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“Health is my life”: female refugee health in Glasgow

Abstract

This Global Health MSc dissertation explores how female refugees define health, how they take care of themselves and what helps or hinders their efforts. It fulfils this aim by providing insights into how these three lines of enquiry manifest across participants': definitions of health; physical health; mental health; social and structural contexts.

Its approach is infused with theory from a range of social research disciplines and has employed a case study design to explore female refugee health among members of a refugee integration network in Glasgow. It provides in-depth qualitative insights that contribute to existing academic research and inform local services and policy makers in their decisions affecting the health of female refugees in Glasgow.

In taking these lines of enquiry and through using such methods, the findings contribute to gaps in existing research about female refugees while also contributing to academic theories debate about agency and health. It finds a complex interplay between the ways in which female refugees take care of their health and the structures which help or hinder their efforts, sometimes in multiple, cross-cutting and ambiguous ways. Further, insights into how female refugees cope with miscarriages are provided, about which few studies have been undertaken. Concluding remarks highlight the positive role that such a network can play alongside other organisations in supporting and enabling female refugee health, cautioning that changes to the asylum system arguably need to be made if their health is to flourish.

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Lastly and certainly not least, heartfelt thanks for their guidance and support are given to my supervisors Dr Gareth Mulvey and Dr Heide Weishaar.

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1. Introduction

This Global Health MSc dissertation explores how female refugees define health, how they take care of themselves and what helps or hinders their efforts. Its approach is infused with theory from a range of social research disciplines and has employed a case study design to explore female refugee health among members of a refugee integration network in Glasgow. It aims to provide in-depth qualitative insights that contribute to existing academic research and inform local services and policy makers in their decisions affecting the health of female refugees in Glasgow.

The refugee integration network (referred to as the network) involved in this project supports the integration of asylum seekers and refugees, as well as settled black and ethnic minority individuals, into Glasgow. Its name and location has not been disclosed to protect the identities of participants, which is discussed in Chapter 4.2. Integration networks are charities facilitated by the Scottish Refugee Council and each cover a geographical area of Glasgow (Piacentini, 2015, p. 437). The networks bring together refugees, community groups, local agencies and volunteers, providing services to refugees in their area, including information and advice, English classes, drop-in services and a range of activities (Piacentini, 2015, p. 437).

This introduction sets out broad social and political contexts which have influenced the choice of topic. Female refugee health is a arguably a timely topic, for several reasons. Researchers have argued that research about refugee health in the UK remains patchy (Spencer et al., 2006, p. 24), as too in Glasgow (GoWell, 2009). Meanwhile a recent report about a peer education project piloted with refugees in Glasgow highlighted their agency in promoting health among their communities via activities such as swimming (Strang, 2015, p. 30). The report also highlighted service

providers' appetite to facilitate health knowledge and improvement among refugees, such as NHS Greater Glasgow and Clyde, who helped fund the project (Strang, 2015). It therefore seems timely to examine how female refugees look after their health in ways that contribute to academic research and to local services.

Research on refugee health indicates a gender difference in which female refugees often experience poorer health than their male counterparts (Mulvey, 2015, p. 13; Scottish Government, 2013, p. 24; Scottish Government, 2014, p. 27; Spitzer, 2007, p. 53). Meanwhile, the World Health Organization's constitution enshrines health as a human right (WHO, 1948, p. 1), its intention being that signatories 'promote and protect the health of all peoples' (WHO, 1948, p. 1). The United Kingdom is such a signatory and so focusing on female refugees in Glasgow is influenced by an ethical consideration that they have the same rights as the rest of the population to health as enshrined by the WHO.

In parallel to the academic need for more information about refugee health, current global contexts indicate the importance of understanding and supporting the health of refugees who come to the UK, as called for recently in the *British Medical Journal* (Arnold et al., 2015, p. 351). 2015 will stand out in the minds of many in the UK as a year which saw a plethora of press articles and public debate about migrants attempting to reach European countries, including the UK (Blanchard, 2015; Murray, 2015; Taylor, 2015; Townsend, 2015; Traynor, 2015). In 2015, at least 3,770 migrants died attempting to reach Europe (International Organization for Migration, 2015); many were refugees seeking safety from war-torn countries, persecution and violence (UNHCR, 2015).

As Phillimore and Goodson have argued, refugees fleeing their homes is not a new phenomenon (2006, p. 1715) but global numbers of refugees reached unprecedented numbers of approximately 59.5 million individuals in 2014 (UNHCR, 2014, p. 1). The UK received some 31,260 new applications for asylum by the end of 2014, an increase of five per cent from the previous year (UNHCR, 2014, p. 19). At the end of 2014 there were 153, 560 refugees in the UK, amounting to 0.24% of the country's population (UNHCR, 2015, p. 52). These numbers may be modest compared to global numbers of refugees, however a recent landmark case saw UK judges ordering the UK Government to allow four young asylum seekers into the country to join their families (ECRE, 2015). This decision arguably has implications for other refugees seeking refuge in the UK, and perhaps indicates pressure on the Government to accept more than currently admitted, again highlighting the timeliness of researching female refugee health.

Since the Immigration and Asylum Act 1999, the UK Government relocates asylum seekers across major cities through a 'dispersal' programme (Hynes, 2011; Vickers, 2012; Scottish Government, 2013). Glasgow is a dispersal city (Scottish Government, 2013) and the number of refugees living in the city are estimated to be 20,000 (Shisheva et al., 2013, p. 5). This figure may not include family members of an asylum seeker arriving through a family reunion programme (Scottish Government, 2013, p. 10).

At the same time, researchers have commented on past negative attitudes among the Scottish public (Williams and de Lima, 2006, p. 512) and the press towards ethnic minorities, including refugees (Barclay et al., 2003; Buchanan and Grillo, 2003; Coole, 2002; ICAR, 2004; Smart et al., 2007; Wilson, 2004). To better support refugees and promote positive public attitudes, Glasgow City Council

established a Refugee Support Team, the Scottish Government developed a Refugee Integration Action Plan (Scottish Government, 2003) and the Scottish Refugee Council facilitated the creation of Refugee Integration Networks in several parts of the city (Kearns and Whitley, 2015, p. 2109). This social context is an important backdrop because research has found that negative public attitudes, and sometimes violence, can increase refugees' reluctance to access services such as healthcare, which can in turn affect their health (Spencer et al., 2006, p. 13).

Today, the Scottish Government pursues a positive strategy for Scotland to be a 'safe, welcoming place, wherever new residents come from' (Kearns and Whitley, 2015, p. 2108; McConnell, 2003; Williams and De Lima, 2006, p. 512). Researchers have found there are still hostile attitudes towards refugees (Lewis, 2006; Stewart, 2009), but policy indicates a markedly more positive climate. In 2013 a national strategy was launched to welcome refugees into Scotland's communities (Scottish Government, 2013). Immigration matters are reserved to the UK Government while health is devolved to Scotland (Scottish Parliament, 2016). The Scottish Government applied such powers to instruct the NHS that all refugees (Scottish Government, 2013, p. 39), whether recognised as refugees by the UK or not, should be allowed to access NHS services like the population at large. Meanwhile refugee integration networks in Glasgow have received funding cuts (Kearns and Whitley, 2015, p. 2109; ODS Consulting, 2007), which arguably strengthens the need to better understand how female refugees who are members of such a network take care of their health.

The structure of the remainder of this dissertation is as follows. Chapter Two reviews literature relating to female refugee health, explaining how current research informed the research questions: 1) how do female refugees define health; 2) how

do they take care of their health; 3) what helps or hinders their health? Chapter Three outlines the aims and objectives. Chapter Four explains the researcher's position, ethical considerations, the design and methods employed in response to the research questions. Chapter Five presents the findings in light of the research questions. Chapter Six discusses the findings in light of the questions and the literature reviewed. Conclusions are provided in Chapter Seven.

2. Literature review

To gain an overview of existing research relevant to female refugee health, the literature was reviewed with regard to the following five topics: definitions of the term refugee; academic debate about definitions of health; the asylum process and structure; female refugee health; and female refugee agency.

2.1 Refugee

Firstly, to define what is meant by 'refugee', the best starting point is the United Nation's definition according to its 1951 Convention Relating to the Status of Refugees, supported by its 1967 Protocol (UNHCR 2011). The Convention describes refugees as possessing a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political' (UNHCR for Refugees, 2011, p. 14). The UK signed the Convention and is obliged to consider applications made by individuals claiming to flee such persecution (UNHCR, 2011, p. 14). Individuals seeking such refuge are termed 'asylum seekers' by the UK Nationality, Immigration and Asylum Act 2002 (UK Government, 2002, p. 11-12). Anyone seeking refuge under the UN 1951 Convention is termed a refugee in this dissertation, including asylum seekers, individuals who or have not been recognised as refugees by the UK and those who are destitute. The Immigration and Asylum Act 1999 defines destitution among asylum seekers as not having adequate accommodation or the means of obtaining it but not satisfying other essential living needs (Gillespie, 2012, p. 2; The Immigration and Asylum Act, 1999). This dissertation includes this definition and also aligns itself with Gillespie's understanding of destitution as an extreme form of poverty (Gillespie, 2012, p. 2). Gillespie further acknowledges that it can be short or long term and those without

income, financial support or refugees unable to access mainstream benefits can also be destitute (Gillespie, 2012, p. 2). When such individuals are collectively referred to, the term 'refugees' is used.

Some authors highlight that while the term 'refugee' might imply homogeneity, this is not the case (Malkki, 1995, p. 496). Rather, they emphasise refugees' diversity in terms of their many differences such as language, nationality, social and cultural practices (Burnett and Peel, 2001, p. 544; Malkki, 1995). In response, the research questions were designed to be open to a range of approaches that female refugees may take to taking care of their health.

2.2 Health

Researchers have argued that research about refugee health in the UK remains patchy (Spencer et al., 2006, p. 24) as too for research about refugees in Glasgow (GoWell, 2009). At the same time, academic interest in this topic is increasing (Spencer et al., 2006, p. 60), indicating the timeliness of focusing on female refugee health.

For a definition of health, the World Health Organization's constitution provided an initial focus. The WHO defines health as a 'state of complete physical, mental and social well-being' (WHO, 1948). This definition has received much comment and criticism by researchers. Antonovsky argued that it represents what health might be ideally but is rarely experienced (1979, p. 52). He further argued that rather than a dichotomy of health and illness, health should be seen on a continuum in which humans experience varying degrees of health throughout their lives (Antonovsky, 1987, p. 12). The WHO's seemingly static image of health as a *state* was also criticised (Nichter 2008, Skolnik, 2008, p. 6), with some arguing that health

is more dynamic and is rather an ever changing state of being (James and Corbett, 2010, p. 406). Such a dynamic sense of health is moreover imbued with many meanings, depending on a person's place in the world, their culture and their perspective (James and Corbett, 2010).

