get a valid data. The transcribed interview data was reported to the informants before being included in the research report. This was made in an attempt to increase the validity of this study. Interviewees were given the permission to contact the student-researcher if they worried about the information they gave. This permission procedure was implemented because good research practice means using practices that respect the principle of openness in order to get a valid and credible data. The validity of this research could be attested from the fact that respondents' responses to the interview questions followed a pattern of similarity (Hammersley & Atkinson, 1995).

Group interviews were used to collect a detailed and rich data for this study. Semi-structured questions were used for the interviews; a method that made it possible for the informants to express themselves in a more detailed manner. Two group interviews were conducted on different days, with the same respondents. This was to ensure that the instruments used in this study are natural in their effect, and would measure the same findings when applied to the same respondents on different occasions. This credits this study of its reliability (Descomber 2003, 273).

Joppe (2000, 1) describes reliability as the extent to which research results are consistent over time and an accurate representation of the total population under study. Any person using the same research instrument should arrive at the same findings and that should be consistent and stable. Priority was given to reliability in this study thereby ensuring that it could be applied by others interested in the same subject to come out with the same findings, when the same instruments are used. Interviews were recorded to enable the focusing on the interviewing situation and reacting with questions. Notes were also taken alongside the recordings in order to ensure the clarity of responses. Interviews were carefully transcribed. When transcribing the interviews, this study did so word for word. When all interviews were transcribed, they were given a thorough review to ensure getting a clear sense of the responses given to the questions. The reliability of interview data in this study takes its basis from the established reliable relationship between the interviewer and the informants. Findings in the two different interviews were compared, grouped into subcategories and thereupon formulated by interpreting the contents of those sentences.

This study was conducted to find out about the housing and health care service provisions for women seeking asylum in the Bradford district. The study instruments were constructed in such a way that it would be applicable to the general situation of the United Kingdom. Due to the sample size however, the findings from this study can not be generalised and transferred to consider that of the whole UK.

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Appendices

Appendix 1 Interview guide

INTERVIEW GUIDE

Background Information

What is your nationality?

What language(s) do you speak?

Healthcare

How do you describe health services you receive as an asylum woman?

How easy is it to get health services?

What are the main barriers in accessing healthcare services in Bradford?

What are your suggestions for better healthcare service provisions for women seeking asylum?

Housing

How did you get into your accommodation?

What do you think about your accommodation?

How do you describe the support you get in your accommodation?

What are the impacts of the asylum seeker dispersal on your social life?

In your opinion, what need to be done to ensure better provision of accommodation services for asylum women?

Appendix 2 Consent Form

Consent Form

My name is Sulemana Fuseini, a Bachelor of Social Services Degree student from Laurea University of Applied Sciences (Finland). I am carrying out a thesis, as a requirement of my Degree Programme. The theme of my thesis is to study Housing and Healthcare Services in Bradford for Asylum Women. This will be done from the experiences of women seeking sanctuary. The rationale behind this study is that I feel that the asylum service providers in the UK, and especially in the Bradford district, need to be made aware as to whether or not their services meet the users' needs and expectations.

To complete the thesis, I am carrying out this study in collaboration with the BEACON project. I, with consultation with BEACON and my thesis supervisors, have chosen to carry out this in the form of focus group interview as I feel this is the best method of gaining accurate information to fully understand your views on the matter. I will be very grateful if you could partake in a recording interview with me which will last for approximately 1 hour to 1 hour, 30 minutes. Should you agree to be in this study, you will be asked your experiences on housing and healthcare services you receive in Bradford as an asylum seeker. If consent is given, I may transcribe and reference some of the information. However, following this study there will be no way to connect your name with your data as any data collected from you will be coded in order to protect your identity.

Any data collected from you will be used only within this study and shall thereafter be disposed off confidentially. Participation is voluntary and you can withdraw from the study should you wish not to continue. To withdraw, please send me an e-mail or call me on phone within two months from day of interview. Should you agree to participate, please sign your name below to indicate that you have understood the nature of the study.

Thank you for the time taken.

Sulemana Fuseini

E-mail: Sulemana.Fuseini@laurea.fi

Tel: 07950175473

Participant's Name:

Signature:

Appendix 3 Minutes from Thesis Project Meeting

Minutes from Thesis Project Meeting

March 6 2009

Venue: Desmond Tutu House, 2 Ashgrove, Bradford. BD7 1BN. UK

Present: Revd. Chris Howson, Will Sutcliffe, Juddy Midgley, Sulemana Fuseini

Apologies: None

Welcome

Everyone was welcomed to the meeting by Revd. Chris Howson.

Initial Idea

The idea of the thesis project was introduced to members by Chris. I (Sulemana) explained the idea topic - to research on services for asylum seekers.

Discussions

The idea and topic was welcomed by members present. However, there were suggestions to re-structure the topic. Will Sutcliffe suggested that the study should consider the services by interviewing both the asylum seekers and service providers; and that both State and voluntary providers should be looked at. Chris brought a concern of the workload on the 'student' (myself), pointing out the burden in data analysis and timing. I (Sulemana) gave out my assurance of being able to carry on with the workload, so it was agreed that the research should consider both the service users and providers. Chris said a project of this kind needn't be too broad; it was therefore agreed that the study should be focused on women.

Juddy suggested that the research should take a holistic view of the experiences of women seeking asylum including health, housing, family, finance and torture. That was applauded to and Will Sutcliffe added that those are the aspects severely challenging women asylum seekers.

Conclusion

It was affirmed that the project will do much good to BEACON, and it has the support of all members. Chris raised an issue that the suggested ideas are flexible and that I (Sulemana) could modify it in the process. That was agreed by all members present.

I (Sulemana) was asked to contact Chris or any BEACON staff whenever I need assistance.