# Iraqi Community Association

**Health Resource Centre**

# Health Needs Assessment Study of the Iraqi Community in London

## 1998-1999

***by***
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# CHAPTER ONE

## *1.1 Summary*

It has to be clearly stated from that the findings of this report do not represent the full range of health and social problems experienced by the Iraqi community living in this country; and further research into this area is needed.

The aim of this study is to identify some of the roots of ill health of the Iraqi and Arabic speaking communities, and to make recommendations to tackle these problems.

This community-based study was conducted by the staff of the newly established Health Resource Centre of the Iraqi Community Association.

The findings were based on a total of 420 questionnaires completed by adult members of the Iraqi community in London.

Many of the health and social welfare problems expressed could be seen as stress-related and caused by a variety of factors e.g. communication barriers, unresolved trauma and lack of appropriate help and support networks - particularly in the case of the newly arrived refugee. Indeed Mental Health problems were found to be quite prevalent amongst this group. The whole experience of flight, loss of friends, family, society, home, security and social status was found to be a major factor in the mental health problems identified. Lack of appropriate services was also a common experience, and was found to seriously compound existing problems. However the one over-riding factor identified throughout the study was a basic difficulty in accessing the services that are already available, largely due to language barriers. Basic issues, such as limited interpreting services and a lack of written information in community languages, are making it very hard for the community to become aware of the NHS, what it is, how it works, and how to get the basic health assessments and interventions they require.

Although the levels of GP registration in the community appeared reasonably high, many of the problems in accessing the NHS as described above were still identified.

In summary then, this study has provided a real opportunity to identify community issues and needs in relation to healthcare, and could prove a major asset in the development of services to meet these needs.

## *1.2 Background*

Twelve years ago the Iraqi Community Association was established to promote the health and welfare of the Iraqi community in Britain. The Iraqi Community Association represents and serves all individuals in the community without discriminating against any religious, ethnic, political gender or social group.

Iraqis began arriving in the UK in significant numbers during the last decade, as a consequence of the persecution, war and brutality taking place in Iraq.

When the Health Resource Centre was established at the ICA in 1997, it became clear through our day to day casework with clients that there was a great need for a comprehensive study into the health needs of the community. Existing research into the health problems of refugees in the UK is limited (1). Despite the fact that there is a sizeable Iraqi community in this country and has been for some years, a study into their health needs and problems has, to our knowledge, never been undertaken.

Yet health is an issue of vital relevance to all refugee communities, and the Iraqi community is no exception. Asylum seekers may arrive with the physical after-effects of war, torture, displacement and the journey to the UK, yet remain unacquainted with the National Health Service and how to access it. Mental health problems following trauma can be significant for some groups and individuals. In addition, there are the widespread social and psychological problems arising from coping with a new culture, loss of status etc. (3)

Many of the health problems of refugees are not necessarily specific to refugee status, but overlap with health problems of deprived or excluded groups, ethnic minorities, or new entrants to the country (1). Indeed, there is some evidence to suggest that the health status of new entrants may become relatively worse in the 2-3 years after entry to the UK. (1)

The problems of other members of the community who have been settled here for some time may be quite different; issues such as disability, old age, mental health problems and ongoing cultural and language barriers may prevent their health needs being met.

## *1.3 Introduction*

This survey has been prompted by the increasing levels of concern being expressed by different sectors of our community about their health and social welfare difficulties, particularly in accessing existing services. It is also a rare opportunity for our community to offer direct feedback and input into the planning and delivery of healthcare services.

The main purpose of the research is to highlight the health needs of the Iraqi community in different boroughs of London, needs that frequently remain unrecognised or overlooked. ICA monitoring statistics show that the number of Iraqi refugees and asylum seekers has increased steadily over the last ten years. Obstacles to accessing services, along with desperate inadequacies in existing healthcare provision, means that many of these needs have, to date, gone unmet.

This study also aims to highlight the needs of vulnerable groups within the community, such as new asylum-seekers, the elderly, disabled, and those living in a generalised state of poverty and ill-health, groups whose existence and needs are in danger of remaining hidden from view.

During the course of this project, we examine the health problems of the community and their ability to access existing services; we look carefully at the problems of refugees, women and the elderly as the most vulnerable sections of the community.

### *1.4 Aims and Objectives*

1. To identify the obstacles facing Iraqi community, especially refugees and asylum seekers in accessing the National Health Service.

2. To assess the levels of the health awareness and knowledge and understanding of the NHS amongst Arabic and Kurdish speakers, and highlight areas for future development.

3. To identify the main areas of need for Health Promotion work amongst our communities.

4. To identify existing levels of liaison and support networks amongst GP's and other health and welfare organisations.

5. To identify the level of need for a specialised health service for Arabic and Kurdish speakers.

6. To identify the special support needs of Iraqi refugees.

7. To establish the best means of dissemination of health-related information to the community.

8. To establish the number of elderly people within the community and the level of information about health services currently available to them.

9. To establish the level of need for an Elderly Day Centre and Resource Centre.

10. To research the existing networks for health-related care and support amongst the community.

11. To enable the Iraqi community to take an active role in the development of its own services.

12. To assess how difference in gender affects perception and experience of health and health related problems.

13. To assess the role of social and welfare needs as related to health needs.

14. To identify the special health needs of Iraqi women

### *1.5 Methodology*

This research was conducted using three main methods:

(1) Postal questionnaires
(2) Face-to-face interviews
(3) Questionnaires distributed at community events

The survey was conducted during the period (between) September 3rd 1998 and November 30th 1998.

One thousand postal questionnaires were sent to members of the community based throughout Greater London, with 200 of these questionnaires being returned to the Health Resource Centre via pre-paid envelopes.

The mailing list for the questionnaire was randomly chosen by selecting the first 1000 entries in the ICA's database of 3 000 plus, and included clients, members and non-members of the organisation throughout London.

A group of 5 volunteers was then recruited to conduct face-to-face interviews with visitors to the ICA who had not featured in the random postal sample. During these interviews, interviewees were able to elicit further information on any aspect of the questionnaire they did not understand, and were able to either complete the interview face-to face with the interviewer, or send it on by post if preferred.

Community events and activities were used to distribute questionnaires to those who had not received them by any of the other means described above.

The questionnaire was distributed as follows:

| | |
|---|---|
| - postal distribution by ICA | 1,000 |
| - via face-to-face interview | 150 |
| - via community activities | 650 |
| **Total** | **1,800** |

Returns were received as follows

| | |
|---|---|
| - by post | 243 |
| - via face-to-face interview | 131 |
| - via community events | 46 |
| **Total** | **420 (23%)** |

### *1.7 Methods of data analysis*

The data collected was entered onto a custom-built database, using software packages Access97 and Excel97.

# CHAPTER TWO

***Findings of the Research-***

## *2.1 Distribution of Sample by Borough of Residence.*

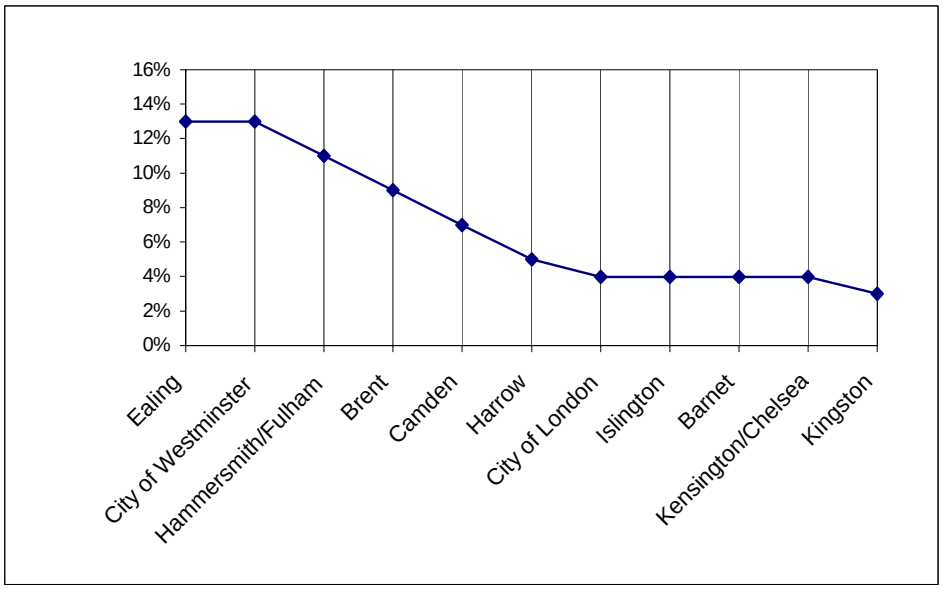
### 2.1.1 Distribution of Sample by Region.