Understanding health as dynamic was also key to Antonovsky's concept of salutogenesis – understanding why and how people stay healthy (Antonovsky, 1979, p. 35). His argument for this line of enquiry was that efforts towards combatting diseases shed light on preventing illnesses but do not necessarily help understand how people maintain health (Antonovsky, 1987, p. 3). He proposed learning from people's good health could be applied to promoting health in others, while recognising that what one person does to stay healthy might not work for another (Antonovsky, 1979, p. 36). In looking at how people stayed healthy, Antonovsky was also particularly interested to see how peoples' coping mechanisms for managing their lives could be conducive to good health. His term sense of coherence took into account how people make sense of their lives, their perceptions about the resources at hand to manage their lives and if there were areas of life that were important to them (Antonovsky, 1987, p. 18). In response to the literature, it is not assumed that all female refugees see health as inherently a good thing to pursue or always try to look after themselves. Nevertheless, the concepts of salutogenesis and sense of coherence have been key in focusing on what things they might to do look after their health on the basis that helpful insights might help contribute towards knowledge about, and decisions affecting, the health of female refugees in Glasgow.

The literature showed that definitions of health can be ranging and contested. This led to development of the first research question: how do female refugees define health? From the literature was also a sense that health can be

multidimensional, dynamic and that focusing on how people take care of themselves might help promote further understanding about health. This led to development of the second question 'how do they take care of their health?' to understand the means and processes they employ.

2.3 The asylum process and structure

The asylum process is a legal one in which, as highlighted by Mulvey, individuals must prove they are a refugee according to the UN 1951 Convention, therefore bearing the burden of providing evidence (2015, p.15). Literature reviewed revealed that refugees' experiences of this process can impact their health (Spencer et al. 2006, p. 13).

Ryan et al. (2009) reviewed empirical studies between 1988-2007 of the mental health of adult asylum seekers awaiting a decision on their application in Western countries. Controlling for ethnicity, they found that waiting for a decision resulted in negative impacts on mental health. Mulvey found that in Scotland, the wait for a decision was also linked to negative effects on health (Mulvey, 2009, p.24) partly due to such individuals felt that they did not have control over their lives, that things were being put on hold (Mulvey, 2013).

The dispersal system, and levels of social and health support provided within it, is also a factor found by researchers to negatively impact on mental health (Burnett and Peel, 2001; Murphy et al., 2002; Phillimore et al., 2007, p. 7; Summerfield, 2001). However, researchers have also found that refugees' responses to dispersal have sometimes been positive for their health in terms of opportunities to form new groups in which to socialise and support each other (Hunt, 2008; Hynes, 2011; Piacentini, 2014/ 2008).

It has been widely documented that asylum seekers are not permitted to work, placing them in poverty (Gower, 2015; Hynes, 2011; Phillimore et al., 2007; Vickers, 2012; Scottish Government, 2014). Financial support provided by the UK Government already placed them below the official poverty line, at around 70% of income support (Chantler, 2012, p. 320). However, support was further reduced in 2015 and they now sit at approximately 64% of standard income support rates (UK Government, 2015). Individuals receive a little over £5 a day (Gower, 2015, p. 7). Families receive £73.90 - £147.80 a week depending on their situation – a cut of up to £39 a week (Gower, 2015, p. 7). If the UK refuses to recognise someone as a refugee, it is possible they become destitute, with no financial support accommodation in some cases (Gillespie, 2014; Green, 2006; Taylor, 2009).

Refugees recognised by the UK are allowed to work but research has shown that a variety of factors can reduce the likelihood of employment, including discrimination from employers (Bloch, 2007, p. 31) and competence in English (Bloch, 2007; Lindsay et al., 2010; Phillimore and Goodson, 2006, p. 1720). The literature highlights too that the length of time a person waits for a decision about their asylum claim can reduce their chances of finding work (Phillimore et al., 2007, p. 7; Phillimore and Goodson, 2006, p. 1721). Those with skills needing regular honing such as medicine can also be in danger of losing these during the asylum process (Vickers, 2012, p. 58). Lindsay et al. found that the employed refugees in their research were poorly paid and had unstable jobs (2010, p. 21), many considering themselves to be living in poverty (2010, p. 21).

As seen in the above literature, a lack of work and poorly paid or unstable work can lead to poverty. Literature reviewed highlighted that poverty and ill health are linked, particularly for mental health; not just for refugees but for any individuals

experiencing poverty (Chantler, 2012, p. 322; Murali and Oyebolde, 2004; Ramon, 2006; Shaw and Taplin, 2007). In light of this literature, it was anticipated that participants would have similar experiences of poverty, leading the research questions to include exploration of any interplay between their efforts to look after themselves and structural contexts.

The asylum process, poverty and employment - these things can be termed by some as structure. Structure has been described by some research as large structures beyond individual control, such as immigration, the job market and poverty (Farmer, 2001, p. 304; Hunt, 2008). Theorists such as Giddens have argued that structures can be virtual, manifesting dynamic processes in a constant state of becoming (1979/ 1976), while Sewell argued that structures can vary widely (1992). Theorists such as Foucault have gone further to write about concepts of biopower and biopolitics in which matters of health, such as life expectancy, become instruments for governing a human population (2005/ 1978). More recent research has further argued that structural inequalities and power imbalances can have a direct effect on an individual's body (Moore and Sanders, 2006, p. 12). Others have explicitly highlighted inequalities and power imbalances created by some structures that leave some parts of the human population marginalized, suffering health inequalities as a result (Farmer, 2006/ 2002; Nichter, 2008; Scheper-Hughes, 2004/ 2002).

In defining structure, it is almost impossible not to address agency. Theorists such as Giddens and Sewell argue that agency and structure are intimately linked (Giddens 1979/ 1976; Sewell 1992). Secondly, researchers highlight that agency can be constrained by structure (Brettell and Hollifield, 2008, p. 5; Hunt, 2008). Two concepts of agency were taken for this dissertation. Hunt aligned with Williams and Popay's definition of agency as peoples' capacity to act, collectively or individually

(Hunt, 2008, p. 281; Williams and Popay, 1999). Ortner split agency into two concepts. Firstly, Ortner described it as influence exerted by individuals and secondly as individual intention, though in practice Ortner argued they are inseparable (2001, p. 81). Ortner's concept of co-existing types of agency resonated with the topic of this dissertation for exploring how female refugees look after themselves and their desires for their health. Hunt's inclusion of collective, as well as individual agency, aligned with the focus on members of an integration network and taking into account how they took care of themselves as individuals and as group members.

In light of the literature, it was important to ensure the research questions included structural contexts beyond individuals' control, such as employment in addition to focusing female refugees' agency in looking after themselves. This led to the third question: 3) what helps or hinders their health?

2.4 Female refugee health

Literature on refugee health indicates a gender difference. Research shows that female refugees often experience poorer health than their male counterparts (Mulvey, 2015, p. 370; Phillimore et al. 2007, p. 7; Scottish Government, 2013, p. 29; Spitzer, 2007, p. 53). Reasons for a gendered difference in refugee health appear to be several. Firstly, female refugees, particularly asylum seekers, seem to perceive their health to be worse than men because they express significantly lower self-reported health and wellbeing outcomes than almost any other part of the Scottish population (Scottish Government, 2013, p. 63). Phillimore et al. (2007) caution however, that individuals themselves may have a gender bias which in this case may affect how they report their health.

Literature indicates that the UK asylum process itself may disproportionately affect female health in negative ways (Allsopp et al., 2014; Mulvey, 2015, p. 370), particularly mental health (Chantler, 2012, p. 324). Women wait longer than their male counterparts for a decision (Scottish Government, 2014, p. 29). The literature reviewed in Chapter 2.3 showed that waiting for a decision involves living in poverty and potentially experiencing worse health. This could therefore have particular implications for female refugee health. The dispersal of refugees across UK cities may also affect health as researchers have argued that refugee women are more seriously affected by displacement (Burnett and Peel, 2001).

UK decisions to recognise individuals as refugees are taken in light of the UN Refugee Convention's definition of what a refugee is. Yet research has highlighted that the UN Refugee Convention was produced through a lack of understanding that a person's gender could affect, or be a reason, for the kind of persecution they suffer (Querton, 2012, p. 7). Researchers have argued that this can be problematic for women who have been persecuted due to their gender (Camus-Jacques, 1989; Hunt 2008; Cipriani, 1993, p.548) and have for instance suffered female genital mutilation (FGM), forced marriage, forced sterilisation, forced abortion, domestic violence, rape or sexual violence (Freedman, 2015; Mancini Billson, 2005; Querton, 2012: 7).

Other factors have also been found by researchers to impact female refugee health. Studies and reports highlight that female refugees are less likely to speak English or to be literate than their male counterparts (Burnett and Peel, 2001; Gammell et al., 1993; Scottish Government, 2013, p. 53). Researchers found that while competence in English language did not necessarily guarantee employment (Bloch, 2007, p. 25), it affected refugees' employability (Bloch, 2007, p. 557; Cebulla

et al., 2010, p. 2; Lindsay et al., 2010, p. 17). The Scottish Refugee Council found that employment for female refugees than for males (Scottish Government, 2013, p. 37) as did Bloch (2007, p. 27). Vickers found that female refugees who found work were more likely than male refugees to be in less skilled work and more likely to experience a climb down in their social status (Vickers, 2012, p. 6). The literature reviewed in Chapter 2.3 highlighted that a lack of, or poorly paid and unstable, work leads to poverty, which can negatively affect health. The above literature indicates that female refugees may be more likely to experience this negative spiral. Research also found however, that some female refugees do not work due to responsibilities such as childcare (Bloch, 2007, p. 27; Vickers, 2012, p. 60), so it is not necessarily the case that unemployment results in negative health outcomes.

Phillimore et al. highlighted that female refugees are more vulnerable than male refugees to physical assault, sexual harassment, rape and domestic violence in the UK (Phillimore et al., 2007, p. 7). Research by the London School of Hygiene and Tropical Medicine and the Scottish Refugee Council also revealed a very high rate of gender based violence among female asylum seekers in Scotland (London School of Hygiene and Tropical Medicine and the Scottish Refugee Council, 2009; Scottish Government, 2013; 63). This again reveals another, striking, factor affecting their health.

The above literature strengthened the case for focusing on female refugees because of such complex gender differences and interplay with their health. Such gender differences also added further importance for the research questions to take into account: a) individual contexts, such as their own efforts to take care of themselves (outlined in Chapter 2.2); and b) structural contexts such as gender and employment which could impact on health (outlined in Chapter 2.3).

2.5 Female agency

The literature reviewed showed that research has tended to focus on female refugees' poor health (Chantler, 2012; Cheung and Phillimore, 2013a; Hunt, 2008; Maternity Alliance, 2002a, 2002b; Phillimore et al., 2007a; Williams and Kaye, 2010) and vulnerability to sexual exploitation and violence (Allsopp et al., 2014, p. 20; Phillimore and Goodson, 2010; Querton, 2012; Scottish Refugee Council, 2015; London School of Hygiene and Tropical Medicine and the Scottish Refugee Council, 2009). Research about positive aspects of their health are scant. One study found hypothesising a higher rate of breastfeeding among female refugees in Glasgow than the indigenous female population, however it focused on how they looked after their babies and did not focus explicitly on what they did to look after themselves (GoWell, 2008, 2012).

