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TITLE

HEALTH VISITING AND REFUGEE FAMILIES IN INNER LONDON: ISSUES IN PROFESSIONAL PRACTICE

ABSTRACT

Background and rationale

Women who are refugees and asylum seekers in the UK are more likely to experience depression than either non-refugee women or male asylum seekers. Health visitors provide a universal public health service to all women on the birth of a child, or with children under five and as such are well placed to identify emotional and mental health problems of women who are refugees. Despite successive waves of refugees to the UK in the twentieth century there are no empirical studies concerned with health visiting practice with this vulnerable group. There is no body of evidence to inform health visitors new to working with asylum seekers and refugees.

Aim

This paper reports on the perceptions of experienced health visitors working with refugee families in Inner London.

Methods

An exploratory study, informed by the interpretative tradition of social theory, was undertaken in Inner London. Semi-structured interviews were conducted with a purposive sample of 13 health visitors experienced in working with women and families who are refugees.

Findings

A range of structural challenges was identified that mediated against the development of a health promoting relationship between the health visitors and the refugee women. With the refugee families, who were living in temporary accommodation, the health visitors were prioritising basic needs that had to be addressed: in addition, they prioritised the needs of children before that of the women. Health visitors were aware of the emotional needs of the women and had strategies for addressing those with women in more settled circumstances. The health visitors considered themselves ill-prepared to deal with the complexities of working with women in these situations.

Conclusions

This study identifies issues for further exploration, not least from the perspective of refugee women receiving the health visiting service. Health visitors, in countries receiving refugee women, are framing their work with these women in ways that reflect Maslow's theory of a hierarchy of needs. This study suggests ways that public health nursing practise could be improved and issues for further study.

KEYWORDS

Health visiting, refugees, primary care nursing

SUMMARY STATEMENT

What is already known about this subject?

- The prevalence of depression is higher amongst refugee women than non-refugee women in the UK, and women asylum seekers in the UK are more likely to report ill-health and depression than male asylum seekers
- Health visitors are state funded, public health nurses providing a health promoting and illness prevention service to all women with newborn babies and children under 5 in the UK.
- Despite successive waves of refugees to the UK throughout the twentieth century, there are no empirical studies informing health visiting practice with women who are refugees, or specifically refugee women who become mothers and are at risk of postnatal depression.

What this study adds

- This study provides descriptive data of health visitors perceptions in working with mothers who are refugees and asylum seekers in Inner London
- It suggests that health visitors working with these families initially frame their activities based on Maslow's theory of a hierarchy of needs and that the health visitors prioritise addressing the children's' needs before the women's' needs.
- It suggests that experienced health visitors employ strategies to ensure their work is effective but that those strategies are individually developed rather than professionally developed.

- The study identifies further empirical work that needs to be undertaken and points to the lack of empirical evidence on the benefits and problems in public health nursing posts that specialise in working with socially excluded groups in the population.

Word count 5,000

INTRODUCTION

It has been estimated that at the end of the 20th century some 15 million people globally are refugees, 75-80% per cent of these are women and children. (UNHCR 2000). The United Nations High Commissioner for Refugees has noted “refugee women continue to be disproportionately affected by physical and sexual violence and abuse, have unequal access to asylum procedures and humanitarian assistance and often do not receive individual identity documents. International laws, standards and policies on this issue abound: the problem is that they are inadequately implemented. “ (UNHCR 2002 p1). This paper reports on an exploratory study into health visitors’ strategies in addressing the health needs of women who were asylum seekers and refugees (Box 1) living in Inner London.

Terminology

The term ‘refugee’ has a specific legal meaning. Under the Geneva Convention (United Nations 1951) refugee status can be granted by a host country to those who have been ‘judged’ to leave their own country or are unable to return ‘owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.’

The term ‘asylum seeker’ is used to describe someone who has crossed an international border and submitted an application for protection under the Geneva Convention.

