Submission from RAPAR to DoH Guidelines group c/o angela burnett
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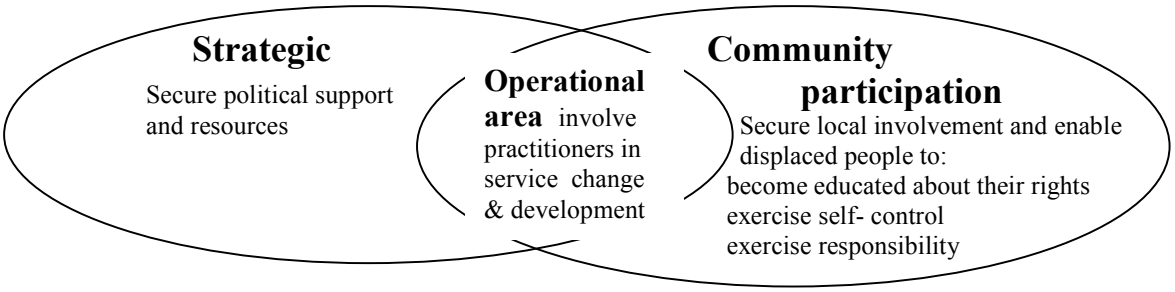
Refugee and Asylum seeker participatory Action Research (RAPAR)

1. Aim, Objectives and User Centred Approach

With the overall aim of delivering sensitive and appropriate services within an increasingly diverse community, Refugee and Asylum seeker Participatory Action Research (RAPAR) was formed in July of 2001. It has the following objectives:

- In general, develop participatory action research with (not on or for) displaced people, practitioners and applied academics
- Specifically, enable specific service development for specific communities on the basis of robust evidence
- Develop a parallel approach:



Centering the User

The engagement of potential non-academic users of research is integral to our work. We have set up a multi-agency and multi-sectoral consortium that crosses administrative and geographical boundaries. This has been achieved through involving policy formulators and practitioners from a range of statutory and voluntary sector agencies, asylum seeking and refugee communities and academics across Trafford, Salford and Manchester. Most importantly, it includes individuals with commitment, coal-face experience, research capability and the power to deliver services that build on the research results.
Our methodology includes social relations patterning which means that it reaches people without formal contact with agencies or community organizations: it is this approach that is enabling their voices to begin to be heard within our work.

2. Developments to Date

Building on from work in development with our Somali refugee communities since 1998 RAPAR also has the advantage of the involvement of dedicated primary care health service personnel (0.5 Health Visitor, wte Administrator in Salford via a submission developed by Salford CHC with support from University of Salford) who recognise the importance of being able to work from solid evidence when developing service. RAPAR has:

- Set up and conducted monthly multi-sectoral action orientated development planning meetings since July 2001

- Generated seedcorn money to enable the start of research development
- Held a series of outreach ice-breaking sessions with initially exclusively Afghani, male and, more recently, mixed groups (from different countries and including women). See further details below.
- Constructed temporary environments in community settings within which natural leaders of groups of asylum seekers have been able to emerge and now are moving forward, with support, in their capacities to be community opinion formers and leaders
- Developed and submitted a series of bids for participatory action research projects and also for service development
- Started collecting information about needs, and acting upon that information e.g. series of discussion/meetings with Salford Police Force and creating opportunities for asylum seekers to communicate with police about their experiences of harassment and abuse; enabling a surgery where Asylum Seekers began to explore their educational and training needs
- Initiated and enabled an increasingly complex and productive network of contacts between asylum seekers and voluntary and statutory agencies across the Health Action Zone area (Manchester Salford and Trafford)
- Acted as an informal support and information-sharing forum for a wide range of people working with asylum seekers including contributing to a heightened understanding about the isolation of their work in this field, the strain that that is imposing upon individuals, their frustrations around their attempts to help their colleagues to understand both the complexity of this work and the profound needs of what are the most vulnerable population group in this society

To date, this work has been developed by staff with several other responsibilities and very limited time, academics who have been involved without any payment for their time and refugees and asylum seekers themselves.

3. RAPAR's perspective on specific issues

1. Refugees and Asylum Seekers are **themselves part of the solution,** not part of the problem
2. Refugees and Asylum seekers have critical skills, knowledge and understanding of their own needs and their own experiences and are resourceful people who **need initial opportunities to enable them to work through to their own solutions** and in partnership with agencies.
3. **General Practice** Presentations to GP's may be inappropriate through:
    - Misunderstanding about what General Practice can offer
    - Lack of appropriate interpretation facilities
    - Cultural differences which can include exclusively bio-medical diagnoses of mental health needs that fail to associate well-being protection with socially based interventions
    - Lack of understanding, by the G.P.s, of displaced peoples' issues (Keynes et al 2002)

    Linkworkers Through RAPAR the capacity of refugees and asylum seekers to offer interpretation and translation services to support one another has been

demonstrated time and again. Developing a pool of interpreters who work for Primary Care Trusts across conurbations would be a useful way forward with refugees and asylum seekers themselves who being supported to compose the membership of this pool.
Anecdotal evidence indicates a general lack of awareness within General Practice about those link worker services that are available.