In contrast, this dissertation addressed how female refugees take care of their health. Some of the literature about refugees' actions might not have a health focus but have been included here because they offer relevant insights. Piacentini investigated refugees' collective agency in Glasgow via refugee community organisations (2008), providing solidarity, resources such as micro-credit (2008, p. 19), accommodation or social enterprises (2015, p.439, 442). Hunt's study described female refugees' abilities in joining community groups, attending college or volunteering (2008, p. 287), finding that their efforts changed things not just for them but for future arrivals of refugees (2008, p. 290) who could benefit from their skills, knowledge and experience (2008, p. 290). If Antonovsky's concept of salutogenesis (see Chapter 2.2) was that learning about maintaining health can be potentially shared, the literature about refugee agency also highlights how refugees can actively change things for themselves and others, even in constrained circumstances as

described in Chapter 2.3. Using these concepts of salutogenesis and agency therefore seemed mutually helpful for working with members of the integration network (referred to as the network) and considering their individual and collective efforts.

In summary and based on the literature review, this dissertation take a positive approach to understand how female refugees steward their health on an everyday basis and the complexity this might manifest. It also proceeds with caution and sensitivity by bearing in mind that the contexts (individual, social, political and structural) within which they live which can also play a dynamic part in their health.

3. Aims and objectives

This dissertation aims to understand how female refugees define health, how they take care of their health and what helps or hinders their efforts.

To fulfil this aim, five objectives were developed so that female refugee health, and its complexity, could be understood across dimensions encountered during the literature review (see Chapter 2). Participants' responses to the research questions were analysed in light of the information they provide according to their:

1. Definitions of health: Chapter 2.2 highlighted the need to understand how participants defined health and this objective responds to the first part of the aim.
2. Physical health: such as disease, fitness and pregnancy.
3. Mental health: such as emotions and mood.
4. Social context: social relationships with families, friends and marital status.
5. Structural and political contexts, such as the asylum process, education and employment: Chapter 2.3 highlighted the importance of understanding female refugee's agency within the structural contexts they find themselves.

4. Methodology

4.1 Researcher's position

The epistemological stance of this project is focused on method – how things can be found out (Moore and Sanders, 2006, p. 1). It is assumed that there is a reality and the enquiry is 'how can female refugee health can be understood within this reality?'

The position taken as researcher in this project was influenced in two ways. Firstly, fieldwork undertaken as community engagement manager for GoWell¹ indicated that participatory methods would work very well for this project. Specifically, conversations woven around an activity were helpful in facilitating discussions about health, the topic of this project. Since the research questions focused on what female refugees do to look after their health, it therefore seemed useful for the fieldwork to involve an activity that they generally do every day to look after themselves.

As outlined in Chapter Two, while the focus was on how participants look after their health, it was anticipated they had experienced some form of persecution. In this light, an ethical stance was taken for the research process to be empowering for participants whilst employing approaches that would focus their health. The researcher position therefore committed to elements of community-based participatory research. Community-based participatory research sites the researcher as a collaborator with participants in their community (Singer, 2003, p. 3; Washington, 2004), involving them in the research (Brydon-Miller et al., 2008; Schensul et al., 2015; Schensul and Le Compte, 2002/ 1999; Singer, 2003; Washington 2004). Researchers using this approach have found it useful for working with marginalized people because it produces knowledge and helps redress power imbalances that participants have experienced while achieving some form of change (Schensul et al., 2015; Singer, 2003; Washington, 2004, p. 19). In light of this research, it seemed a useful approach to take with participants in exploring how they take care of their health.

¹ GoWell is a research and learning programme investigating the impacts of regeneration on residents' health and wellbeing in Glasgow (GoWell 2015).

4.2 Ethics

Chapters Two and 4.1 outlined the ethical underpinnings for the choice of topic, methods and role as researcher. This chapter explains additional ethical considerations.

A principle guiding the research was to think about to whom I was responsible (Pink, 2006, p. 12), helping to identify ethical considerations for participants, the network, myself, future researchers wishing to work in this field and the wider refugee communities. Ethics were considered in terms of harm and *effects* of the research – positive and negative (Association of Social Anthropologists, 2014). Aware that ‘ethical and legal dilemmas occur at all stages of research’ (ASA, 2014), I reflected on ethics during the design, fieldwork and analysis.

The University of Glasgow’s College of Social Sciences ethics procedure required thorough arrangements to minimise risk and distress (to participants and to me). Given the approach taken to collaborate with participants and employ an empowering fieldwork process, it seemed logical to also consider *positive* outcomes. For instance, regarding benefits of the research to participants in the short term, it was hypothesised they might want to enquire about a service, join a new group and build on or learn new skills. This led to signposting arrangements anticipating positive outcomes as well as for any participant who might be distressed.

For signposting arrangements, a list of local agencies and organisations that provide refugees with free support and advice was drawn up, in positive and negative circumstances (see Appendix One). I contacted a number of these organisations and established pathways through which I could also refer participants to named individuals.

Given this range of anticipated outcomes, my ethics form to the College of Social Sciences argued that the plain language statement needed an alternative content to the one stipulated. Normally the plain language statement is expected to state:

‘Please note that assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm is uncovered. In such cases the University may be obliged to contact relevant statutory bodies/agencies’ (University of Glasgow College of Social Science, 2016)

The alternative statement proposed and approved was:

‘If you think that you would benefit from speaking to any other organisations, we can discuss this if you wish.’

The latter statement was designed to recognise participants’ reasons, positive and negative, for wanting to speak to other organisations. It was also designed from an ethical wish to respect the ‘rights and needs of all participants’ (Phipps, 2013, p. 17), which seemed especially important to ensure given the persecution participants might have already encountered, as outlined in Chapter Two. If I contacted an organisation on a participant’s behalf without their consent, this could have done untold damage to their health if it re-triggered any previous trauma. This approach seemed an appropriate balance between reasonably ensuring participants received any support they needed and avoiding causing them further distress.

Practical issues were also considered. Participants’ real names were replaced with pseudonyms of their choosing for two main reasons. Firstly, previous experience in working with refugees confirmed that while they often wish their voices

to be heard without disclosing their full identities, they also wished to still have some sense of identity rather than being a nameless voice. Secondly, enabling participants to choose pseudonyms (if they wished) was part of the participatory approach and their active role in parts of the research process, as described in Chapter 4.1. Other details about participants were also removed, including the network's name, their countries of origin, language and any particular health condition that might identify them. Recordings and notes were confidentially stored, to be destroyed after the project.

To ensure participants were not out of pocket, I paid their travel expenses. In terms of an ethical duty to myself, these travel expenses (bus fares and the odd taxi for one participant with significant health conditions) were affordable. GoWell paid for the venue hire. The University of Glasgow College of Social Science stipulates that payment to participants should not act as an 'inducement' (University of Glasgow College of Social Science, 2016), however as outlined in the Chapter 2.3, refugees often live below the official poverty line. Indeed, without travel expenses being paid, many of the participants would not have been able to afford the bus fare to the venue.

Interpreters were also booked for participants that needed or requested them so that they could express themselves in the language they felt most comfortable with and so that they were also able to understand the purposes of this project, what was involved and give informed consent. NHS Greater Glasgow and Clyde's interpreting services team provided an interpreter on two occasions. Using interpreters brought additional ethical considerations, highlighted by Phipps et al.'s recent research on interpreters in clinical sessions (2014). Firstly, the researcher needs to be competent at working with interpreters and able to gauge if the

interpreter is fulfilling their role properly (Phipps et al., 2014). Thirdly, participants need to know what to expect from the interpreter (Phipps et al., 2014). I was trained in working with interpreters by Scottish Refugee Council and this satisfied such ethical considerations.

In summary, key ethical implications for this project were considered throughout the research phases and included philosophical as well as practical ethical issues.

4.3 Design

This project is characterised by a qualitative design. Qualitative research consists of a range of methods (Seale et al., 2007) chiefly concerned with words (Agar, 2003; Bryman, 2012, 380). They often try to understand and interpret (Bryman, 2010, p. 384) an individual's perspective, how they make meanings and the contexts in which these happen (Seale et al., 2007, p. 9). This design was taken because the project concerned itself with how participants defined health, how from their perspective they sought to take care of their health and what helped or hindered their efforts.

The design employs an intrinsic case study. It is a design that has been used in a number of disciplines, including by ethnographers, sociologists and historians (Hancock and Algozzine, 2012, p. 33). This type of study aims to arrive at a deep 'description, interpretation, and explanation' (Maxwell, 2013, p. 79) of a particular individual or group of people (Hancock and Algozzine, 2012), which suited this project's aim of producing in-depth insights about female refugee' health.

A single case was used and there are key justifications for this. Research about, and projects with, has found that refugees typically live across half a dozen

areas of Glasgow (GoWell, 2006; Kearns and Whitley, 2015, p. 2108; Strang, 2015, p. 19). The spread of refugees across Glasgow's neighbourhoods represented a logistical challenge in terms of choosing a fieldwork site or sites. Time constraints of this project also influenced the numbers of participants that I could recruit and work with. It took time, for instance, to make contact with and build up a relationship with the network. Further time was needed to plan the fieldwork, which involved hiring a community kitchen (see Chapter 4.5). These constraints led to choosing a single case, meaning I could concentrate on providing in-depth insights from the network's members.

Furthermore, the purpose of this study was not to generalize the findings to the wider refugee population in Glasgow but instead focus was on how female refugees from a group manage their health, and the contexts within their practices are situated which was another key reason for choosing one case (Maxwell, 2013, p. 79). It should also be noted that several participants were members of a number of networks and groups, including the one I worked with. Choosing any number of fieldwork sites may still, therefore, have ended in working with the same or similar participants.

4.4 Methods

An intrinsic case study design was taken to work with one integration network, as outlined in Chapter 4.4. The network was chosen because they worked with refugees of a range of nationalities, could negotiate access to a community kitchen and were very interested in the project. This latter point about their interest was important because it meant they were committed to using the research findings to build on their work, fulfilling one of the project's criteria to provide useful insights to local groups as well as contributing to academic debate. The name and location of

this network has not been disclosed to protect the identities of participants, discussed in Chapter 4.2.

Chapter 2.4 highlighted the agency which female refugees may exert and possible constraints on their efforts. If researchers have an ethical duty to do no harm to participants (Association of Social Anthropologists, 2014), this project sought to try to do some *good* by involving them in an empowering process. In this light and as described in Chapter 4.1, I committed to collaborate with participants by involving them in shaping the fieldwork elements of the research process. I also committed to signposting participants for any advocacy matters that could arise from discussions about their health.

As described in Chapter Three, the dissertation had five objectives. To fulfil these, two methods were employed. Firstly, group sessions facilitated collective discussion about definitions of health. Secondly, in-depth qualitative interviews gained deeper insights into individual's efforts to look after their health. This section describes these in more detail.

An ethnographic approach was taken for the cooking sessions and the in-depth interviews. Ethnography can be understood as a suite of methods seeking to understand social and cultural behaviour (Schwandt, 2007) among distinct groups of people (Cruz and Higginbottom, 2013, p. 36). It does so by using detailed observation, first-hand experience and participation - also termed participant observation (Ingold, 2011, p. 229). Ethnographic studies often devote substantial amount of time (up to years) to a project (Ingold, 2011; Sunderland and Denny, 2007, p. 50). The aim is to produce a detailed textual description that richly describes (Geertz, 1993) how people view themselves and the world around them.

Whereas ethnographies tend to focus on groups of people from a particular culture, it was anticipated that participants would come from a range of cultures. As explained in Chapter 4.4, there were also constraints regarding time and the logistics of researching refugees spread across the city. This dissertation therefore centred on elements of *focused ethnography*.