The term refugee and asylum seeker is used in this paper to include also those people who are appealing against Home Office decisions not to grant refugee status.

Box 1

BACKGROUND

Asylum Seekers and Refugees in the UK

Many countries, including the UK, have explicit immigration laws, with criteria for granting refugee status. Seeking refugee status in the UK can be very protracted (Home Office 2002). In 1999, there was estimated to be 250, 000 asylum seekers and refugees in London (Aldous et al 1999). In 2001, 70,000 people sought asylum in the UK, the majority aged between 21 and 34, and male (Home Office 2002). The National Asylum Support Service (NASS) coordinates the dispersal of asylum seekers away from the South East of England. In London, NASS places asylum seekers in temporary accommodation such as hostels and low cost bed and breakfast hotels. Refugees, who are accepted by Local Authorities as unintentionally homeless and vulnerable as defined under the homelessness legislation (e.g. adults with dependent children), are also placed in similar temporary accommodation for some months until permanent accommodation is offered or obtained.

The Health of Asylum Seekers and Refugees

Asylum seekers and refugees to the UK come from countries across the globe and experience a wide range of socio-economic and health problems (London Health Observatory 2002). The limited analysis of the health of refugees in London suggests that most are physically fit on arrival but subsequently experience deterioration in health (London Health Observatory 2002) . The health problems characteristic of refugee populations are derived from three sources:

- Communicable diseases prevalent in their home country,
- The experiences which caused them to seek refuge including war and persecution,

- Experience of being a refugee including; the journey to the UK, uncertainty in the process of claiming refugee status, and hostility in the host community.

Surveys in the UK reveal that one in six settled refugees have a physical health problem and over two thirds experience anxiety and depression (Carey Wood et al 1995). Mental health problems following trauma is significant issue for some individuals, while emotional distress is much more widespread (Burnett and Peel 2001). There is very little investigation specifically into the health needs of refugee women, who are in the minority in the UK.

There is some evidence that the prevalence of depression is higher amongst women who are refugees than that of non-refugee women in the UK and other European countries (Health Education Authority 1998; CVS Consultants 1999, Iglesias et al 2003). A study in one part of London indicated that women asylum seekers were more likely to report ill health and depression than men and less likely to speak English or be literate (Gamell et al 1993). A recent study of maternity experiences of 33 women asylum seekers in England (McLeish 2002) reported that while many of them reported crying endlessly after the birth none of them had been offered assistance. Half of these women reported experiencing neglect, disrespect and racism from the maternity services.

Difficulty in accessing primary care health services by asylum seekers has been a recurrent theme in previous studies (Karmi 1992, Ramsey et al 1993, Refugee Health Consortium 1998, Hargreaves et al 2000, Ghebrehewet et al 2002). It should be noted that in the UK primary health care services act as the gatekeepers to other specialised health services. These studies however focus mainly on general practice and fail to consider the wider services provided by nurses and health visitors in primary care.

Health Visitors

Health Visitors are public health nurses predominantly focused on families with children under the age of five. They provide a service to all families in their own homes, in community clinics and community settings. The statutory process of birth notification in the UK includes the transfer of that information to the health visiting service. Health visitors visit new mothers at home before the 14th postnatal day in order to identify and help address health needs. During this home visit, the health visitors and families negotiate the subsequent use of the health visiting service based on the families identified needs and public health programmes such as childhood immunisation. Health visitors are encouraged to address issues of maternal depression and facilitate parenting skills in the postnatal period (The Home Office 1998, Department of Health, 1999a), particularly with families with complex social and health needs (Department of Health 1999b, 1999c). One group within Inner London who meet these criteria are families who are asylum seekers and refugees.