The survey found respondents to be concentrated in West London, North West London, and Central London. A total of 420 questionnaires were returned from all 33 London Boroughs, with the greatest number of respondents coming from the following ten Boroughs: Ealing, City of Westminster, Hammersmith & Fulham, Brent, Camden, Harrow, City of London, Islington, Barnet and Kensington & Chelsea.

**(Table 1) Distribution of Sample by Region.**

| Borough | No | % |
|---|---|---|
| Ealing | 54 | 13% |
| City of Westminster | 53 | 13% |
| Hammersmith/Fulham | 48 | 11% |
| Brent | 38 | 10% |
| Camden | 29 | 7% |
| Harrow | 20 | 5% |
| City of London | 17 | 4% |
| Islington | 17 | 4% |
| Barnet | 16 | 4% |
| Kensington/Chelsea | 15 | 4% |
| Kingston | 13 | 3% |
| Hackney | 9 | 2% |
| Hounslow | 8 | 2% |
| Merton | 8 | 2% |
| Newham | 8 | 2% |
| Croydon | 7 | 2% |
| Sutton | 7 | 2% |
| Greenwich | 6 | 1% |
| Bromley | 5 | 1% |
| Wandsworth | 5 | 1% |
| Bexley | 4 | 1% |
| Lambeth | 4 | 1% |
| Richmond | 4 | 1% |
| Southwark | 4 | 1% |
| Waltham Forest | 4 | 1% |
| Barking & Dagenham | 3 | 1% |
| Havering | 3 | 1% |
| Haringey | 2 | 0% |
| Hillingdon | 2 | 0% |
| Lewisham | 2 | 0% |
| Tower Hamlets | 2 | 0% |
| Enfield | 1 | 0% |
| Merton | 1 | 0% |
| Redbridge | 1 | 0% |
| **Total** | **420** | **100%** |

**(Figure 1) Distribution of the Sample by Borough of Residence**



### 2.1.2 Distribution of Sample by Region and Gender.

The table shows the number of respondents broken down according to gender. Of the total number of London respondents, 152 were female and 268 were male.

**(Table 2) Distribution of Sample by Region and Gender.**

| Borough | Male | | Female | |
|---|---|---|---|---|
| | NO | % | NO | % |
| City of Westminster | 33 | 12% | 20 | 13% |
| Ealing | 32 | 12% | 22 | 14% |
| Hammersmith/Fulham | 28 | 10% | 20 | 13% |
| Brent | 24 | 8% | 14 | 9% |
| Camden | 20 | 7% | 9 | 6% |
| Harrow | 14 | 5% | 6 | 4% |
| City of London | 11 | 4% | 6 | 4% |
| Islington | 11 | 4% | 6 | 4% |
| Kingston | 11 | 4% | 2 | 1% |
| Barnet | 10 | 4% | 6 | 4% |
| Kensington/Chelsea | 10 | 4% | 5 | 3% |
| Hackney | 8 | 3% | 1 | 1% |
| Merton | 7 | 3% | 1 | 1% |
| Greenwich | 5 | 2% | 1 | 1% |
| Newham | 5 | 2% | 3 | 2% |
| Wandsworth | 5 | 2% | 0 | 0% |
| Bexley | 4 | 2% | 0 | 0% |
| Croydon | 4 | 2% | 3 | 2% |
| Hounslow | 4 | 2% | 4 | 3% |
| Southwark | 4 | 2% | 0 | 0% |
| Bromley | 3 | 1% | 2 | 1% |
| Sutton | 3 | 1% | 4 | 3% |
| Waltham Forest | 3 | 1% | 1 | 1% |
| Barking & Dagenham | 2 | 1% | 1 | 1% |
| Lambeth | 2 | 1% | 2 | 1% |
| Lewisham | 2 | 1% | 0 | 0% |
| Havering | 1 | 0% | 2 | 1% |
| Redbridge | 1 | 0% | 0 | 0% |
| Richmond | 1 | 0% | 3 | 2% |
| Endfield | 0 | 0% | 1 | 1% |
| Haringey | 0 | 0% | 2 | 1% |
| Hillingdon | 0 | 0% | 2 | 1% |
| Marbon | 0 | 0% | 1 | 1% |
| Tower Hamlets | 0 | 0% | 2 | 1% |

| | | | | |
|---|---|---|---|---|
| **Total** | **268** | **100%** | **152** | **100%** |

## *2.2 Distribution of Sample by Age and Gender (excluding Under 18 Year- Olds)*

The most notable finding in relation to age distribution is that 25-50 year olds made up by far the largest group, comprising 69% of males and 63% of females (see Table 3).

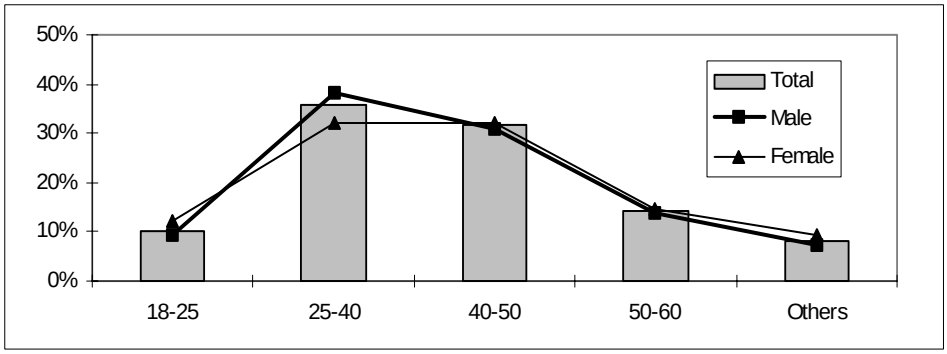
The relative youth of the Iraqi community in London, as indicated by the survey findings, is a probable result of its situation as an immigrant community.

(Please note that, as the number of respondents under 18 was very low, it was felt that the graph would be more meaningful if this group was excluded.)

**(Table 3) Distribution of Sample by Age and Gender (excluding Under 18 Year- Olds)**

| Age | Male | | Female | | Total | |
|---|---|---|---|---|---|---|
| | No | % | No | % | No | % |
| **18-25** | 25 | 9% | 18 | 12% | 43 | 10% |
| **25-40** | 102 | 38% | 48 | 32% | 148 | 36% |
| **40-50** | 83 | 31% | 48 | 32% | 131 | 32% |
| **50-60** | 37 | 14% | 22 | 15% | 59 | 14% |
| **Others** | 20 | 7% | 14 | 9% | 34 | 8% |
| | | | | | | |
| **Total** | **267** | **100%** | **150** | **100%** | **415** | **100%** |

**(Figure 2) Distribution of Sample by Age and Gender (excluding Under 18 Year-Olds)**

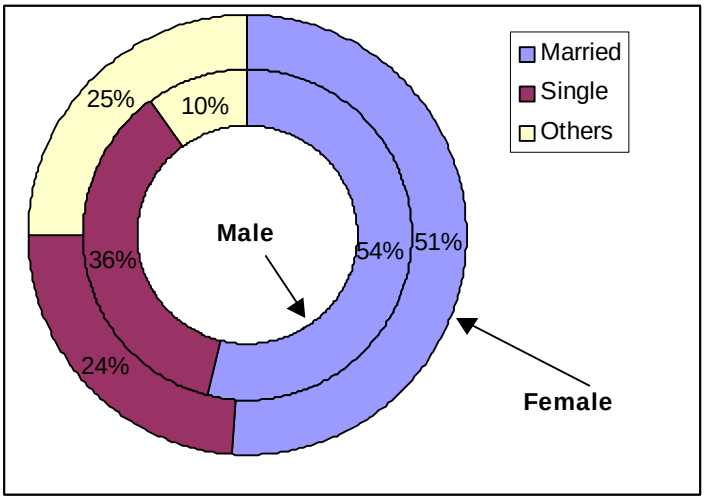


### *2.3 Adults Within the Sample by Gender and Marital Status*

Adults within the sample tended to fall into two status groups, as follows:
- Male: married (54%) or single (36%);
- Female: married (51%) or single (24%).

The remaining categories, covering widowed, separated, and divorced, represent 10% of males, and 25% of females.