Focused ethnography is an applied version of ethnography because it can be used to explore specific topics as part of contributing solutions to real-world problems (Cruz and Higginbottom, 2013, p. 38; Richards and Morse, 2007). Researchers have found that it can be particularly helpful for studying people who are diverse or fragmented (Cruz and Higginbottom, 2013, p. 38; Knoblauch, 2005) because it investigates how they approach a single issue (Roper and Shapira, 2000). This suited the project, which anticipated working with refugees from a range of backgrounds to understand how they defined and looked after their health. Additionally, focused ethnographies tend to have pre-selected lines of enquiry and use interview topic guides that are highly structured around the issues to keep the research centred on its lines of enquiry (Higginbottom, 2011; Morse, 2007; Spiers and Wood, 2010). Pre-selected lines of enquiry and structured topic guides further suited this project because since time with participants was short, the research needed to remain firmly rooted in the topic of female refugee health.

Focused ethnography was carried out in a number of ways. Firstly, detailed observation was used during group cooking sessions in addition to hands-on experience by taking part in the activity with participants. A topic guide was used to ensure that the activity centred around the first research question: how do female refugees define health?

Cooking was chosen because it was anticipated that participants already cooked and would accept it as a method for the fieldwork. Pink cites the importance of methods being acceptable not just to the researcher but also to the researched (2007, p. 43). During previous work with refugees in Glasgow as a volunteer with Scottish Refugee Council, I learned that many female refugees came together to cook; one group published a book on haggis recipes across the world (International Women's' Group, 2014). Cooking was also an activity that I enjoyed and I anticipated that a common enjoyment of food would help form a rapport with participants. Based on this literature and experience, cooking seemed an acceptable activity.

Watts argued that connecting with participants is important to form a rapport with participants when seeking to understand them and can be especially helpful when working on sensitive topics (2008). His argument was in response to earlier conventions of researcher neutrality and objectivity (2008). Building on feminist research's acknowledgement of the researcher as instrumental in how, and what, knowledge is produced (Edwards and Ribbens, 1998; Watts, 2008, p.5), Watts combined this approach with theoretical underpinnings developed by Gilbert which argued for emotion to also figure in the research process (2001a). He arrived at research methods that used his own empathy and emotions, where appropriate to produce ethnographic qualitative research. In light of this literature and since participants were anticipated to have experienced some form of persecution it seemed especially important that empathy would be used as part of a sensitive approach to discussing their health.

Some research has used cooking as a way to understand other cultures (Bagelman, 2015; Counihan, 1999/ 1998; Petridou, 2001; Stoller, 1984). For Stoller food was the metaphorical 'stew' (Stoller, 1984, p. 5) of social relations among the

Songhay of Niger. Bagelman cooked for her participants and ate with them while she interviewed them. Richards (1939/ 1932) led pioneering research that showed how food can shed light how humans make meaning of themselves and the world around them (Counihan, 1998, p. 1). In contrast, this project used food differently as a way into understanding female refugee health. Female refugee health then, rather than food, was the focus. As the literature above highlights the usefulness of food understanding peoples' everyday lives (Counihan, 1999/ 1998; Petridou, 2001; Stoller, 1984), cooking therefore seemed a useful method as a way into understanding what female refugees do to take care of their health.

The group cooking session was structured to be participatory and collaborative, in line with the community-based participatory approach. The cooking sessions took place in a community kitchen used by the network because it was a setting the participants already used because it was therefore likely to be a comfortable setting for them. The development worker was on site as a local point of contact for the participants and I.

The participants chose the recipe, I bought the ingredients and they led on the cooking process. I designed the start of the session so as to include introductions and some ice-breaker exercises to facilitate an interactive dynamic. As we cooked, I interwove research questions from my topic guide into our activities. The cooking session was planned to last four hours, which included time to sit down together and eat. It proved to help bring the session to a gentle close.

Two cooking sessions were initially planned and four-five participants were recruited for each session. Numbers of participants for each session were kept low for a number of reasons. Firstly, four-five participants were a manageable number to

work safely in the small kitchen space. Secondly, previous experience in recording workshops had taught me that keeping the numbers of participants low would enable the Dictaphone recorder to pick up their voices. I also kept numbers low to create a fairly intimate group in which to discuss their health.

The development worker of the network helped recruit participants for the cooking sessions, in essence using a snowball sampling method (Gobo 2007: 419) so that recruited participants could then recruit others to the project. This method was used because researchers have found it useful to accessing people who might be more 'hidden' and might be one of the most effective methods for gaining access to refugees (Bloch, 1999a; Hunt, 2008, p. 284). Researchers argue that refugees can be in effect invisible because of social exclusion they may experience - see Chapter 2.3 and also Hynes (2011), Gillespie (2012), Phillimore and Goodson (2006).

Participants from the cooking sessions were then invited to an individual interview. Focused ethnography was also used for individual qualitative interviews because researchers have found they enable a depth, variety and qualitative of information to be gleaned (Cruz and Higginbottom, 2013, p. 37). Data from individual interviews have been used by researchers to understand often complex meanings that participants from a range of backgrounds give to a particular topic, such as health (Cruz and Higginbottom, 2013, p. 37). Further, qualitative interviews enable the researcher to understand the emic (insider's) perspective of the topic (Fetterman, 1998; Kilian et al., 2008, p. 335). Qualitative in-depth interviews can give 'undiluted' (Ritchie, 2003, p. 36) and rich details (Rubin and Rubin, 2011) of each participant's experiences of health from their perspective. A qualitative interview is designed to enable understandings about events that the researcher might not have experienced

(Rubin and Rubin, 2011, p. 3), such as taking care of their health as a refugee in the UK. Such interviews can suit personal topics (Rubin and Rubin, 2011, p. 4), such as health, because in addition to focusing on participants' point of view, they can purposefully provide a confidential setting for discussing things they might not talk about in front of others. Qualitative interviews gather detailed information because the research questions are posed with follow up questions where necessary (Rubin and Rubin, 2011, p. 6) which encourage the participant to explain *why* they have a particular point of view or how something happened. Qualitative interviews therefore seemed a helpful method for discussing questions two – three: how they take care of their health; and what helps or hinders their efforts.

Interviews were structured by a topic guide (see Appendix Two) that incorporated these research questions. Follow up questions were designed to probe for insights to answer the five objectives (see Chapter Three). Interviews ended with an open question so participants could add anything that had not been covered. The interviews lasted from 30 minutes to two hours. They took place in a location of the participants' choosing in response to literature arguing that this approach enables participants to have some control over the fieldwork process which can help them feel more comfortable at discussing personal or sensitive topics (Bergen, 1993; Hunt, 2008, p. 284), such as health. Most participants chose to be interviewed at the centre used by the network apart from two, who asked for an interview in their home alongside an interpreter.

Throughout the cooking sessions and walking interviews conversations were recorded using a dictaphone. After all fieldwork sessions research journal entries were written to note down observations and reflections about each fieldwork session.

4.5 Analysis

Analysis of the data was carried out by firstly transcribing the data with intelligent verbatim to leave out extraneous noises or irrelevant parts of the conversation (such as cookery instructions or walking directions) and concentrate on sections relevant to the research topic. Transcriptions also included nonverbal conduct, such as laughter, intonation and loudness of voice because many researchers have argued the importance of nonverbal conduct in understanding others (Jenks, 2011, p. 72; Mondada, 2009; Singer, Radinsky and Goldman, 2008; Streeck, 2008).

As outlined in 3.5, field notes were taken after fieldwork sessions. These notes were used as a secondary source of data and provided the etic (outsider's) perspective which could then be compared against emic insights gleaned through interviews and cooking sessions, enable analysis of both perspectives (Fetterman, 1998; Kilian et al., 2008, p. 335). This triangulation of data also provided a degree of rigor to the study (Garcia and Saewyc, 2007, p. 43; Ritchie, 2003, p. 58).

As outlined in chapter 4.4, a case study design was used which made use of qualitative methods. These approaches are characterised by an element of interpretation of the data (Maxwell 2013, p. 79). The analysis was interpretative, but also systematic because as described in Chapter 4.5, this dissertation made use of focused ethnography to focus on female refugee health. The transcriptions and my research journal entries were therefore analysed according to the research questions to keep the focus of the project on female refugee health: how participants defined health; how they sought to take care of their health; what helped or hindered them along the way.

These three questions served as broad themes under which I analysed the data to code using Nvivo analysis software. By a code, I mean a word or short phrase that sums up the essence or content of a section of the transcript data (Saldaña, 2009: 3). Coding in this way required a degree of interpretation on my part. The codes acted as 'markers' to help organise, and come back to, the data for further analysis (Guest et al., 2012, p.10). Codes were pre-determined according to the five objectives of this project – see Chapter 3. These codes were used as ways into analysing how female refugees viewed their health and to contribute to debate about existing definitions of health.

5. Findings

Nine female refugees participated in fieldwork over a period of two months between November and December 2015. All participants participated in a total of three group cooking sessions and eight completed individual interviews.

Unfortunately, two participants were discounted; one participant had health conditions so complex that she was unable to give informed consent and another was discounted because she was not a refugee. Chapter Six discusses implications this had for the research and for participants.

Participants came from four countries in Asia and Sub-Saharan Africa. As explained in Chapter 4.4, this project employs a case study design and findings are presented in terms of the richness of insights from working with these participants.

Participants were aged in their mid-twenties through to early sixties, providing some insights into both younger and older female refugee health. Two participants were destitute after their asylum claims were refused. Four participants were asylum seekers while three participants had been recognised as refugees and granted leave to remain for an initial period of five years. This range meant that the project gained insights into female refugee health across their different experiences of the UK asylum system.

My research questions were: 1) how do female refugees define health (and how does this compare to the World Health Organization's definition); 2) how do they seek to take care of their health; 3) what helps or hinders their health along the way. As outlined in Chapter 4.6, these three questions served as themes under which the data was coded according to the topics which constituted the five research objectives (also see Chapter 3). The findings are therefore structured according to

these five objectives and explain throughout how the findings shed light on the three research questions.

5.1 Definitions of health

The question ‘what does health mean to you’ was specifically open-ended so that participants could give their own definitions of health. Beverley’s response that “health is my life” summed up participants’ overall definition of health as being all-encompassing. Their responses indicated that health to them was holistic, dynamic multidimensional.

This did not mean that all of their definitions were the same. Some for instance, thought that health, for instance meant not contracting diseases, while others indicated health involved “good doctors” and taking medication for their chronic conditions. However, it was clear from their responses that health was so holistic to them that it could not be pinned down to any one definition or aspect of their lives. Rather it was a dynamic and all-encompassing part of their lives.

For example, health figured in all elements of Beverley’s life, whether it was housework, managing a chronic health condition, her mood, religious beliefs or coping with being destitute. Natacha, Chloe and Nicole echoed this too, emphasising that health was a “way of living” which they employed to look after themselves, involving elements of their physical, mental, social and spiritual activities.