4. **Inter-agency working.** The experience of working across organizational and geographical boundaries has meant that the work developed through RAPAR has been able to be proactive and far more holistic than previous experience where practitioners worked in isolation. In practice RAPAR is bringing together health, social services, education, youth and leisure services, housing, community safety, community development workers, advocacy agencies, church groups and local resident groups and Red Cross and into direct contact with asylum seekers as groups and individuals.
   Past experiences of law enforcement services, both at home and as people have moved towards and into the U.K., have led to a severe lack of trust towards such agencies on the part of the overwhelming majority of displaced people that RAPAR has worked with to date. For this reason, RAPAR maintains a constant dialogue with the police over issues of community safety while recognizing the sensitivity of this area of work. In addition, the issue of data protection in relation to any suggestions about sharing datasets, and ethical codes of practice as observed by a range of practitioners and researchers, need to be constantly borne in mind.
5. **Communication.** Among the many issues relating to communication in the health field, the use of children to interpret invokes child protection issues. More generally, any misunderstandings that result from inadequate interpretation could expose GP's themselves to charges of malpractice and is completely contrary to all contemporary policy directives that focus on quality care (Clinical Governance) e.g. A Kosovan woman, prescribed anti-depressants and told they would help with her headaches, took them pro re nata (as painkillers).
6. **Mental well-being.** Psycho-social problems need socially based, rather than medicalised, interventions where displaced people themselves are involved in identifying, developing and delivering such interventions in partnership with local agencies. This form of peer support has been tried and tested in other population groups. Within RAPAR and also through earlier work with Somali refugees the experience has been that the displaced communities are extremely keen to be involved in planning for their futures: they are very responsive to offers of help, are willing to trust where trust is justified and are highly reliable as working partners.

7. **Community Health Development and Participatory Action Research Approach** RAPAR's commitment to a community development and PAR approach is greatly enabled through the ability to make contact with the target population through the dedicated health visiting service that has been available for just over a year, the first of such posts within the HAZ area.
8. **The New Strategic Health Authority.** Current reorganization within the NHS creates an important opportunity for the service to configure an holistic response

to the needs of displaced people that builds upon current interagency and participatory working. To this end, opportunities should be grasped that create cross-boundary services, centred on the displaced people themselves who are having to cross these boundaries constantly in order to secure culturally appropriate support and provision.

9. **Infection Control .** There is an important example of successful infection control that has been developed in Salford where a TB Nurse works with groups and families of asylum seekers offering and delivering screening in their homes. This form of group work can be very effective for health promotion as it is non-threatening for the displaced people themselves, it creates opportunities for people to hear questions that they themselves are unable or unwilling to articulate – and the relevant answers – and it is a highly efficient use of healthworker time. It may be that this model can be usefully extended into Manchester and elsewhere.
10. **Community Gynaecology Development** RAPAR includes the involvement of the individuals and groups responsible for the opening of the first community based sexual and reproductive health clinic outside London that has developed through work with refugees in the Rusholme area of the city of Manchester.
11. **Developing Employment Opportunities.** The population of displaced people who are currently living in Greater Manchester includes medical doctors, educationalists, engineers, linguists, lawyers, economists, mechanics, judges, business people, religious leaders. While there are currently a number of restrictions that operate in relation to work, the displaced people that we are working with are very keen to regain and retain control over their lives through employment – paid or voluntary. This combines with the fact that they offer a range of skills that could prove to be most useful in the development of appropriate services, enabling integration over the longer term and meeting some of the skill shortage needs. The post-graduate medical work under the leadership of Doctor Keaney is a good example of a productive approach that should be developed in relation to other competencies and professions.
12. The **issue of housing**, and its interrelations with the experience of health/ill-health is of fundamental importance. Housing allocation is a lottery with some accommodation providers giving excellent service and others appalling housing conditions and minimal support. It is essential that housing providers become integrally in the future development of initiatives.

References

Clarient Management Consultants 2001 Report on Linkworkers, commissioned by Manchester Race and Health Forum

Keynes, Mohamed, Farah, Lovel, Mynott and Moran. Not another note! **British Medical Journal.** In press 2002