Health Visitors and Refugees

Health visitors have provided a universal primary care service to successive waves of asylum seeking and refugee mothers and children in Britain since the creation of the NHS in 1948. Given this history there is a singular paucity of published research into health visitor involvement or health visiting practice issues. The few published accounts are descriptions either by the individual health visitors working in multi-agency refugee projects (Goodburn 1990, Savigar 1998, Crouch 2003) or by journalists in general articles about health care for asylum seekers and refugees in the UK (see for example Daniel 1999, Wolmuth 1996, Carlisle –Pestic 2001).

Both of these types of accounts emphasise the multi-professional collaborative activities, subsuming the health visiting perspective. The issues they all identify are:

- The challenges of working with people who do not speak English,
- The importance of supporting people to access mainstream services,
- The imperative of addressing issues of isolation and hostility from the host community.

Those health visitors describing situations where the refugees are placed in temporary accommodation, such as hostels, also report that the shortcomings of the environment are a key issue.

The published literature by health visitors does not differentiate between the health needs of men and women. While isolation was a noted problem, the identification of depression and in particular post-natal depression are not mentioned. Written requests by the researchers to every lead nurse for health visiting across Greater London in 2000 failed to identify any unpublished reports addressing aspects of health visitor practice with refugee families.

The absence of a professional literature broader than the individual experience has meant there is little on which to identify effective health visiting interventions with this group of mothers. There is a paucity of evidence on which the profession draws to inform the practice of health visitors who are new to working with refugee mothers. The Home Office policy of dispersal throughout the UK has increased the volume of health visitors likely to meet women who are asylum seekers and refugees.

One group who share some experiences with those who are asylum seekers and refugees are homeless families, placed in temporary hostel and bed and breakfast accommodation,. There

is slightly more published literature on health visiting work with families in temporary accommodation. A survey of health visitors working with homeless families placed in temporary accommodation (Drennan and Stern 1986) and descriptive accounts of health visiting work with such families (Lovell 1986, Cross 1988, Lee and Goodburn 1993, Hutchinson and Gutteridge 1995) indicate that the health visitors have to address health needs concerned with shelter, warmth, food and safety, before being able to work on other needs, such as depression and isolation. Their work has been clearly framed by the hierarchy of need described by Maslow (1968). Maslow described a hierarchy in which physiological needs and safety needs are foundation levels which underpin an ascending order of social needs, esteem needs and at the pinnacle those of self realisation. Families that are asylum seekers and refugees share some characteristics with those families accepted as unintentionally homeless, in need of public support and placed in temporary accommodation. The researchers hypothesised that health visitors framed their work with mothers who were asylum seekers and refugees using the same hierarchy of need. This study was undertaken to explore that hypothesis through the perceptions of health visitors', who were experienced in working with refugee mothers, as to effective professional practice strategies they employed to meet the health needs of refugee mothers. .

METHODOLOGY

Aim

The investigation aimed to:

1. Explore and describe health visitors experiences working in Inner London, in identify and addressing the health needs of refugee woman in the first three months after the birth of a baby,

2. Investigate health visitors' perceptions of effective and ineffective strategies in identifying and addressing health needs with women who were refugees in the first three months after the birth of a baby.
3. Investigate whether health visitors utilised a framework corresponding to Maslow's theory of a hierarchy of needs to prioritise their public health work.

Design

The approach of this study was exploratory, drawing on the interpretative tradition of social theory to inform the research design (Robson 2002). Semi-structured interviews were used to collect data from a purposive sample of health visitors experienced in working with refugees. The Local Research Ethics Committee approval was obtained.

Sample

A purposive sample of thirteen health visitors, who identified themselves as having significant numbers of refugee families on their caseloads, in two Boroughs in inner London, North of the Thames, were recruited. All of the health visitors had worked in Inner London for over five years. Nine of the thirteen participants were themselves immigrants to the UK. Four of them had home languages other than English. The health visitors reported that they were currently working with asylum seekers and refugees from across the globe.