Religion figured strongly in their definitions of health. Ruby, Natacha, Chloe, Nicole and Memory said that health meant being “spiritually well”, signifying that their faith and health was inextricably linked. Ruby explained that being a Muslim, her

faith was part of her health. This indicating a sense of reciprocity whereby Allah gives her health but with an acknowledgement on her part that he had given her the health she had and not necessarily the best health. In response she worships:

“I’m Muslim. And because Allah’s provided everything for us, he’s given us this life, He’s given us this health, we have to give thanks to Allah, through praising him for everything he’s given us”, Ruby, individual interview.

Natacha and Nicole did not seem to see their God as having given them their health, as Ruby seemed to believe. However, they both explained that their Christian faith played a part in helping them to keep well, partly through the “hope” that church services taught them to keep and support they gained from the congregation.

Good health was seen as an enabler by participants, as something that enabled them to be physically and mentally strong enough to live their lives. Bad health was seen as something which could prevent them from living their lives.

In summary, from the first question about their definitions of health, it was apparent that health figured across many aspects of their lives and involved processes, such as the way they lived and worship.

5.2 Physical health

When asked what health meant to them, participants thought that physical health was an important component and saw varying extents to which they could look after it.

Since participants were cooking during the fieldwork, it is perhaps not surprising that they all defined “good food” as part of their health, explaining that this comprised of vegetables, spices, fruit, meat, chicken and fish. They all thought fresh

food was central to who they were, saying for instance “this is what we Africans/Asians eat”. They all displayed a wide knowledge of food items during the cooking sessions and where to obtain them in Glasgow. Observations during these sessions also found that participants were curious about food items and dishes they had not encountered before. In addition to tasting each other’s dishes some were keen to also learn how to make these dishes.

Meanwhile, they all described having limited resources due to limited support while their asylum claims were being processed, being destitute or having few financial means after their claims had been approved. It seemed a dual combination of their drive to continue eating as Africans/Asians and limited finances shaped their resultant actions. They were resourceful and optimised access to fresh food by travelling to food banks run by churches and community groups to either to supplement their food intake or as a total source. This kind of resourcefulness had an emotional element, some describing their anxiety over eating food provided to them by the food banks that was on or close to its best before date. Time, energy and the ability to afford bus fares generally limited how often they could make such trips. Just taking food as an example, then it was apparent that they were clear about what food would be good for their health and they sought to optimise food options in the face of limited financial resources.

Participants said that the cooking and preparation of meals was also very important. Indeed, they all displayed an ease with cooking and talent at preparing delicious meals during the cookery sessions out of simple ingredients. Participants were adept at making a variety of dishes out of similar staple ingredients such as rice and potatoes. Beverley prided herself on being able to prepare chicken and vegetables in several “different ways”. Chris explained that:

“Even if I go out to the city centre eating rice, chicken, chips, when I go home I just take my pot and [mimes pounding food in a pot]. Because if you don’t cook... [] Me, I feel like I didn’t eat [if I did not cook]”, Chris, third cooking session.

Joy, Memory and Beverley, explained being physically “strong” was an essential part of their health because it enabled them to get on with their everyday lives, such as doing housework, getting out and about or looking after children:

“health is when your body is fit and strong ...[] – it’s functioning well, you’re not sick. You – you can have appetite. You can exercise, You can do your hou- your work. Or go out to work. If you are not healthy you can’t do that. If you are not healthy, you can’t even – even the appetite is gone sometimes cos of the health is not good”, Beverley, third cooking session.

“Like if you are working or taking care of a child, if you are not healthy, you can’t take care of the child”, Joy, first cooking session.

Yet most, except two, described having complex physical health either as a result of disease or (in some cases repeat) miscarriages. Being strong then, for most, was an exercise in being as strong as they could amid current circumstances. Anees and Beverley had chronic health conditions which they partly coped with by taking medication. Beverley’s decision to take medicine seemed to have been partly down to the nurse’s patience, taking her blood pressure several times so that she could see it was high and would not go down by itself. It also seemed to have been partly a result of resolving a personal dilemma connected to memories of her mother taking medication for the same condition:

“because I was thinking of my Mum who was taking tablets when I was still young, for many years taking tablets so I didn’t want to do the same”,

Beverley, third cooking session.

Memory and Natacha had untreatable health conditions. Nevertheless they endeavoured to make the most of the health they had. One of Memory’s kidneys had failed and when she could get out and about, she participated in a number of different groups because she thought that socialising was good for her health (see Chapter 5.4). Natacha had a chronic condition that caused considerable pain, leaving her often house-bound which she said made her feel very depressed. On days that she was mobile, she went to a charity for complimentary therapy which helped to reduce the pain.

Some participants thought exercise was in theory good for their health. Ruby chose to walk as much as she could. Some explained that a lack of money hindered their abilities to do the kind activities they would like. Joy for instance, wanted to swim regularly and Chloe wanted to go to the gym.

In summary, the way that participants experienced physical health and sought to take of themselves highlighted was a complex interplay between the ways they identified themselves, their resourcefulness and determination to do the best they could to take care of themselves. The findings indicate that participants might look after their physical health differently and in more diverse ways if they had more resources, especially money. Sometimes their decisions were complex, involving personal reflections about their family and their emotions, outlining just how closely linked their physical health was to other parts of their health and lives, which is explained in the next chapters.

5.3 Mental health

All participants described their emotions and mood as being import, although some of them did not necessarily see these as *mental health* but as part of their overall health. Similarly to Chapter 5.2, there were things they did to look after their mental health, also acknowledging things outwith their control which impacted on their health too.

Ruby described mental health as important, which she defined a “fresh mind”. To look after herself, she went outside for short walks because she associated fresh air with having a “fresh mind”. Similarly, Natacha and Nicole described good mental health as being in “good spirits”. To them, looking after their mental health was important because they thought that if these were in a poor state then this could trigger ill health.

All participants explained they got out of the house to look after their mental health. For some like Ruby, getting out of the house and having some fresh air was in and of itself beneficial. For others, they got out of the house in order to meet with others, usually other women. Beverley explained that socialising was a chance to share her problems with others and for them to do the same, which benefited her mental health and potentially the health of those she talked with:

“...When we share problems – if we have problems, we share, we talk and you know...And you know, we live different if you tell someone your problem, than if you keep it inside. That’s why some people, they hang themselves, they make suicide, they So it’s good to talk to others. To share, maybe they will give you advice or they will comfort you”, Beverley, individual interview.

“...to share someone else’s pain. [I] you share their pain as if it was your own”, Chloe, interview with Nadia.

For Joy, going to community groups and non-governmental organisations had been a way to get to know her “rights” here in Scotland which had in turn helped her mental health. Specifically, joining such groups had helped her regain trust in others which made her feel safe. Joy had been raped by the police in her country of origin but through such groups she had learned about the role of police officers in this country and her rights:

“...cos know that yes, I’m in a safe hand [in Scotland], I don’t think any policeman can mess around with me like when I was in [name of country]”,
Joy, individual interview.

Three participants had health experiences specific to their gender which affected their mental health considerably. Nadia, Chloe and Ruby explained that they had miscarried here in the UK. Chloe and Nadia said the miscarriages left them feeling very depressed. To cope, they both saw counsellors and doctors, taking medication which they found helped to an extent but did not solve their mood. Chloe also coped by getting out of the house and trying to mentally “turn the page”, which helped to some degree but she still wasn’t able to concentrate enough to resume her college course that she had dropped when she miscarried. Nadia seemed to cope by accepting the emotional pain. For Ruby, her miscarriage meant that she lost a hoped-for third child but she seemed to cope by focusing on bringing up her two children with her husband.

In summary, it was impossible to disentangle their mental health from their physical health as well as structural and social contexts. Rather, there seemed a

complex interplay between their mental health, social and structural contexts, such as Joy's fear while she was an asylum seeker, her empowerment in knowing her rights and the role that community groups played in helping her trust others. Findings indicate too the role of social relations established by participants with others, often women, in helping their mental health. This signifies a quality of reciprocity in which women use social relations to look after themselves and in doing so, potentially helping those they socialise with. There is a sense then that sometimes participants act individually and also sometimes in a collective sense with others to look after their health.

5.4 Social contexts

Most participants socialised as ways of looking after their health: physically, mentally and socially. Again, there was a complex interplay between their social and structural contexts and their physical and mental health. Singing in groups was a popular activity. Memory, Joy and Beverley explained that singing with a group of people made them feel good. Nadia was quite shy and did not often socialise but she liked singing, explained that it buoyed her mood:

How do you feel when you sing?

"...[] content and at ease. Because I love singing...", Natacha, individual interview.

Memory thought that socialising helped her physical health because she got to laugh with others, which she described as a "remedy":

"But normally I prefer laughing, chatting with people. It makes – it goes to my immune system as well", Memory, second cooking session.

As described in Chapter 5.1, for some participants religion was integral to their health. Nadia and Natacha described how churches here were different to the ones in their country of origin. The main difference was that here, they could turn to the congregation for practical and emotional support as well as receiving accommodation that a family from the congregation provided to one of them.

For some participants, coming to Glasgow as a refugee had meant a loss of social status and financial resources which was hard to cope with. To alleviate financial pressures they borrowed money from friends, which gave them modest and temporary relief from the stress they experienced at not being able to afford basic items such as clothes and household goods.

Meanwhile, there did not seem to be anything they could do to reduce their anguish at experiencing a lower social status. From their responses it was clear they thought finding employment was the answer, which they were not allowed to do while they were in the asylum system. Indeed, the research question that asked them 'what got in the way' of their health received many responses and showed a strong interplay with structure, such as the asylum process. Ruby previously "had a good life" in her country of origin; her husband had a decent job, they had a car and the family was generally financially comfortable. Currently in the asylum process, they tried to cope with their loss of such a life by focusing on bringing up their children and satisfaction at their glowing school reports. However it was clear that Ruby was desperate for her husband to work again and worried about how unemployment was affecting his job prospects. Anees was a qualified staff nurse and had built a successful nursing career as well as raising two children with her husband. Anees showed me her plethora of nursing qualifications and cried as she

described her anguish at feeling like her clinical skills were wasting away and the effect this had on the whole household's standing:

"I feel like I'm being wasted away. I'm not allowed to do anything.... made me mentally disturbed because they're just not letting me do anything...we find we're getting lower and lower we're falling", Anees, individual interview.

In contrast, participants Nadia and Chloe had experienced extreme poverty in their country of origin and had not lost established careers. They therefore did not seem to perceive a climb down in their social and seemed to see asylum process as a means to potentially a better life:

"...no life, no good food, desperation. Imagine five, ten years of desperation – I'm not even talking about one month! Here you can eat and you have some worries but over there...." Nadia, interview with Chloe.

In one instance, a participant contemplated the benefits of socialising but did not yet have the confidence to put this into practice. Anees thought that speaking to her neighbours would help her establish friendships and that her mental health would benefit from having someone "to talk to". However, she currently felt isolated from her English-speaking neighbours because she was not too confident about her own levels of English and would have liked to be living close to others who spoke her language. This finding seems to correlate with the contemplation participants had about what they would do to look after their physical health if they had the money, highlighting the potential different reasons why they might consider but not act on way to look after themselves.

Family relationships also played a part in participants' health, both positively

and negatively, often in complex ways. Asylum seeker participants said they thought that going on family outings would be good for everyone's health but two families either couldn't afford the bus fares to travel together or had to plan a family outing very carefully in order to afford it.