**(Figure 3) Marital Status of Adults by Gender**



## (Table 4) Distribution of Sample by Marital Status and Gender

| Age Group | Married | | | | Single | | | | Divorced | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | | Female | | Male | | Female | | Male | | Female | |
| | No | % | No | % | No | % | No | % | No | % | No | % |
| 18-25 | 5 | 20% | 2 | 11% | 19 | 76% | 16 | 89% | 1 | 4% | 0 | 0% |
| 25-40 | 41 | 40% | 23 | 50% | 56 | 55% | 9 | 20% | 3 | 3% | 8 | 17% |
| 40-50 | 59 | 71% | 32 | 67% | 12 | 14% | 6 | 13% | 8 | 10% | 7 | 15% |
| 50-60 | 30 | 81% | 13 | 59% | 4 | 11% | 2 | 9% | 0 | 0% | 2 | 9% |
| Others | 10 | 50% | 5 | 36% | 4 | 20% | 2 | 14% | 4 | 20% | 1 | 7% |
| | | | | | | | | | | | | |
| **Total** | **145** | **54%** | **75** | **51%** | **95** | **36%** | **35** | **24%** | **16** | **6%** | **18** | **12%** |

| Age Group | Separated | | | | Widowed | | | |
|---|---|---|---|---|---|---|---|---|
| | Male | | Female | | Male | | Female | |
| | No | % | No | % | No | % | No | % |
| 18-25 | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| 25-40 | 2 | 2% | 3 | 7% | 0 | 0% | 3 | 7% |
| 40-50 | 2 | 2% | 2 | 4% | 2 | 2% | 1 | 2% |
| 50-60 | 3 | 8% | 4 | 18% | 0 | 0% | 1 | 5% |
| Others | 1 | 5% | 0 | 0% | 1 | 5% | 6 | 43% |
| | | | | | | | | |
| **Total** | **8** | **3%** | **9** | **6%** | **3** | **1%** | **11** | **7%** |

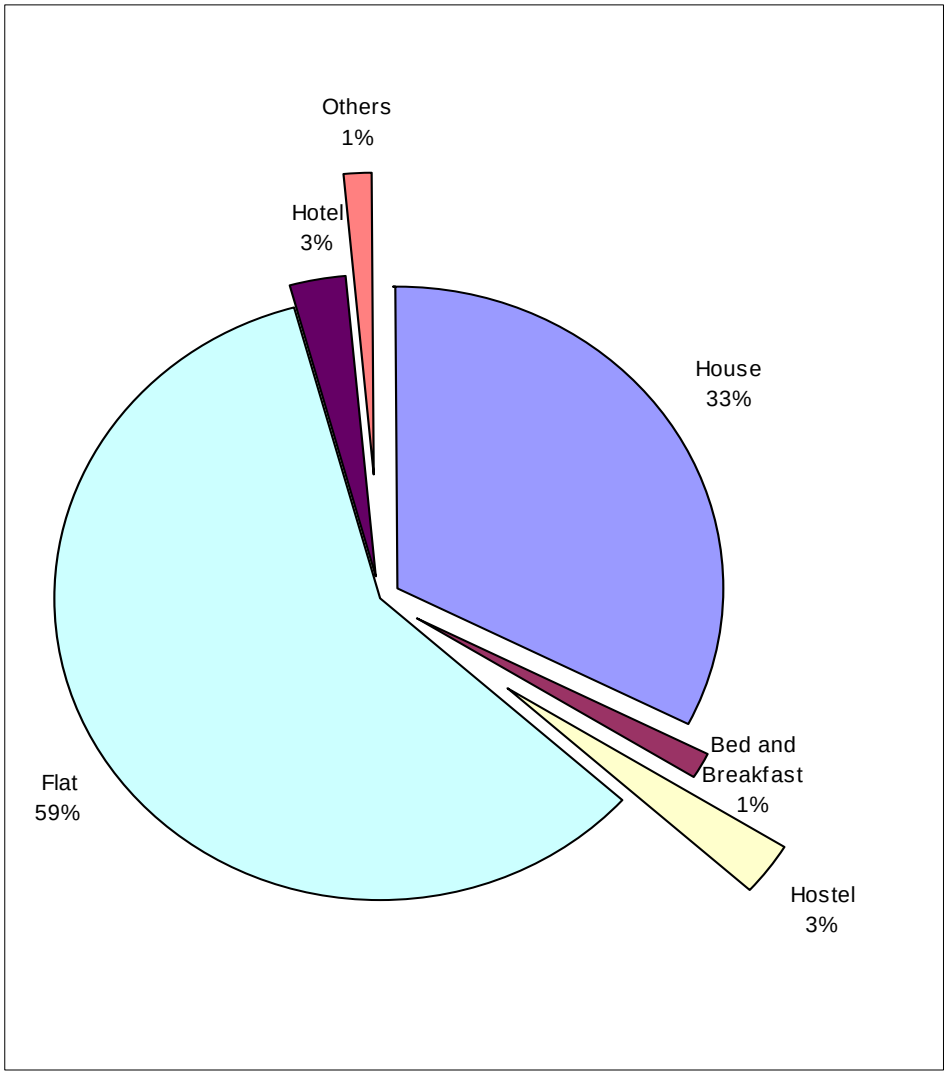
## *2.4 Type of Accommodation*

The majority of respondents were those living in settled accommodation, such as flat (59%) or house (33%). The remaining categories represent 8% of the sample: (with 3% living in hotels, 3% in hostels, 1% in Bed and Breakfast, and 1% in other unspecified forms of accommodation). These results may not give a true picture of the housing status of the community as a whole, given that those in unsettled accommodation are much less likely to respond to a questionnaire or survey such as this. They may therefore be under-represented in the survey results.

27% of those living in houses were owner-occupiers, with most of the remainder privately renting. Only 6% of those living in flats were owner-occupiers, with the remainder renting.

Compared with the results of the Needs Assessment Survey “Now We Are Here” (1995-96), the number of people living in flats, hotels, hostels, and Bed and Breakfast accommodation has increased by 3%, whilst the number of those living in houses has decreased by 11%. This indicates an increasingly mobile population, and points to a general worsening of housing conditions for the community, particularly for newly arrived refugees, over the last four years.

**(Figure 4) Type of Accommodation.**



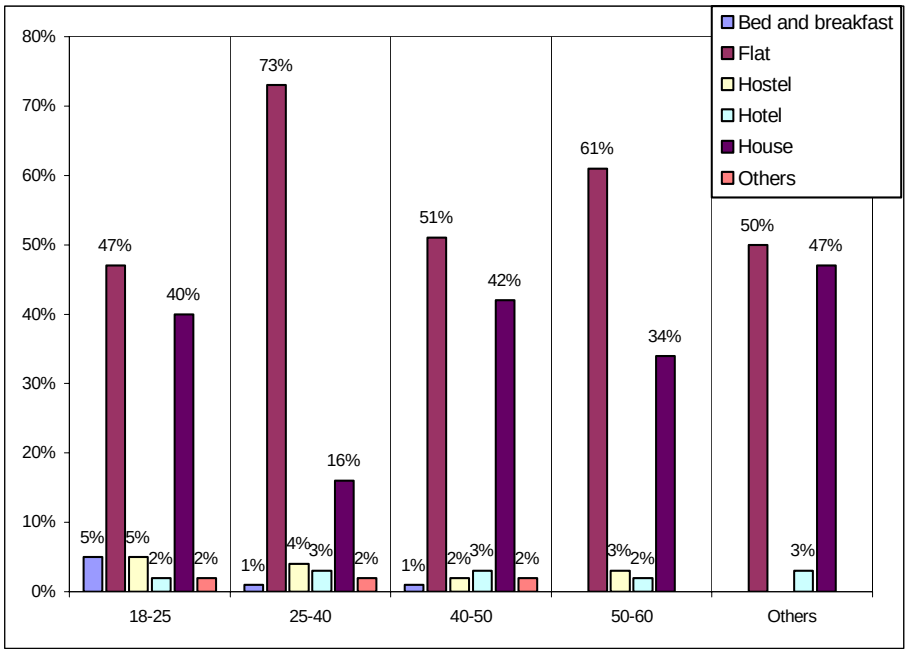
### 2.4.1 Type of Accommodation by Age

Adults within the sample tended to fall into two main groups, either living in flats 73% or house 16% (Age Group 25-40.). The remaining categories each represented 4% or less for the same age group.