Data Collection

Individual semi-structured interviews were undertaken in the health visitor's place of work in 2001. Broad, open-ended questions were used in the interview, inviting informants to be

discursive and reflective in recounting their experiences. Question areas focused around: previous and current experience of working with refugee families, problems and supporting factors in working with refugee families, strategies for addressing the health needs of refugee women in the post natal period and views of developing and improving health visiting practice with refugee women. Each interview lasted between forty-five minutes and an hour. The interviews were taped with permission and subsequently transcribed.

Data analysis

The data were thematically analysed, employing the “framework method” described by Ritchie and Spencer (Ritchie and Spencer 1994). The theoretical issues identified in the literature were used to devise the coding framework. The interviewer and second author independently coded the transcripts against the framework using word processing and spreadsheet functions software. Additional codes were assigned as the data suggested new themes and issues. A small number of discrepancies in coding between the two analyses were resolved through subsequent discussion. The coded material was then analysed for: a) commonalities between informants, b) conflicting perceptions between informants and c) evidence to support or disprove the use of a hierarchy of needs in framing practice.

This was a small-scale study intended as an exploration within limited resources. The researchers identified that the study could be strengthened by carrying out an exploration of health visitor and client interactions from a client perspective.

FINDINGS

The findings of the study are reported under four broad headings:

1. The complexity of the relationship between health visitors and clients who are refugees,

2. The Identification and prioritisation of the health needs of the asylum seeking and refugee families,
3. Health visitors perceptions of successful outcomes to their work,
4. The impact on the health visitors from working with asylum seekers and refugees.

The complexity of the relationship between health visitors and clients who are refugees.

Health visiting practice is built on the establishment of trust between the health visitor and their clients (Health Visiting Association and UK Standing Conference 1992). The health visitors reported that this aspect of their practice was affected by three factors:

1. The refugees' anxiety and expectations about state officials,
2. The impact of short-term accommodation,
3. The wide diversity of languages and cultures.

The health visitors reported that some asylum seekers and refugees were very anxious when approached by state officials. They had to make great efforts to explain the system and whom they represented:

'I always make it clear I am nothing to do with Home Office or passports, because you know many refugees are very frightened. They don't know I am a health visitor, - I could be the Passport Office right hand woman for all they know.' (Interview 5)

The health visitors described the need to spend time explaining their services in the context of other publicly funded services to people who had no experience of such services, in their own country.

“Working with the indigenous population, one goes in to confirm the system. This is very different when working with the refugees who have no knowledge of the system so you have to start from the beginning.” (Interview13)

The health visitors recounted the difficulties in establishing trust with people placed in short-term accommodation, particularly in hostels.

“One day it will be one family sitting there [in a hostel room] and you put your mind around trying to sort things out, the dreadful things that have happened to them, and then the next week it will be a different family there and you start the whole process all over again, trying to build up some sort of trust so that they might tell you what their most pressing health needs are.” (Interview 5)

The health visitors recognised that they needed to obtain a great deal of information quickly yet sensitively from families who were likely to move on.

“It is really about just the complexity in trying to get information in the very short space of time, because they move on quickly. Trying to get as much information about their history, without, not prying but being as sensitive as possible.” (Interview 11)

Challenges to the continuity of service were also reported from the attachment of health visitors to general practices.

“I have another refugee family who has had a new baby, and I visit them and then they move further down my [geographical] area and try and register with the local GP. Then the GP refused to have her. I did another home visit there again to find they’ve registered with another health visitor’s GP. “ (Interview 7)

Primary care staff in the study areas had access to an NHS funded advocacy and interpreting service. The health visitors reported that the issues of rapid address change made it particularly difficult to obtain timely help with communication. Some health visitors described pragmatic decisions of using children as interpreters rather than wait until an official interpreter could be arranged. The health visitors were however aware of the risk of inadequate communication. One health visitor cited a refugee mother who was given a rubella injection in hospital after the birth of her child. The health visitor, working with an interpreter, discovered the mother thought it was a contraceptive injection, as she described it: *‘things happen to refugees in a rushed way without the use of interpreters’* (Interview 11). Although the health visitors valued the interpreting services, they also described the complexities in trying to build relationships through a third person. They pointed out that many of the asylum seekers and refugees came from countries with civil conflict so that often ethnicity was an issue in obtaining suitable interpreters.