One participant spoke of her emotional pain at being separated from her child who remained in her country of origin. Other participants whose children were in their countries of origin did not speak much about how they coped with separation and they were not questioned further about this in case this caused them distress. Those participants whose children were with them spoke at length about their children, indicating the importance that family relationships may play in their health. It also begs the question about how family separation impacts on the health of female refugees.

Joy and Ruby seemed particularly buoyed by their children, with Joy saying that she wanted to be healthy so that she could look after her daughters. At the same time, Joy spoke of her fear of social services. She was aware that there were different approaches to parenting here compared to her country of origin and she was afraid of being perceived as a bad parent or having her children taken away by social services. Joy cited stories she had heard about women having their children taken away. Ruby sometimes felt stressed because she and her husband could not afford the things her children asked for, such as a bag from the Disney film Frozen. Sometimes Ruby's focus on her family, which usually helped her feel mentally strong, meant she employed a trade-off in getting treatment for her chronic heart condition:

"When I feel unwell I don't like to go to the doctor or the hospital because then

I get admitted and then I'll be away from the kids and then husband has to manage both the kids so I don't tell him until I get really bad and then I have to phone A&E or something.....I don't want the kids to worry when I'm not well so I just keep pushing myself and keep going until it gets too much and then...”, Ruby, individual interview.

In summary, there were things that most participants did socially to look after their health. Again, similar to the summary in Chapter 5.3, the findings indicate that participants' agency in looking after themselves operated on an individual and collective level through the social relations they created. Family relations in particular highlighted the complex interplay with health and that there was sometimes not a clear distinction between what helped or hindered participants' health. Participants could find joy in their children, while also feeling stressed if they could not afford to go on family trips or treat them. Family could also motivate a parent to be “strong” (see Chapter 5.2) but a focus on their health also led one participant to put off hospital visits and potentially jeopardising her own health. There was also obvious distress experienced by participants if they knew they had a capability, for instance to work, but were prevented from applying this. This seems to contrast with participants' experience of chronic or untreatable conditions which too were challenging to manage, but coping with this seemed distinct from the mental distress at being prevented from working or from having a claim for asylum refused.

5.5 Structure

As described throughout Chapters 5.1 – 5.4, all participants thought they could do things to look after their health, such as eating well, socialising and following religious guidance and prayer. This is not to say that participants thought health was solely down to them. Their answers pointed to structural factors which could

influence their health.

Ruby was the only participant who saw positives in the asylum system and she was thankful to the government for housing her family. At the same time, Ruby also found limited financial support and the ban on working stressful, as described in Chapter 5.4. Most others saw that the asylum process itself was largely bad for their mental health in several ways.

Firstly, Anees described her exhaustion at having to prove “everything” and her struggle that the Home Office did not believe she was a staff nurse despite hard copies of her qualifications. As described in the previous section, not being able to continue her career as staff nurse because she was not permitted to work while she was in the asylum system was a significant emotional and mental strain.

Chloe described her upset at barriers she was encountering, such not being allowed to work, indicating her surprise at encountering such obstacles in this country:

“I want to work like everyone else....to have money like everyone else. I thought that when I came here, it would be safe, that I would be at ease but you find so many barriers...and problems. I get discouraged and it upsets me a little”, Chloe, interview with Nadia.

Natacha, a young woman in approximately her thirties who was destitute, seemed completely crushed, saying she felt “*useless, good for nothing*”. She had gone to an NGO and staff were helping her find a lawyer to try and appeal the Home Office’s decision. However, she had already spent five years submitting asylum claims and going through appeal processes and was exhausted.

While Joy now had leave to remain, she explained that the “Home Office” had made her “want commit suicide”. Joy did not explain what she meant by this and was not probed further in case this made her distressed. She did say however, that as an asylum seeker she was constantly afraid of being “deported” and kept herself to herself. Joy explained that she felt able to join these kinds of groups when she had gotten leave to remain because she knew she was not going to be taken away. Natacha and Beverley also referred to feeling suicidal at times, highlighting the distress these participants experienced. That participants are resourceful at looking after their health in the context of such mental distress highlights their strength and determination.

Other structural contexts that figured significantly in the data were the NHS and the network of churches and community groups that participants used. All participants had located and accessed several churches and community groups in order to access free or cheap food, clothes, household goods and social activities. The findings highlight that participants received help from such networks and also were spaces where participants could exert their own agency, forming social relations (See Chapter 5.4) that helped their health and potentially those they met. These structures contrasted sharply with participants’ experiences of the asylum process with the former having distinctly more positive impacts on participants’ health.

Less frequently mentioned but significant nonetheless were informal structures of money lending that some participants cited. These participants had formed these structures themselves through friendships they had established. Money borrowed was used by participants for essential household items or public transport costs.

Some experiences of the NHS were mixed highlighting perhaps an ambiguity in the way they thought this structure did and did not help their health. Participants had varying views on the extent to which the NHS services helped their health. Anees was confused why her diabetic medication was stopped while Beverley discovered that medication for her blood pressure helped her condition. Ruby thought that doctors over prescribed medication and should be doing something else. Anees mentioned that sometimes she had not been provided an interpreter at the GP despite asking for one, although all the other participants did say interpreters were provided to them.

Whilst participants did not explicitly say what they did expect from such encounters the implication was that sometimes they expected something different. Chloe and Nadia's interview seemed to shed some light on this when they described wanting to help other refugees one day once, and if, they got leave to remain. Both felt that because of their own experiences, they would particularly be able to be compassionate with other refugees. When asked what they meant by compassion, they replied:

Nadia: "love"

Chloe: "to share someone else's pain... [] you share their pain as if it was your own."

Interview with Chloe and Nadia

Their definition strikes at the heart compassion, perhaps taking it beyond an act of empathy and into a visceral domain – literally sharing somebody's suffering. This is what participants may have been partly getting at, that in their health encounters they were hoping to encounter compassion as part of their medical

treatment. Strengthening this are the findings outlined in Chapter 5.2, describing Beverley's decision to take medication partly because of a patient and compassionate nurse.

In summary, the findings indicate that some structures were good for participants' physical, mental and social health such as the network of churches, community groups, NGOs and NHS services. On the other hand, this was not always clear cut, as seen in participants' mixed views on the ways they thought the NHS did or did not give them the help they were looking for their health. That some participants had created money lending structures in order to purchase essential items might highlight the extent of the poverty they experienced. Striking was the effect of the asylum system on participants' mental health, forming a stark context in which they also sought to take care of themselves.

5.6 Findings conclusions

In concluding these findings several key points can be made. Firstly, health was to participants holistic, multi-dimensional and all-encompassing. Some participants did not see their health as being compartmentalised according to distinct categories such those figuring in this project's objectives, but instead more fluid across aspects of their lives. Some did compartmentalise while emphasising that health was all-encompassing across these categories. Health to them was also dynamic involving processes they employed by themselves, in collaboration with other humans and deities through religious worship.

Efforts taken by participants to look after themselves were enacted on individual and collective levels. As well has being enacted on such varying levels, health also took place across multiple contexts at any one time, including their

physical health, mental health, social and structural contexts. The findings highlight a reciprocity that participants have both with their own self and private decisions as well as with others. The interplay between their efforts and structural contexts is dynamic, complex and sometimes ambivalent.

6. Discussion

This section discusses the findings of this project in two main ways. Firstly it discusses successes and limitations of the design and research methods in eliciting answers to the research questions. Secondly it discusses insights the findings generated in response to the research questions and the literature reviewed.

6.1 Methods

The intrinsic case study design enabled participants from the same network to participate and produced diverse findings about their definitions of health, what they did to look after themselves and what helped or hindered their health.

Focused ethnography methods were useful in bringing together a diverse range of participants to understand their definitions of health and how they looked after themselves. Focusing on health was useful in also understanding commonalities in their experiences and differences. In the literature reviewed, Cruz and Higginbottom reviewed focused ethnographic studies that had used visual methods, such as drawing maps or giving participants cameras (Cruz and Higginbottom, 2013; Dupuis-Blanchard et al., 2009; Garcia and Saewyc, 2007) Findings from this project show that focused ethnography also works well with activities, such as cooking, in eliciting rich material.

The group cooking sessions were successful in igniting group discussion about their definitions of health and in providing useful observations of participants' resourcefulness. They were also effective in helping participants feel comfortable about discussing this topic. Participants frequently said that they felt comfortable with me and this rapport seems to have been also instrumental in enabling them to share insights. This rapport was developed on the researcher's part through a common enjoyment in cooking and the use of empathy, by listening without judgement and sometimes paraphrasing their responses to signal my concern to understand them. When participants displayed emotions, such as laughter, frustration or sadness, these were acknowledged with sensitivity and tact. Empathy enabled participants to describe their views to order better understand how they defined and looked after themselves. Participants frequently commented that the "way" I was with them helped them feel able to discuss their health. This resonates with the literature reviewed which highlighted that intelligent use of the researcher's emotions and empathy can be helpful in working with participants on sensitive topics (Gilbert, 2001a, p.11, Watts, 2008, p. 3).

The cooking sessions were designed so that participants would follow *one* recipe. However it became clear that participants wanted to prepare between two – three recipes so that they could show and learn from each other about each other's way of cooking. This echoed previous research about community-based participatory approaches which found that communities' desire for social knowledge does not always match the academic knowledge being sought (Riger, 2001; Washington, 2004, p. 19). Following a variety of recipes highlighted participants' skills in being able to teach and also in their enthusiasm to learn. Participants made it clear that

they enjoyed this element of the project as much as also feeling they were “helping others” in terms of helping to shape insights about female refugee health.

The cooking sessions were instrumental in participants’ take up of individual interviews. This seemed partly due to the rapport that had been established with them during the activity, which had made them feel comfortable and also empowered by the enjoyment they had in teaching and learning from others about making “good food”. Also clear was participants enthusiasm to discuss their health so that the research could be of wider benefit to the health of female refugees in Glasgow.

Two participants asked for a female interpreter during their individual interviews. The same female interpreter was used for both interviews. In addition to the rapport established with participants, the interpreter’s empathy and sensitivity also meant that they were comfortable with her, also benefiting the research process.

In terms of participants’ willingness to talk about health, it is acknowledged that participants may have constituted a bias towards those who are enthusiastic in talking about health and about research. Three participants were key members of local organisations and in some respects were more empowered and confident than other refugees. The project have also have been biased towards individuals who were well enough to travel to the fieldwork venue. However, as outlined in Chapter 5.2 and 5.4 two participants had limited mobility and several experienced mental distress. Therefore, some went to considerable lengths to participate. As explained in Chapter 4.5, studies have found that refugees can be hidden populations, due to marginalisation, exclusion and destitution (Green, 2006; Hynes, 2011; Taylor, 2009; Zetter et al., 2005). Two participants were destitute, one of whom described not

participating in any groups outside of church for a “long time”. This project argues that therefore that a range of known, and not-so-known, female refugees participated.