**(Table 5) Type of Accommodation by Age.**

| Type of Accommodation | 18-25 | 25-40 | 40-50 | 50-60 | Over 60 |
|---|---|---|---|---|---|
| Bed and breakfast | 5% | 1% | 1% | 0% | 0% |
| Flat | 47% | 73% | 51% | 61% | 50% |
| Hostel | 5% | 4% | 2% | 3% | 0% |
| Hotel | 2% | 3% | 3% | 2% | 3% |
| House | 40% | 16% | 42% | 34% | 47% |
| Others | 2% | 2% | 2% | 0% | 0% |

**(Figure 5) Type of Accommodation by Ownership and Age**



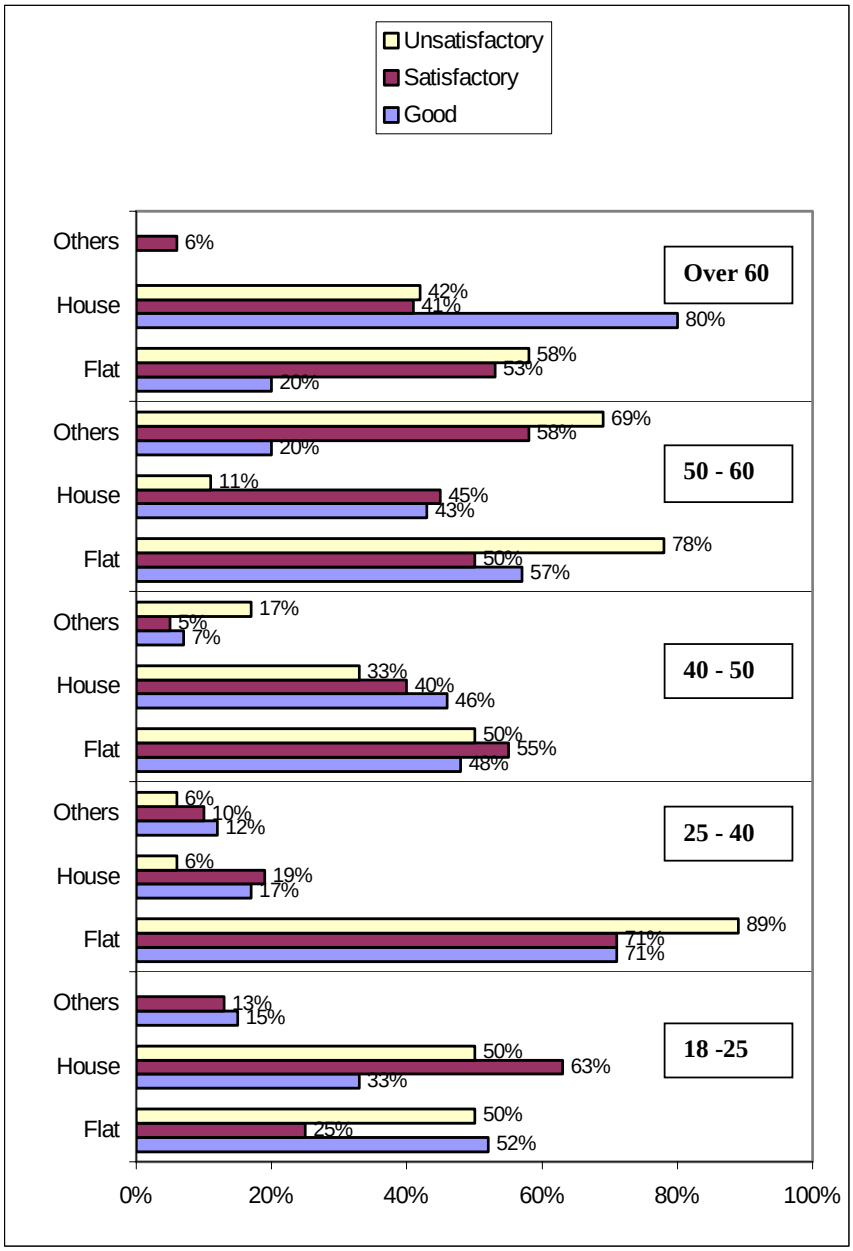
### 2.4.2 Type of Accommodation and Health Status

When looking at the relationship between type of accommodation and health status, it transpired that a high proportion of those describing their health as unsatisfactory were living in flats, or hostels and bed and breakfast hotels. A range of problems was described by respondents, all of which could have a direct effect on mental and physical health. These included:

Noise and overcrowding
Damp
Lack of repairs
Infestations
High rise with no/inadequate lift
Isolation of accommodation from amenities, services and community networks
Racial harassment

From Figure 6, we can see an overall picture of those living in houses being far more satisfied with their health status than those living in flats and other accommodation. The group that reported their health to be the most unsatisfactory were 25-40 year olds living in flats. In contrast, a large proportion of over-60 year olds living in houses reported their health to be good.

**(Figure 6) Health Status by Type of Accommodation and Age**



## *2.5 Competence in Written and Spoken English according to Gender*

Respondents judged their levels of competence in the English language as generally high: 42% assessed their level of spoken and written English as good. There was a significant difference between the responses of men and women: 26% of men assessed their English as good, whilst only 16% of women responded in the same way. Behind these figures lie two main factors: the much greater role that women play in childcare in the home, and the likelihood that men in the community will be given priority over women in learning English and in other educational opportunities.

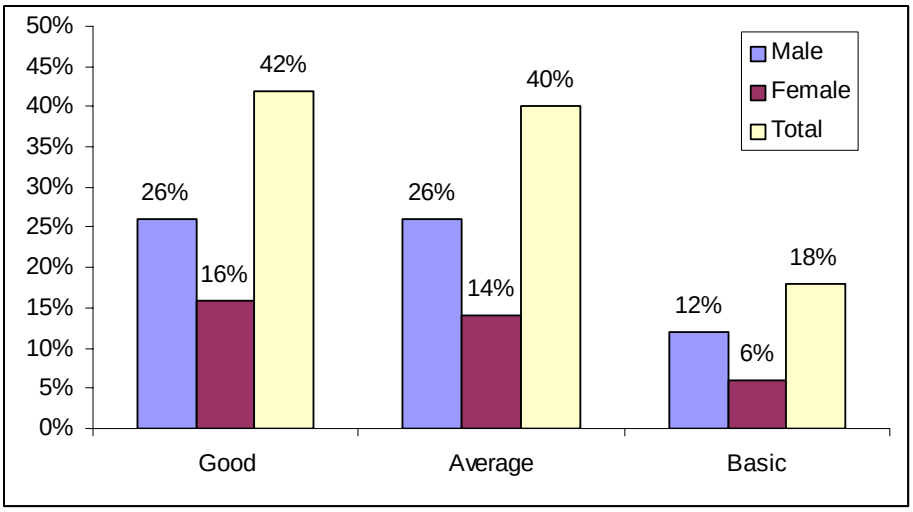
A total of 40% of respondents described their English as average, with 17% describing their English as poor or elementary. Some respondents cited language difficulties as the major barrier to participating in everyday activities confidently such as shopping, consulting a GP, or seeking other support and assistance.

Competence in English has proven to be an essential factor in building a new life in this society. It is likely that respondents within the above two categories are facing significant difficulties each time they are required to interact with the host community, whether to access services or for any other reason.

**(Table 6) Competence in Written and Spoken English according to Gender**

| Level | Male | | Female | | Total | |
|---|---|---|---|---|---|---|
| | No | % | No | % | No | % |
| Good | 110 | 26% | 67 | 16% | 177 | 42% |
| Average | 111 | 26% | 59 | 14% | 170 | 40% |
| Elementary | 47 | 12% | 26 | 6% | 73 | 18% |
| | | | | | | |
| **Total** | **268** | **64%** | **152** | **36%** | **420** | **100%** |

**(Figure 7) Competence in Written and Spoken English according to Gender**



### *2.6 Registration with GP, Dentist and Optician, and Awareness of the Patients' Charter - by Gender.*

It appears that the sample is relatively proactive in seeking medical assistance. 89% of respondents were registered with a GP, and those who were not registered reported reasons as given below.

396 respondents out of the total sample number of 420 were registered with a GP, and 320 had consulted a dentist and optician. However the sample was less knowledgeable about the Patients' Charter, and was less good at accessing allied services, such as Social Services. Language barriers could lie behind this finding, blocking information and hindering access to these services; however cultural factors could also be playing a part, indicating the reluctance on the part of respondents to use such services.