The health visitors described how they worked in a way that acknowledged differences and tried to be aware of important cultural issues.

“You know, I would never expect to understand a culture, because it is hard enough if you have lived there. But there is a sort ofworking relationship which is mutually respectful” (Interview 11).

The health visitors emphasised the importance of history taking, listening, and a willingness to learn about other values and cultures.

“Now one thing I always do when I do my visits is to ask through the interpreter, you know, ask them if they want to tell me about what their practices are. For instance in terms of (infant) feeding, so that I can advise them accordingly.” (Interview 4)

At the same time the health visitors found themselves in the role of explaining the UK law, which is built on often completely different cultural mores and expectations. The example was given of the difference between culturally acceptable ages to leave children alone in charge of younger siblings and English law.

Identification and Prioritisation of Health Needs

The health visitors were all very clear that faced with destitute families with children in short term accommodation, with no family networks in a foreign country, the priorities were always to address the fundamental physiological and safety needs.

“ So it’s a Friday afternoon ... I am sitting there in this small bedsit room doing a new birth visit. They had been given a cot but they had no blanket, they had barely anything for the bed. She had no nappies, no clothes and no money and she was seriously struggling with breastfeeding she [the refugee mother] needs money, she needs milk, she needs a steriliser, she needs clothes and she needs it now”

(Interview 4).

This health visitor then related spending the next few hours persuading the Local Authority Asylum Seekers Team to act that afternoon and then herself returning to the family with donated second hand baby clothes and free sample nappies from the child health clinic.

The health visitors were more than aware that the women were likely to have a huge range of issues and experiences impacting on their health, particularly those arriving from war zones. Even encouraging women to take up the UK women’s health screening programmes raised issues:

“I think it’s quite difficult for refugee women to understand the services around sexual health and contraception. Having to explain about smear testing, whereas in their

own country there isn't a programme. Women can be very reluctant. ...and taking a smear is very invasive, isn't it and you don't know what's happened to them before they got here.” (Interview 8)

Some of the health visitors acknowledged that they, and they felt the mothers, prioritised the children's health over the women's' health. Sometimes this was a result of the rapid accommodation change, sometimes because the enormity of the issues to be addressed with these families.

“People who have lost their home, their countryyou know...How are they? I don't know.... You focus on the children, really, and it shouldn't be, but by the time you've moved from prioritising the children's well-being – the family have moved on.”.
(Interview 7)

Overall, the health visitors worked on the premise that because of their situation, the refugee mothers in the post-natal period were likely to experience depression.

“I know it sounds terrible but I generally work on the assumption that they're likely to have some element of depression anyway, because of their circumstances... “
(Interview 4).

A key activity that all the health visitors described was trying to help address the perceived isolation of the refugee mothers through giving information about local community organisations working with people who were refugees or people from their country. They described accompanying women to community organisations in order to help introduce them.

The health visitors also provided examples of the value of continuity and long-term relationships with women who were settled refugees. The health visitors gave examples of deep-seated emotional distress only being shared with them after years of inter-action, as in this example:

“Somebody I have known from a new birth. Her experience must have been awful having to get out of [country], you know, and within a short space of time both her parents died. She’s had three children here, and she was always very anxious and we never knew the reason why. Anyway, we got to the third child and while I am doing the three-year check, I say, is the child left handed or right handed? The child is left-handed and I said, is there a history of being left handed in your family? And this unlocked the whole story. The father who died was not her father –her real father was a [soldier from another country].”

The health visitor went on to relate then obtaining short-term psychological help for this woman.