There were some key limitations to the methods. Recruitment for the cooking sessions took time and in one instance an economic migrant was mistakenly recruited instead of an asylum seeker or refugee, which was perhaps to be anticipated given that the network worked with migrants as well as refugees. Too few participants were recruited at the start of the project and almost too many were recruited at the end; three women participated in the first cooking session, two women came to the second and six women came to the third. This was because the snowballing process took time and also because some participants did not turn up to the first cooking sessions because they had conflicting appointments on the day

One participant who participated in a cooking session was dropped from the project because it emerged during the individual interview that she had suffered an accident a year beforehand. The injury she sustained affected her memory, which meant that she could not give informed consent because she might forget. This emerged during the individual interview because we were using an interpreter. An interpreter had not been used for the group session because she did not want one. This underlines the importance of ensuring that participants can not only understand the researcher but can express themselves accurately. As outlined in Chapter 4.2 and 4.5, signposting arrangements had been made in case participants wished to speak to other organisations. This participant asked to be signposted back to the NHS because she was unclear about what treatment she had received. Her injury was so specific that signposting contacts established in advance were able to help.

Instead contact was made with The Advocacy Project who found an NHS community centre which would take her referral.

Findings were surprising because participants shared many insights about their health including many personal accounts. However, the amount they shared about their health did not necessarily mean that I always gained in-depth knowledge. As outlined in Chapter 2, a sensitive approach was taken to working with participants because it was anticipated they had experienced some form of trauma (also see Chapter 4.2). In some instances, when participants brought up sensitive topics such as miscarriage and suicide which had been distressful for them, they were not asked further questions in case it caused them upset. However, this loss of detail was mitigated by the fruitful responses about how they defined and looked after their health.

6.2 Definitions of health

Participants' definitions contribute to, and challenge, existing theories health, which this chapter discusses. As described in Chapter 5.1, participants indicated that health was to them a complex interplay of physical, emotional, social and structural aspects. This resonates with the WHO's definition of health which acknowledges health as multidimensional (1948). However, participants differed in emphasising the importance of religion in helping them look after themselves and in providing opportunities for support among religious communities (see Chapter 5.4). Although religion might be counted towards the 'social' aspect of health in the WHO's statement, it is arguably a secular definition of health. Meanwhile, participants' religions and their health were inextricably linked in a reciprocal relationship. Their definition of health partly resonates with James and Corbett's theory that health definitions can depend on a person's culture and their perspective (2010) but differs

in that participants' explanations of their faith conveyed a sense that there could be an element of divine intervention (not necessarily providing good health, but providing measures of health nonetheless) or mystery to their health. This was evident in their explanations of the role that religion, and their Gods, played in "giving" them the health they had.

Participants' definition of health further challenges the WHO's definition. Whereas the WHO implies that health manifests across distinct dimensions, participants' definition was more holistic and encompassed their lives in more fluid ways and was not necessarily seen as compartmentalised into dimensions. In combination with findings about how they looked after their health and what helped or hindered them, health cut across multiple levels and contexts any of which could be in play at any one time. For instance they might be act individually to look after their physical health while also looking after family members and coping with the mental strains of the asylum system. This implies that viewing their health through the lens of intersectionality embraces the many levels, structures and contexts they experience and helps identify how they interact (Brah and Phoenix, 2004, p. 76; Hancock, 2007). Intersectionality then helps to understand the multiplicity of health (Oxman-Martinez et al., 2002, p. 23) in any one female refugee life and embraces the diversity of these experiences (Morris and Bunjun, 2007). Further, for marginalized groups, such as refugees, intersectionality focuses on how intersections of domination and subordination interact (Hannan, 2001), which is important in understanding and supporting female refugee health.

The WHO definition of health as a 'state of complete physical, mental and social well-being' sets a high standard (1948). Participants wished to have the best health possible so in a sense, the WHO definition is correct in its aspirations.

However, no participant described their health as anywhere near complete. Yet, in resonance with Antonovsky's theory (1982, p. 12), participants did all have some measure of health.

Some participants, but not all, highlighted that health required a certain know-how because it was about how they lived. A craft or an art to health is absent in the WHO definition. However, participants' definition does resonate with the definition of public health, which is a discipline broadly defined as 'the science and *art* of promoting and protecting health' (UK Public Health Faculty, 2010). What is key about participants' definitions was the emphasis on *their* know-how about how to live their lives rather than being the domain of professionalised knowledge. While participants sought professional help, they clearly saw medics as part of the solution in conjunction with their own efforts to look after their health. Moreover, participants' emphasis on the *way* they live mirrors researchers' arguments that health is dynamic (James and Corbett, 2010; Skolnik, 2008). Participants' definitions also emphasise on the shaping of their health on an everyday basis. Aspects of refugees' everyday lives has been a focus in some of the literature reviewed (Gillespie, 2012; Hunt, 2008; Lindsay et al., 2010; Mulvey, 2013; Phillimore et al., 2007; Piacentini, 2012) however this project highlights the importance of exploring how in particular this shapes their health across multiple levels and contexts.

6.3 How female refugees take care of their health

The ways in which participants sought to take care of their health were similar to some of Hunt's concept of agency (2008) in that they made efforts individually and arguably collectively via social relations with others. Similar also to Ortner's concept (2011) they also displayed instances of desiring agency (for example to speak English with neighbours or go swimming regularly) and also individual influence in terms of their resourcefulness at obtaining food. However, the findings problematise Ortner's concept which does not account for collective agency, as Hunt does (2008).

Similar to Hunt's participants, they made use of places of worship, NHS services, community groups, agencies and NGOs, NHS services activities, volunteering and socialising. In this light, participants did reflect the 'creative' agency that Hunt argues (2008, p. 281). Yet in contrast to Hunt's study, participants in this project commonly used only low-cost or free services and did not have the means to exert other choices such as buying cars, as Hunt found (2008). This may be because participants in this study with leave to remain had not had their refugee status for as long as Hunt's study implied (2008).

These findings then echo and problematise the diversity of refugees as argued by Malkki (1995, p. 496). Participants in this project were from different countries, had different personalities, languages and cultures. They did not all do the same activities to look after themselves – some did not sing for instance. However they all were resourceful and went to similar kind of groups and services to look after their health, sometimes out of necessity, such as food banks. Common to all, regardless of refugee status, were limited resources such as income, housing and transport. The findings indicate that if participants had more resources, then some of them would go on to exert other forms of agency to look after themselves, such as

going to the gym, swimming and to the cinema. This suggests that their ways of looking after their health might be *more* diverse, as Hunt found (2008), if they had the means to pursue their own interests and ways of living. It also raises the question of whether things they would stop doing things they currently do to take care of themselves in favour of other interests.

Participants' ways of looking after themselves also further reflect and challenge concepts agency argued by researchers (Brettell and Hollifield, 2008, p. 5; Kroeber et al., 1952; Gibson, 2002; Hunt, 2008; More and Sanders, 2006; Ortnier, 2011). Many participants were for example resourceful in their knowledge of food items, how to turn them into meals and where to source them. While researchers recognise that agency can be expressed even in constraining circumstances, findings from this project support a criticism of this concept too. Sometimes participants had little choice but to act or risk going hungry. In this light, their strategies could be seen as survivalist. Hunt found that participants in initial phases of rebuilding their lives often focused on survival and there was a complex interplay between their legal status, educational or professional background, interests and how they moved forward with their lives (Hunt, 2008, p. 289). This suggests that further qualitative and longitudinal research to understand how female refugees' ways of looking after their health might change over time.

Findings indicated that participants took care of their health on an individual level and through social relations with others, for example through participating in activities or discussing their problems. These findings echo and challenge Antonovsky's sense of coherence (1987). As Antonovsky theorised, participants did have areas of their lives which were important to them such as their health, family and religion. They also did perceive themselves as making the best of the resources

available to them. However, in contrast to the sense of coherence concept, participants were not always able to make sense of their experiences of the asylum process; they indicated that they fully understood why they had fled their country to seek refuge but often could not make sense of the way the asylum process treated them. This was indicated by participants' distress at not having their asylum case believed or accepted. Also, participants optimised available resources but often acknowledged that these were limited due to their lack of income. Further, Antonovsky's concept of a sense of coherence implies an individuality in ways people cope with their lives whereas participants demonstrated ways they looked after themselves via social relations with others.

6.4 What helps female refugee health

Structures that were helpful to participants' health were the network of churches, community groups and agencies participants used to get food and household goods, socialise and take part in activities. It is striking that some participants *only* knew organisations such as these and it signifies the importance of the role that charities, places of worship and NGOs play in supporting female refugees' health. Striking was the way in which participants socialised with (often female) members of these groups as ways of taking care of themselves, indicating reciprocal relationships which benefited individual health, with the potential to help others collectively too. This highlights that an individual's health is partly shaped them by social relationships and suggesting a more interdependent manifestation of health than perhaps definitions of health, such as that of the WHO, imply. Research about interdependency has included work by Condeluci (1999) and Morris (1993) who theorised interdependence to argue that disabled people are not dependent but construct relationships of interdependency across their communities. Further exploration of

interdependence theories, such as those argued by these authors, and how these shed light on female refugee health could be helpful in further understanding the ways in which they look after themselves.

Most participants explained, with mixed views, how their encounters with NHS services and charities providing complimentary therapy or counselling helped their health. As discussed in Chapters 5.2 and 5.5, some findings implied that empathy and compassion could be partly at the heart of participants' positive or desired encounters. Further, as described in Chapter 6.1, participants seemed to feel comfortable in talking about their health because they felt comfortable with the researcher. Similar then to Chapter 5.3, findings indicate the power, and quality, of relationships in enabling participants to look after themselves and be looked after. The literature reviewed has already pinpointed the role of compassion and empathy among groups and organisations that help refugees, although not in a health setting (Lindsay et al., 2010; Phillimore et al., 2007). Other research reviewed did not explicitly discuss compassion but showcased the dedication of researchers to highlighting the health needs of refugees and their agency implicitly highlights concern in calling for policy makers and services to support refugees (Gillespie, 2012, p. xi; Green, 2006; Hunt, 2008; Mulvey, 2013; Phillimore and Goodson, 2005; Piacentini, 2015; Querton, 2015; Spencer et al., 2006; Stewart and Mulvey, 2014). Indeed, researchers have criticised previously the lack of empathy by policy makers towards refugees (Correa-Velez and Gifford, 2007, p. 279; Dollery and Wallis, 2001, p. 14). Findings from this project indicate that further research about the interplay of empathy and compassion with female refugees' health would be advantageous.

The literature reviewed included research about the awareness that refugees have of health services, their rights and access to these (Allsopp et al., 2014, p. 160;

Burnett and Peel, 2001, p. 546, 547; Gammell et al., 1993), including those of refugees in Scotland (Mulvey, 2013, p. 75, 79/ 2009, p. 24; Lindsay et al., 2010, p. 9; Strang, 2015). In contrast, findings from this project point to the mixed views of experiences and treatment received from health services. In addition to the role of empathy and compassion then is a need for further research about the experiences of refugees who do access health services.

6.5 What hinders female refugee health

Findings indicated a complex interplay between things that helped and/or hindered health. A complex and destructive interplay seemed apparent between the asylum process and participants' ill health, particularly mental distress as described in Chapter 5.5. These findings echo the literature reviewed (Allsop et al., 2014; Chantler, 2012; Mulvey, 2015). Reasons for the process affecting their mental health appear to be several and also echo previous studies.