**(Table 7) Registration with GP, Dentist and Optician, and Awareness of the Patients' Charter- by Gender**

| GP Unwilling to register | | | | Registered with GP | | | |
|---|---|---|---|---|---|---|---|
| Male | | Female | | Male | | Female | |
| Total No | % | Total No | % | Total No | % | Total No | % |
| 18 | 7% | 6 | 4% | 250 | 93% | 146 | 96% |

| Reasons | Not aware | Ignorance | Other reason |
|---|---|---|---|
| Male | 2 | 11 | 5 |
| Female | 3 | 2 | |

| | Optician or Dentist | | Patient Charter | |
|---|---|---|---|---|
| | Aware | Not aware | Aware | Not aware |
| Male | 198 (70%) | 70 (30%) | 96 (40%) | 172 (60%) |
| Female | 122 (80%) | 30 (20%) | 59 (39%) | 93 (61%) |

### *2.7 Percentage of Disabled and Elderly People in the Community*

Almost one quarter of all respondents said that they have a disability or health problem, and amongst these, women (16%) seemed to be more affected than men (10%). A total of 12% of respondents described themselves as disabled; of these, 92% were registered disabled and 8% were self-assessed as disabled but not registered as such.

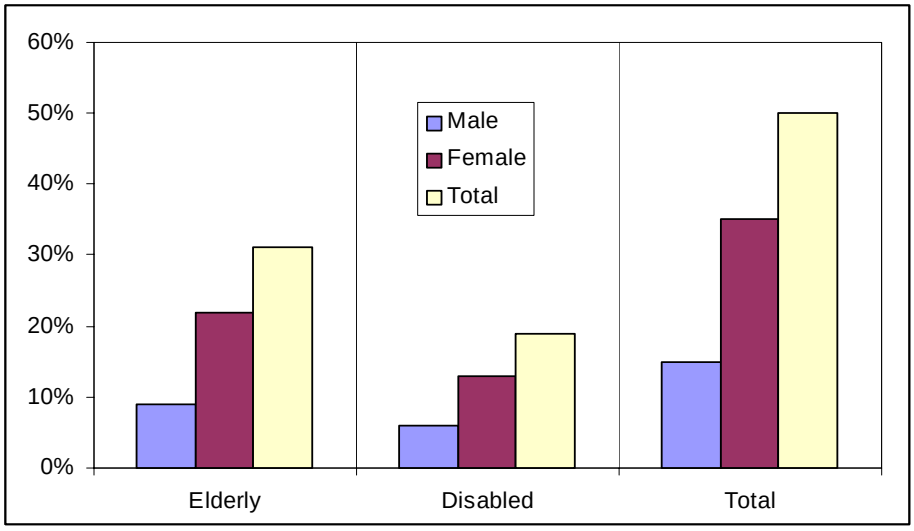
Since the Health Resource Centre was established and publicised its services widely, the number of registered disabled amongst the ICA's client group has increased markedly. In its first year of work, the Health Resource Centre dealt with 29 cases of clients seeking support with disability issues. However in the second year of its work the Centre dealt with 111 cases relating to disability, indicating that the community has been able to benefit greatly from the increased access to rights and services that the Health Resource Centre has been able to provide.

In fact, language difficulties have been identified by both the questionnaire and by client feedback as the most significant barrier facing disabled people. Other important barriers described were the loss of support of the extended family, isolation, poor climate, change in diet, change in lifestyle, feelings of not belonging and hopelessness and racial harassment.

**(Table 8) Percentage of Disabled and Elderly People in the Community**

| | Male | | Female | | Total | |
|---|---|---|---|---|---|---|
| | No | % | No | % | No | % |
| Elderly | 25 | 9% | 20 | 22% | 45 | 31% |
| Disabled | 15 | 6% | 11 | 13% | 26 | 19% |
| **Total** | **40** | **15%** | **31** | **35%** | **71** | **50%** |

**(Figure 8) Percentage of Disabled and Elderly People in the Community**



## *2.8 Requirement for Elderly Day and Residential Care.*

During the course of our daily work at the Health Resource Centre, we have become increasingly aware of the growing number of Iraqi elders living alone in London and the day-to-day issues and problems this raises. Since the Needs Assessment Survey **"Now We Are Here"** was carried out in 1995-96, the number of elderly Iraqis living in London has increased and is set to continue increasing over the coming years. For example, the percentage of the community that is over 60 years old has increased from 2.4% in 1995-96 to 3% today. Despite the low percentage of this group in relation to other sectors of the community, the elderly are likely to have high and disproportionate support needs and to remain a very vulnerable group.

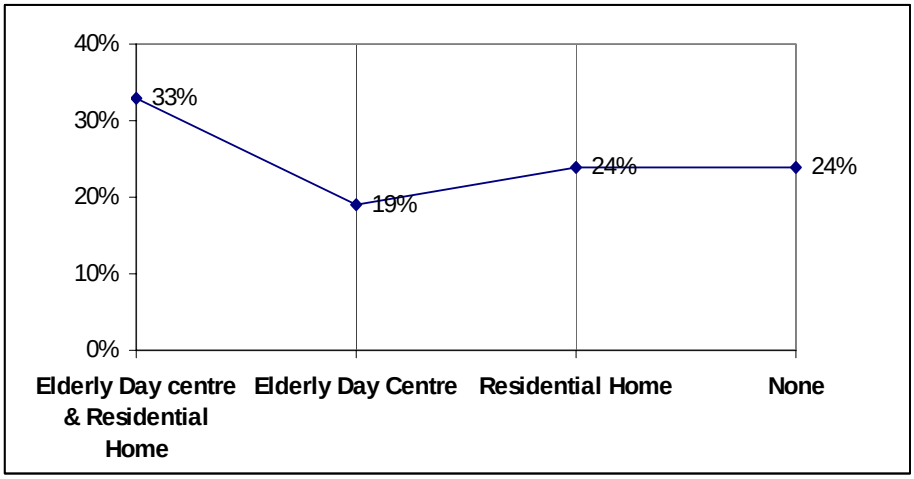
Our starting point for this section of the questionnaire was to ask respondents for their views on formal structures for bringing elderly people from the community together. 33% of respondents were of the view that Elderly Day Centres as well as Residential Homes are required to meet the needs of the elderly in London, with 19% preferring Day Centres only, and 24% preferring Residential Homes only. Interestingly, 24% of all respondents felt that none of these options are necessary. This response can be seen in the light of cultural beliefs and values around the care of the elderly, which are largely socially determined, and can vary from one culture to another. Ideas of Residential Homes and Day Centres may not sit well with traditional views of Iraqi culture, in which the elderly are seen as experienced, wise, important and are highly respected. Traditionally, they have been taken care of by their children and grandchildren, in a family atmosphere of care and warmth. Inevitably many members of the community question whether a Residential Home or Day Centre could provide anything like this type and level of care.

However the high level of response to this question reflects the degree of concern expressed by the community generally about the ability of the elderly to make the physical and psychological adjustment to life in the host culture. Therefore the needs of this very vulnerable sector of our community remain an area for further work and investigation.

**(Table 9) Requirement for Elderly Day and Residential Care**

| | No | % |
|---|---|---|
| Elderly Day Centre & Residential Home | 140 | 33% |
| Elderly Day Centre | 79 | 19% |
| Residential Home | 102 | 24% |
| None | 99 | 24% |