The health visitors reported that in many cases the emotional distress of the mother, resulting from their experiences in their country of origin, would only be revealed through concerns about the health of the children.

“I had one refugee family from [country]. The children were on the Register for child abuse, .. she [the mother] always appeared very depressed. And we could never get to the bottom of this. And she would just say she was fine, she was fine. Things were happening at school and they were really concerned and I would see them at home again..... Eventually it all came out that her father was murdered in front of her when the country was in upheaval and there was a coup and the country was in

anarchy. She was very traumatized. Her husband then left her with all the children. She has no other relatives or children around. ... She is actually suffering from post traumatic stress you know, and it has been quite some time before we actually found out that her father had been executed in front of her” (Interview 8).

Health visitors described the complexity of trying to respond to the women’s needs and this will be discussed in the next section but perhaps the next quote illustrates the very immediate response of some of the health visitors.

“ There was an [country] woman that I had that I can’t find now. She had lost a child. The only boy she had lost in [country]. The husband is missing in [country]. Well you try and say something but what can you say? The mother bursts into tears, the under five [child] is oblivious of what was going on there and she asked her mother for a hug. And so I just gave them all a hug. “ (Interview 3)

Health Visitors’ Perceptions of Successful Outcomes in Their Work

All thirteen health visitors viewed helping refugee families’ to access services as one of the most important areas of their work. It was one aspect they judged success in their activities by. They viewed their contribution to this very pragmatically particularly after the birth of a baby.

“At the new birth visit I aim to get the mother and baby registered [with a GP] to get services.” (Interview 12)

“My aim is to give a parent held record with [her home] language written at the front, for the next service who meet them.” (Interview 5)

They recounted accompanying mothers to appointments or arranging for the same interpreter to be present. In the same spirit, the health visitors emphasised the need to take their own preventative services such as providing developmental checks and immunisations to the hostels and homes of the refugees. They recognised the difficulty for people in short-term accommodation to find their way to clinics and also the problems it created if the people were not in the hostel when meals were served.

They also recounted success in collaborative work to help families address psychological issues that were initially expressed through their concerns for their children.

“One family I had here, a [ethnic group] family but living in [country]. The child at that time when I met him was about 8 months old. The child was continually being brought to the clinic and to the GP’s surgery, mainly for problems around eating..... This family had problems. They’ve been victims of torture in [country] and also the father of the family had been beaten up over here in a racist incident as well... I managed to work with an advocate they had a lot of confidence in. Anyway, I then worked with the psychologist with that family around the eating problem and the child is no longer being presented and is a different child now”(Interview 2).

The health visitors worked collaboratively with the statutory and voluntary sector to offer appropriate services. They however recounted their difficulties in finding out and keeping up to date on the availability and access criteria for local services.

“I have had a refugee lady from [country] I have known her for a long time, and she always seemed to be depressed. Always having difficulties with her children. ‘They are not eating, they are not sleeping, they weren’t heavy enough’ ...and they were huge, you know, and I asked what is the problem and she broke down. She explained she had seen a lot of problems.....I put her touch with a voluntary

[nationality specific] counselling organization to then discover she had to pay and she can't afford it" (Interview 10).

The Impact on the Health Visitors in Working with Refugee Families

The health visitors reported that they found the nature of the work 'stressful', 'difficult', 'isolating' and 'painful'.

"But last year I did find it very traumatic to work with [country] families, ... because some of the stories that you hear are you know, absolutely horrendous." (Interview 03)

"Well the stuff about housing, about the problems, and for some of them no food, quite often hungry. Some of those times I nearly cried in those situation..... sometimes it feels a bit like you are alone in the dark really." (Interview 6)

The study participants obtained professional support from a variety of sources –primary care team colleagues, child protection advisors and other professionals working in the field, but they described their main support as informal from their immediate health visitor colleagues.