Firstly, poverty was particularly stressful for participants who had previously been financially comfortable and a shock for those participants who had experience extreme poverty in their countries of origin and had not expected to be poor in this country. This resonates with research undertaken about refugees experiences of poverty in Scotland and the asylum process (Gillespie, 2012; Lindsay et al., 2010). It also echoes studies about the link between poverty and mental health in general (Chantler, 2012; Murali and Oyebolde, 2004; Ramon, 2006; Shaw and Taplin, 2007).

Frustrations and distress at not being able to work, hone existing skills or pursue higher education courses during the asylum process also affected mental health. The findings resonate with the literature reviewed highlighting the importance of work in rebuilding their lives (Bloch, 2007; Lindsay et al., 2010; Vickers, 2012). The findings further add to research undertaken by indicating the importance of work to some female refugees' health not just because a lack of income can lead to poverty, but because for these participants work was also part of who they were or aspired to be – for themselves and/or their families.

Several participants described having had suicidal thoughts or being very depressed during their asylum claim or since their destitution. This highlights the

distress that participants endure while also trying to look after themselves. Their mental distress highlights the starkness, and even inhumaneness, of the asylum system which has already been criticised by many researchers (Allsopp et al., 2014; Bloch, 2000; Cholewinski, 1998; Crawley et al., 2011; Darling, 2009; Mulvey, 2015; Spencer et al., 2006). Further sensitive research about female refugees' mental would be valuable to build on current research (Cohen 2008; Hiegel and Landrac, 1990) and inform suicide prevention Yet it is clear from the findings and literature that structurally, the asylum process needs to change if female refugee health is to flourish.

The literature review highlighted instances where researchers have made links between structure, power and an individual's health (Farmer, 2006/ 2001; Moore and Sanders, 2006; Nichter, 2008; Scheper-Hughes, 2004/ 2002/ 1992). The findings indicate that this is the case for participants' mental health, that there is a destructive interplay between the asylum process and mental distress.

Three participants had (sometimes repeat) miscarriages. The literature reviewed raised concerns about maternal deaths (Cheung and Phillimore, 2013a; Ramaswami, 2012; Williams and Kaye, 2010) and experiences of breastfeeding (GoWell, 2012/ 2008). Phillimore and Thornhill's study included participants in the West Midlands who had miscarried due to domestic violence (2011, p. 64) but the study did not focus on other experiences of miscarriage among refugees. One report by the Maternity Alliance drew attention to high rates of miscarriage among asylum seekers in two parts of England (2002a). Literature about female refugees' experiences of miscarriage, and of those in Scotland, then seems to be scant. In this respect, this project contributes to a gap in research by providing insights into how female refugees try to cope with miscarriages. That a third of participants disclosed

such experiences, and associated mental distress, signifies that further research could be useful in understanding miscarriage among female refugees in order to support their health.

7. Conclusion

This thesis sought to understand how female refugees define and look after their health, exploring what helps or hinders their health. One of the drivers for focusing on female refugee health was to contribute to gaps in research about such individuals. It has done this in several ways.

Firstly, by focusing on members of one refugee integration network it has contributed insights into female refugees' definitions of health, demonstrating how their understandings contribute to academic debate about health and female refugees. Secondly it has provided empirical insight into how female refugees cope with miscarriage, about which few studies have been undertaken. Thirdly, it has contributed to existing research about the complex interplay between the ways in which female refugees take care of their health and the structures which help and hinder their efforts, sometimes in striking and also ambiguous ways. In doing this it particularly highlights the usefulness of intersectionality theory in viewing the multiple ways, levels and contexts in which female refugees define and look after their health as well as interplay with what helps or hinders their efforts. Intersectionality arguably takes forward the debate on health into exploring the fluidity and diversity of female refugee health and intersections created between themselves, others and structures.

Elements of focused ethnography and community-based participatory research methods were used. This dissertation has demonstrated the usefulness of these methods for undertaking qualitative research with female refugees about their

health. It has also shown how useful these methods are with more unconventional approaches, such as group cooking activities. These activities proved instrumental in developing relationships with participants, enabling them to discuss their health. This arguably prompts a call for more of these kind of activities to be used in research about female refugee health and in community settings as part of efforts to support their efforts. Whilst these activities might not be appropriate for others to use when working with female refugees, such as in healthcare settings, the empathy employed when working with participants is something that service providers and organisations can arguably use more widely than the literature suggests is the case.

Refugee integration networks, charities, places of worship and NGOs were found in this thesis to be important to enabling female refugee health alongside health services. That funding to refugee integration networks has recently been cut ought therefore to be of significant concern to policy makers and services making decisions which affect female refugee health.

While female refugees do many things to take care of their health, individually and collectively, they also associated their experiences of the asylum process with mental distress. For these participants, there seems a clear message: if their experiences are to be associated with better mental health, the asylum system needs to change.

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Appendix one: plain language statement



University
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Participant Information Sheet

Study title: Wellbeing among female refugees living through regeneration

Researcher Name: Cat Tabbner, Global Health MSc Student

*You are being invited to take part in a research study. This study is **not** about your asylum claim or your status in this country. This information explains why the research is being done and what I will ask you to do. Please read the information and ask me if you would like more information.*

What is the purpose of this study?

We want to understand female refugees' health and wellbeing here in Glasgow.

Why have you been invited?

You have been invited because you are a woman and are (or have been) a refugee.

Do you have to take part?

You do not have to take part. Taking part, or not taking part, will not affect your refugee/ citizenship status. Any support provided to you by the network will not change.

What will happen if you take part?

If you decide to take part, you will be invited to both of these activities:

1. You, me and a small number of other female refugees will cook together. I will buy the ingredients, we will talk and we will eat together.
2. You and I will meet to talk about your health.

Will anyone know that you will take part in this study?

Your participation in the study and your answers will be confidential. This means that I will not use your real name when I talk about the study to someone else. Our conversations will be recorded if you agree because this makes it easier for me to listen to what you say. It is important that I am able to listen to you so that we can have a useful conversation. All recordings will be kept in a locked room and destroyed after the end of the study. Nobody will be able to identify you. If during our conversations you think that you would benefit from speaking to any other organisations, we can discuss this if you wish. I have also provided some contact details of some local organisations if you prefer to make contact with them.

What will happen to the results of the research study?

The results of this study will be shared in anonymised form with you, other participants and my supervisors at the University of Glasgow. Results will be published in a dissertation and online. Results might be used to talk to policy makers and organisations so they might improve services and laws that affect female refugees' health and wellbeing. Your identity will always be protected and I will not use information that could identify you.

Who has reviewed the study?

My supervisors and an ethics committee of the University of Glasgow.

Who can you contact for further information?

You can contact me if you have any questions by emailing me at:

0307810t@student.gla.ac.uk.

If you want to speak to my supervisors, you can contact:

1. Gareth Mulvey: Gareth.Mulvey@glasgow.ac.uk / 0141 330 4065.
2. Heide Weishaar: Heide.Weishaar@glasgow.ac.uk / 0141 353 7500

If you have any concerns regarding the way this research project is being done, you can contact the College of Social Sciences Ethics Officer Dr Muir

Houston: Muir.Houston@glasgow.ac.uk / 0141 330 4699

Helpful Organisations

Central and West Integration Network:

Florence Dioka (Development Manager)

Garnethill Multicultural Centre, 21 Rose Street Glasgow G3 6RE

Tel. 0141 573 0978

Email: florence@cwin.org.uk

Scottish Refugee Council:

5 Cadogan Square, Glasgow, G2 7PH. Tel: 0141 248 9799

- Refugee Integration Service: holistic integration support over 12 months for refugees granted leave to remain since April 2013.
- Family Keywork Service: holistic keywork support over 12 months for newly arrived asylum seeking families (including single mums) with children aged 0-8yrs since December 2013.
- Destitute Asylum Seekers Service: drop-in on Tuesdays at St Rollox Church 9.30am-12.30pm and on Fridays at Garnethill Multicultural Centre 10am-12.30pm.

Scottish Refugee Council project:

- SRC Peer Education Project: peer health education for asylum seekers and refugees who speak Farsi, Tigrinyan, Arabic or English. Contact:

peer.education@scottishrefugeecouncil.org.uk

Other services in Glasgow:

- British Red Cross Women's Project/New Mums Project: general support for women in the asylum process and for new mums. Contact: Anniemarshall@redcross.org.uk or gsalih@redcross.org.uk.
- Glasgow Rape Crisis Centre Ruby Project: for survivors of sexual violence including FGM. Contact: CFuller@rapecrisiscentre-glasgow.co.uk
- Glasgow Violence Against Women Partnership: working together to end violence against women and children. Contact: 0141 276 7724
- Glasgow Women's Aid, 4th Floor, 30 Bell Street, Candleriggs, Glasgow, G1 1LG. Tel: 0141 553 2022.
- Hermatt Gryffe Women's Aid, Flat 0/1, 24 Willowbank Street, Glasgow G3 6LZ. Telephone: 0141 353 0859. Email: womensaid@hematgryffe.org.uk
- Drumchapel Women's Aid, 8 Essenside Ave, Glasgow, G15 6DX. Tel: 0141 944 0201. Email: drumwomen@btconnect.com
- Saheliya: mental health and well-being support organisation for black and minority ethnic (BME) women and girls (12+) in Scotland. St Rollox House, 130 Springburn Road, G21 1YL. Tel: 0141 552 6540. Email: khadija@saheliya.co.uk
- Wise Women. Personal safety and confidence building. 120 Sydney Street, Glasgow, G31 1JF. Tel: 0141 550 7557. Email: info@wisewomen.org.uk

Appendix two: topic guide



College of Social
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Topic Guide

Research Questions:

1. How do female refugees define health?
2. How do they try to look after their health?
3. What helps or hinders their efforts along the way?

1. Group cooking questions

1.2 Icebreaker questions

- Can we introduce ourselves to each other [participants will be from the network and will probably know each other, but it is possible that some participants might not have met as the network has a varied membership and a diverse range of activities. I will also be meeting participants for the first time and will need to introduce my name and get to know them].
- Let me explain why we are here [check with participants they understand the purpose of the session, as per the plain language statement]
- Do you wish to participate? [go through consent forms and ask them to be signed, reminding participants this is a voluntary project and that they can stop/ leave at any time].

- This is my dictaphone. I would like to record our conversations because this makes it easier for me to listen to what you say. It is important that I am able to listen to you so that we can have a useful conversation. All recordings will be kept in a locked room and destroyed after the end of the study. Nobody will be able to identify you. Do you agree to me recording this session? Are these the right ingredients? [I will have bought the ingredients based on a list that will have been sent to me by participants in advance of the cooking session].
- [To the women who have chosen the ingredients]: can you please explain to us what these ingredients are?
- [To the rest of the women]: do we have any questions about these ingredients?
- [To the women who have chosen the ingredients]: What are we going to cook? Name of dish? [If the recipe choice has been made by some but not all participants, ask those who chose the recipe to explain to us all what we are going to cook] Can you tell us when you usually eat this dish?

1.2 Focus of cooking session

- Explain that I'm interested in their health. I'm interested in what good health is for them, their hopes about good health. I'm interested in how they try to keep healthy.

1.3 Main questions

- What does health mean for you?
- Can you describe what 'healthy' is to *you*?
- What does health feel like for you?

2. Individual interviews

- Can you tell me a bit more about what health means to you?
- Where do you go to feel good?
- What helps you feel good?
- What stops you feeling good?

Appendix three: consent forms

See over leaf