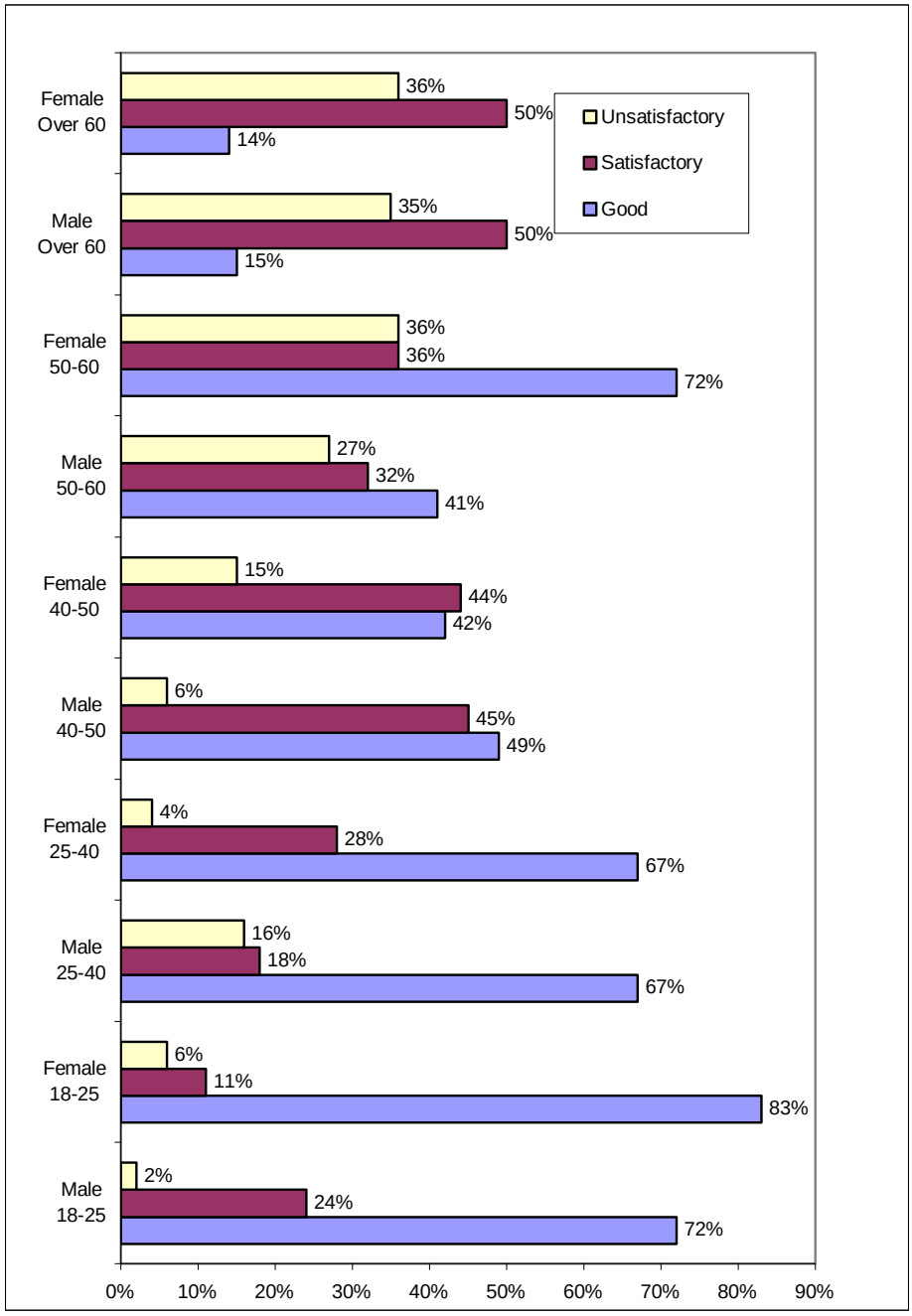
**(Figure 9) Requirement for Elderly Day and Residential Care**



### *2.9 Health Status by Age and Gender.*

Analysis of age and gender revealed that young women (aged 25 - 40) are far less satisfied with their health status than men. 16% of males in this age group described their health as unsatisfactory, as compared to only 4% of females. However, in the age group (40-50), this situation is almost reversed, with 15% of females as compared to 6% of males describing their health status as unsatisfactory. This partially reflects a trend for younger men (25-40) to be more concerned about mental health problems than women, and vice versa for the 40-50 age group (see Figure 11). In the older age group (50-60) high proportions of both men (27%) and women (36%) reported their health status to be unsatisfactory. It is clear from this that the sample groups are experiencing a range of health problems, and that this area requires further investigation.

**(Figure 10) Health Status by Age and Gender.**



## *2.10 Common Illnesses Affecting Iraqi People in London*

Figure 11 indicates that the community is more concerned about mental health problems than any other issue. A common observation of the Health Resource Centre is that refugees often arrive in the UK with the myth that life here is going to solve their problems. Their aim is to set up a new life and recover from the loss and trauma they have experienced in their country of origin. However, in reality newly arrived refugees face a range of key problems and obstacles to setting up a life here, in terms of understanding, accessing and using the system

For example, Figure 21 indicates that more than 50% of our community is concerned about Trauma Related Psychological Problems. As a result the Health Resource Centre is more than ever aware of the need to develop services, such as counselling services, to address TRPP and other allied problems.

**(Figure 11) Common Illnesses Affecting Iraqi People in London**

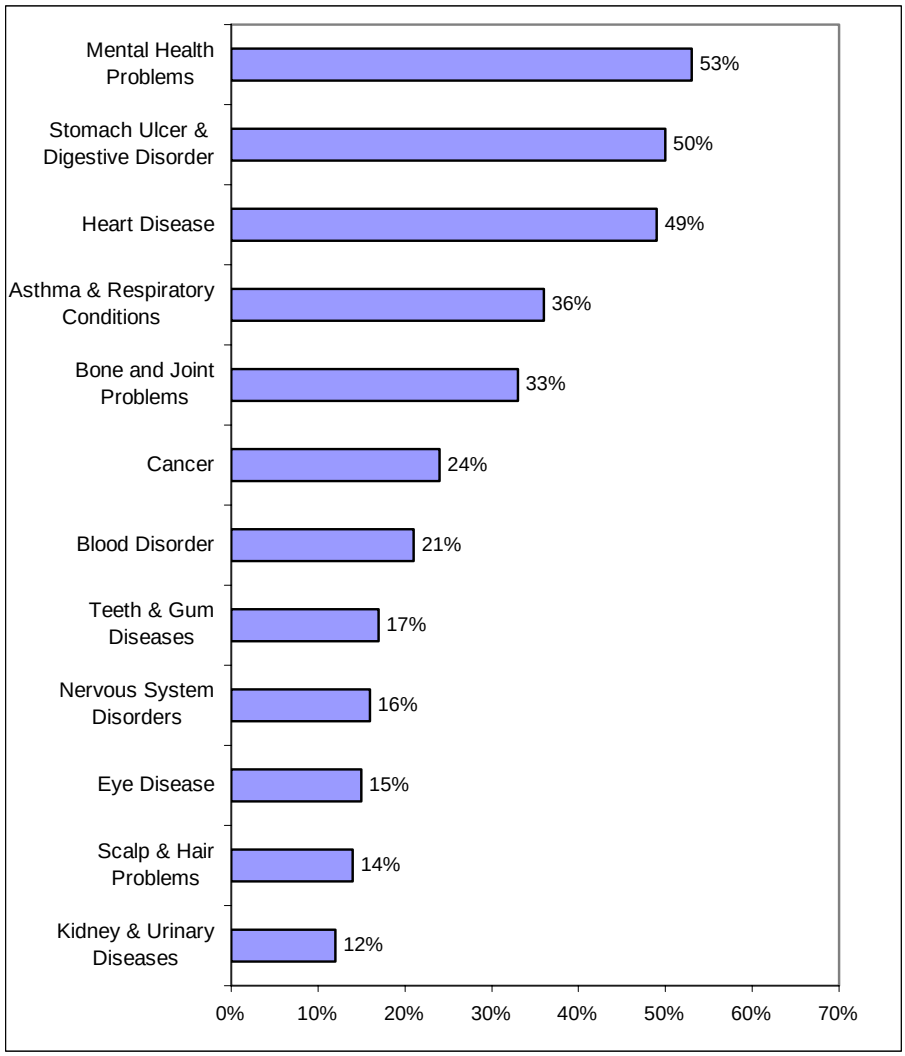
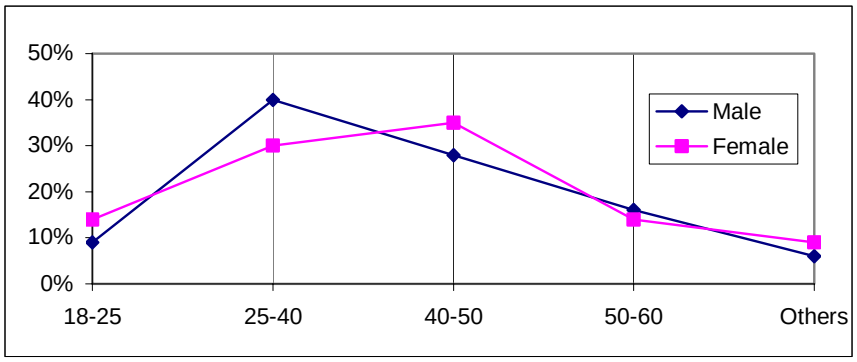


**Table 10** suggests a high level of concern amongst the community about Mental Health Problems. However it is important to make the point that concepts of mental health and ill health differ widely between Iraqi society and Western society. Traditionally, our society has tended to see mental illness as a polarisation of sanity/insanity, whereas Western society in its concept of mental health tends to look at the whole spectrum of psychological problems, and at subjective emotions and experiences. Therefore it was made clear to respondents that questions referred to the wider concept of mental health, and covered issues such as stress, anxiety, depression, and Trauma Related Psychological Problems.