These health visitors described an overall lack of preparation for this work not least on the implications of recently enacted legislation. They expressed their need to have more information on

- Understanding the law and systems on seeking asylum and the regulations for support of asylum seekers and refugees,
- Culture and customs of specific refugee groups,
- Greater awareness on specific issues on the health of refugees
- Appropriate strategies in working with clients who had been traumatized by their experiences such as torture, rape or witness to murder,
- Availability of local services, particularly addressing psychological needs.

They were divided as to the best way to receive some of this information, particularly in relation to cultural awareness. In the main they were uncomfortable with broad based cultural

awareness study days but very positive about issue specific education informed by different community organisations.

They were also critical that they perceived health visiting time and the concomitant administrative support to work with these families as under-resourced. They argued for the need to have access to telephone interpretation to deal with immediate communication for families moving through temporary accommodation. They also argued for training the health advocates and interpreters so that they could contribute more fully in this work

DISCUSSION AND CONCLUSIONS

There is clearly a need to differentiate between the work of health visitors with asylum seekers and refugees in temporary accommodation and that with settled refugees. The health visitors working with refugee families living in temporary accommodation reported that they prioritised working on physiological needs at the base of Malsow's hierarchy (Maslow 1968) just as the health visitors described when working with homeless families placed in temporary accommodation. The speed of transfer between temporary accommodation placements meant the health visitors were unlikely to address needs at higher levels.. The health visitors emphasised their perception of successful practice for these families was facilitating access to other health and social care services. In this they were focusing their professional practice on one of the key health needs of asylum seekers and refugees identified in the UK literature.

Some health visitors reported that there was a hierarchy of whose needs were met in the families they provided services to. In the short-term episodes, the needs of the children were reported to be prioritised before those of the women. It is not clear from these interviews

whether the health visitors were responding to the women's priorities or whether they were determining the prioritisation through their child health service objectives. The childhood preventative health programmes, like immunisations, were more likely to be discussed by the health visitors than the achievement of women's preventative health programmes such as cervical screening, both of which have national public health targets (Department of Health 1999b). Was this another example of the health visitors using Malsow's pyramid i.e. immediate protection from infectious diseases was viewed as a more important need than early detection of future cancer, or were other value judgements informing professional practice? A different empirical study, using client centred data would be required to explore these issues.

The health visitors were aware of the psychological problems and issues the women were likely to be experiencing. A common strategy to address social isolation in first encounters with families was to provide information on local community group provision. The health visitors reported that they were more likely to help address other psychological issues with women in longer term or settled accommodation. Whether this was the result of having the time to establish a relationship with each other so that the women felt safe enough to disclose these issues or whether it was the result of the health visitors prioritising other needs, would need further investigation. The health visitors were clear that working through interpreters meant that the families had to come to trust not only themselves but the interpreter too. It is not clear to what the acquisition of English meant for longer term relationships between health visitors and settled refugees. Certainly many of the examples cited by the health visitors of addressing psychological issues revealed by the women arose after more than a year, if not years of contacts.

The health visitors considered that they were ill prepared for working with such a culturally diverse group with such complex issues. The health visitors' reflections on their own professional needs were used to inform service development such as the production of a local directory and dissemination of a recently produced NHS resource pack (Burnett and Fassil 2003) to all office bases.

The limitations of this exploratory study mean that there can be no firm conclusions only suggestions as to the direction for further empirical work. The literature hints at the cyclical solutions of creating health visiting posts that specialise in working with such socially excluded groups and develop individual expertise. It rarely records the arguments for or against these posts or the decision making when the posts are dissolved and the work dispersed between many health visitors. There is an organisational responsibility to ensure that health visiting practice is developed from the best evidence available and that the collective knowledge and expertise is shared, not left for each practitioner to discover through trial and error. A universal health visiting service means that both the profession and the service providers need to pay attention to the health and social needs of asylum seeking women, who will continue to arrive in the UK irrespective of legislative change.

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