**(Table 10) Mental Health Problems**

| Age | Male(No) | Female(No) | Male(%) | Female(%) |
|---|---|---|---|---|
| 18-25 | 13 | 11 | 9% | 14% |
| 25-40 | 57 | 24 | 40% | 30% |
| 40-50 | 40 | 28 | 28% | 35% |
| 50-60 | 22 | 11 | 16% | 14% |
| Others | 9 | 7 | 6% | 9% |
| **Total** | **141** | **81** | **100%** | **100%** |

**(Figure 12) Mental Health Problems**

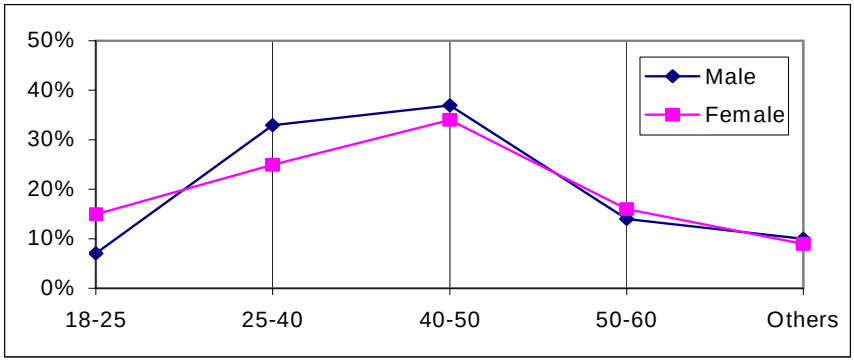



**(Tables 11, 12, & 13** indicate that the sectors of the community most concerned about the health issues referred to (Mental Health Problems, Cancer, Stomach Ulcer and Heart Disease), are men and women in their middle years. It is also of note that Iraqi people of this age group selected cancer as the illness they are most concerned about. This suggests the need to conduct further research into whether perception correlates with fact in this area, and, if so, what does this mean in terms of developing services in the future.

**(Table 11) Heart Disease**

| Age | Male(No) | Female(No) | Male(%) | Female(%) |
|---|---|---|---|---|
| 18-25 | 8 | 12 | 7% | 15% |
| 25-40 | 41 | 20 | 33% | 25% |
| 40-50 | 45 | 27 | 37% | 34% |
| 50-60 | 17 | 13 | 14% | 16% |
| Others | 12 | 7 | 10% | 9% |
| Total | 123 | 79 | 100% | 100% |

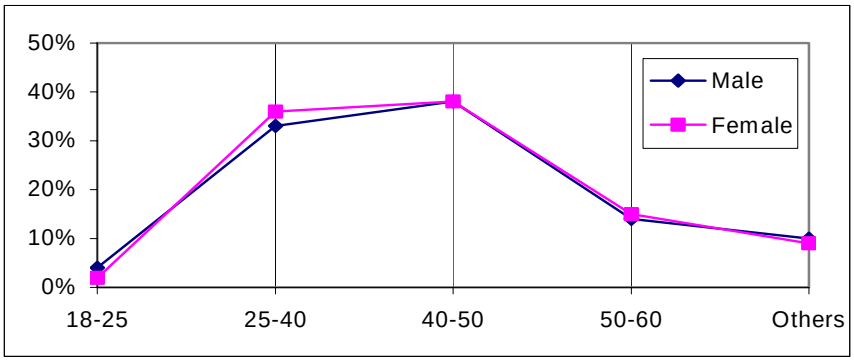
**(Figure 13) Heart Disease**



**(Table 12) Stomach Ulcer**

| Age | Male(No) | Female(No) | Male(%) | Female(%) |
|---|---|---|---|---|
| 18-25 | 4 | 1 | 4% | 2% |
| 25-40 | 30 | 19 | 33% | 36% |
| 40-50 | 34 | 20 | 38% | 38% |
| 50-60 | 13 | 8 | 14% | 15% |
| Others | 9 | 5 | 10% | 9% |
| **Total** | **90** | **53** | **100%** | **100%** |

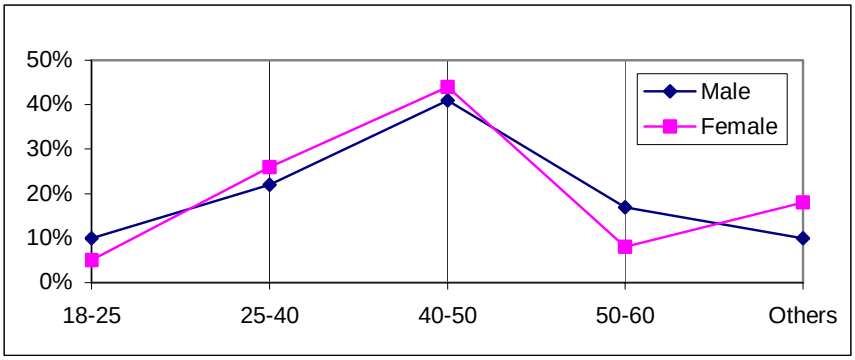
**(Figure 14) Stomach Ulcer**



**(Table 13) Cancer**

| Age | Male(No) | Female(No) | Male(%) | Female(%) |
|---|---|---|---|---|
| 18-25 | 6 | 2 | 10% | 5% |
| 25-40 | 13 | 10 | 22% | 26% |
| 40-50 | 24 | 17 | 41% | 44% |
| 50-60 | 10 | 3 | 17% | 8% |
| Others | 6 | 7 | 10% | 18% |
| **Total** | **59** | **39** | **100%** | **100%** |

**(Figure 15) Cancer**



## *2.11 Demand for Health Promotion Materials/Information in Arabic*

Both men and women identified Healthy Diet and Depression as the subjects about which they most require Health Promotion information in Arabic. The full list is as follows:

1. Healthy Diet
2. Depression
3. Sport and Health
4. Heart Disease
5. High Blood Pressure
6. First Aid
7. Smoking
8. Stress

(See Table 14)

The high demand for information about Healthy Diet is surprising, given that it is not a traditional topic of interest amongst Iraqi society; perhaps it reflects the increasing awareness of Iraqis living in Western society about the importance of diet to health and longevity. The second highest subject was Depression, scoring highly across all categories, indicating a possible correlation between isolation and depression in this society.

Women expressed a slightly higher interest than men in all the subjects listed.

The overall health index was constructed empirically, focussing on the Health Promotion issues most frequently enquired about by the community.

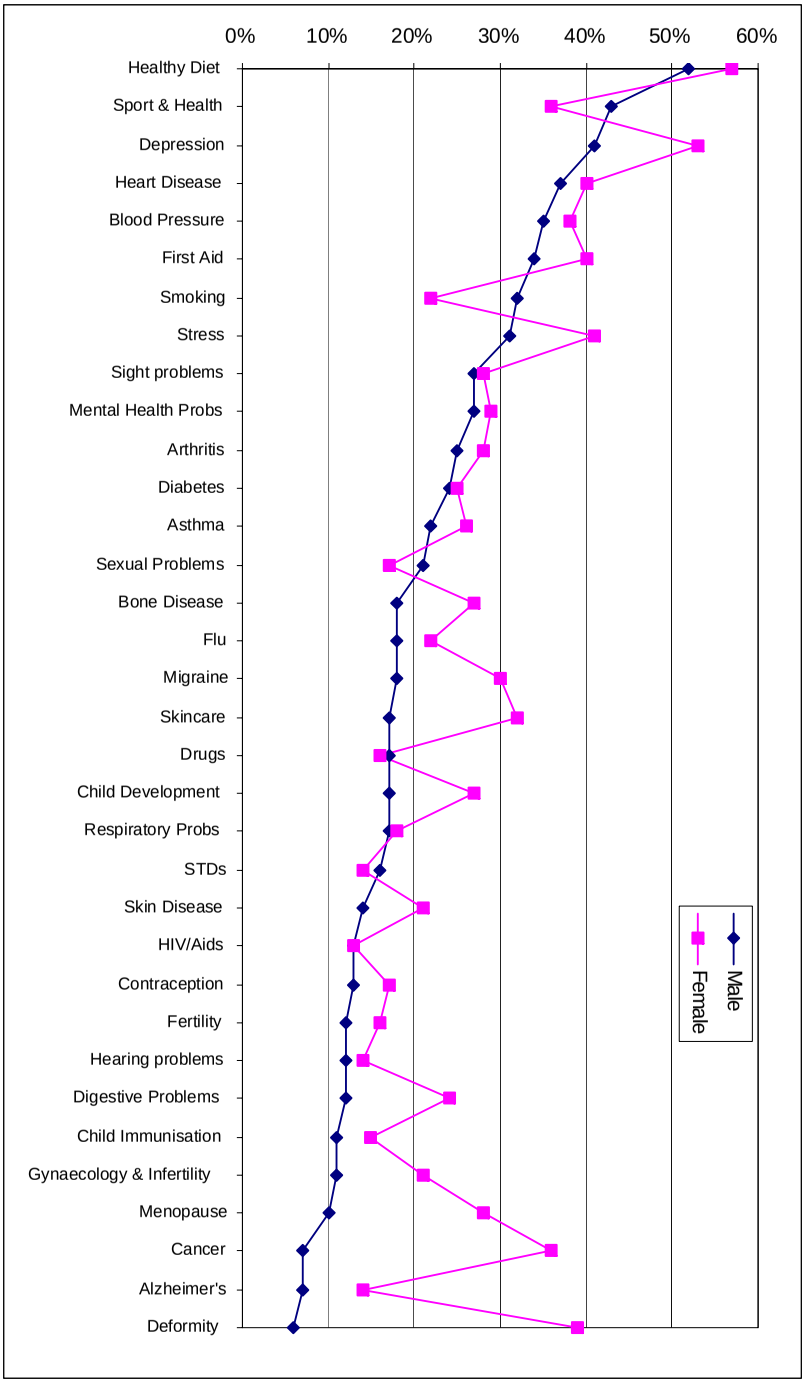
If we look at the highest scoring subjects, we can identify some links between them, except for number (6) (First Aid). They reflect areas of general concern and interest to wider society; however, given that our communities are disproportionately likely to be living in circumstances of low income/social isolation/poor housing/cultural and language barriers, they require particular attention from health and other professionals.

It is also notable that women expressed a strong wish to have more information available about Cancer, particularly Breast and Cervical Cancer, and the possible links between HRT and Cancer. The Health Resource Centre in its day-to-day work also receives frequent enquiries from women who say they have very limited information about these subjects, and would like information to be more readily available in Arabic.

## (Table 14) Demand for Health Promotion Materials/Information in Arabic by Gender

| Male | | | Female | | |
|---|---|---|---|---|---|
| | No | % | | No | % |
| Healthy Diet | 139 | 52% | Healthy Diet | 87 | 57% |
| Sport & Health | 114 | 43% | Depression | 80 | 53% |
| Depression | 111 | 41% | Stress | 63 | 41% |
| Heart Disease | 98 | 37% | Heart Disease | 61 | 40% |
| Blood Pressure | 93 | 35% | First Aid | 61 | 40% |
| First Aid | 92 | 34% | Deformity | 59 | 39% |
| Smoking | 86 | 32% | Blood Pressure | 57 | 38% |
| Stress | 84 | 31% | Cancer | 55 | 36% |
| Sight problems | 72 | 27% | Sport & Health | 55 | 36% |
| Mental Health Probs | 72 | 27% | Skincare | 48 | 32% |
| Arthritis | 67 | 25% | Migraine | 45 | 30% |
| Diabetes | 63 | 24% | Mental Health Probs | 44 | 29% |
| Asthma | 59 | 22% | Sight problems | 42 | 28% |
| Sexual Problems | 56 | 21% | Arthritis | 42 | 28% |
| Bone Disease | 47 | 18% | Menopause | 42 | 28% |
| Flu | 47 | 18% | Bone Disease | 41 | 27% |
| Migraine | 47 | 18% | Child Development | 41 | 27% |
| Skincare | 46 | 17% | Asthma | 40 | 26% |
| Drugs | 46 | 17% | Diabetes | 38 | 25% |
| Child Development | 46 | 17% | Digestive Problems | 37 | 24% |
| Respiratory Probs | 45 | 17% | Flu | 34 | 22% |
| STDs | 42 | 16% | Smoking | 33 | 22% |
| Skin Disease | 37 | 14% | Skin Disease | 32 | 21% |
| HIV/Aids | 35 | 13% | Gynaecology & Infertility | 32 | 21% |
| Contraception | 34 | 13% | Respiratory Probs | 28 | 18% |
| Fertility | 33 | 12% | Sexual Problems | 26 | 17% |
| Hearing problems | 32 | 12% | Contraception | 26 | 17% |
| Digestive Problems | 31 | 12% | Drugs | 25 | 16% |
| Child Immunisation | 30 | 11% | Fertility | 24 | 16% |
| Gynaecology & Infertility | 30 | 11% | Child Immunisation | 23 | 15% |
| Menopause | 28 | 10% | Alzheimer's | 22 | 14% |
| Cancer | 19 | 7% | Hearing problems | 21 | 14% |
| Alzheimer's | 19 | 7% | STDs | 21 | 14% |
| Deformity | 16 | 6% | HIV/Aids | 20 | 13% |

**(Figure 16) Chart for Health Promotion Materials/Information in Arabic by Gender**



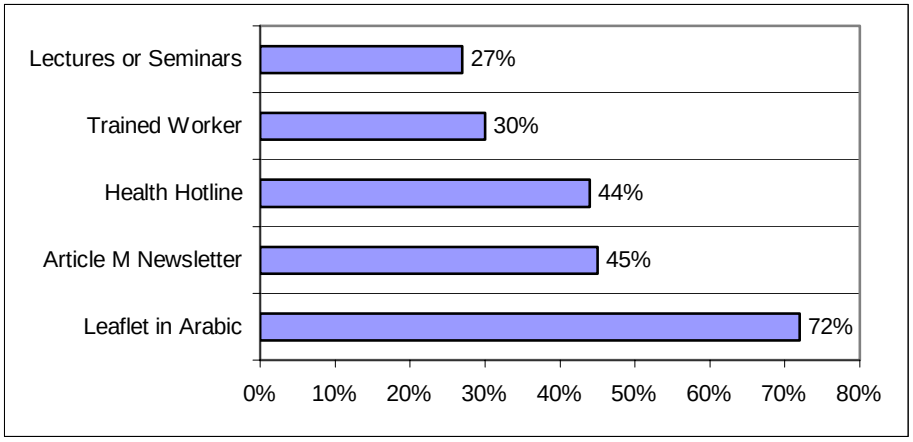
### *2.12 Preferred method for receiving Health Promotion Information*

An overall figure of 72% of respondents selected "Leaflets in Arabic" as their preferred method of receiving Health Promotion or other health-related information. 45% expressed the need for material to be available in the form of articles in our community newspaper "Al-Muntada", with 44% expressing the need for a Health Hotline. 30% of respondents felt there was a need for a Trained Worker in this field. This figure is also unlikely to be fully representative of the community as a whole. Those with literacy problems who are unable to access the other options and would therefore have the greatest need for a Trained Worker are also the least likely to have participated in this survey.

**(Table 15) Preferred Method for Receiving Health Promotion Information**

| | No | % |
|---|---|---|
| Leaflet in Arabic | 303 | 72% |
| Article in Newsletter | 187 | 45% |
| Health Hotline | 183 | 44% |
| Trained Health Worker | 128 | 30% |
| Lectures or Seminars | 113 | 27% |

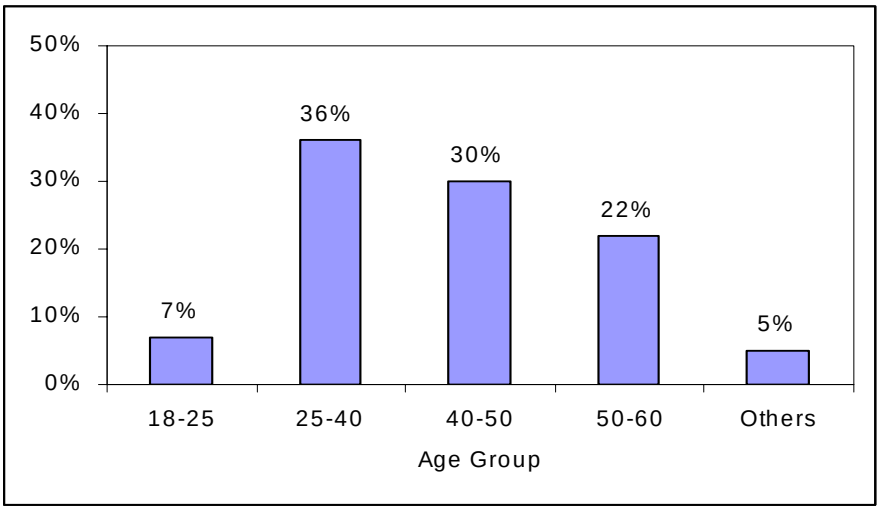
**(Figure 17) Preferred Method for Receiving Health Promotion Information**



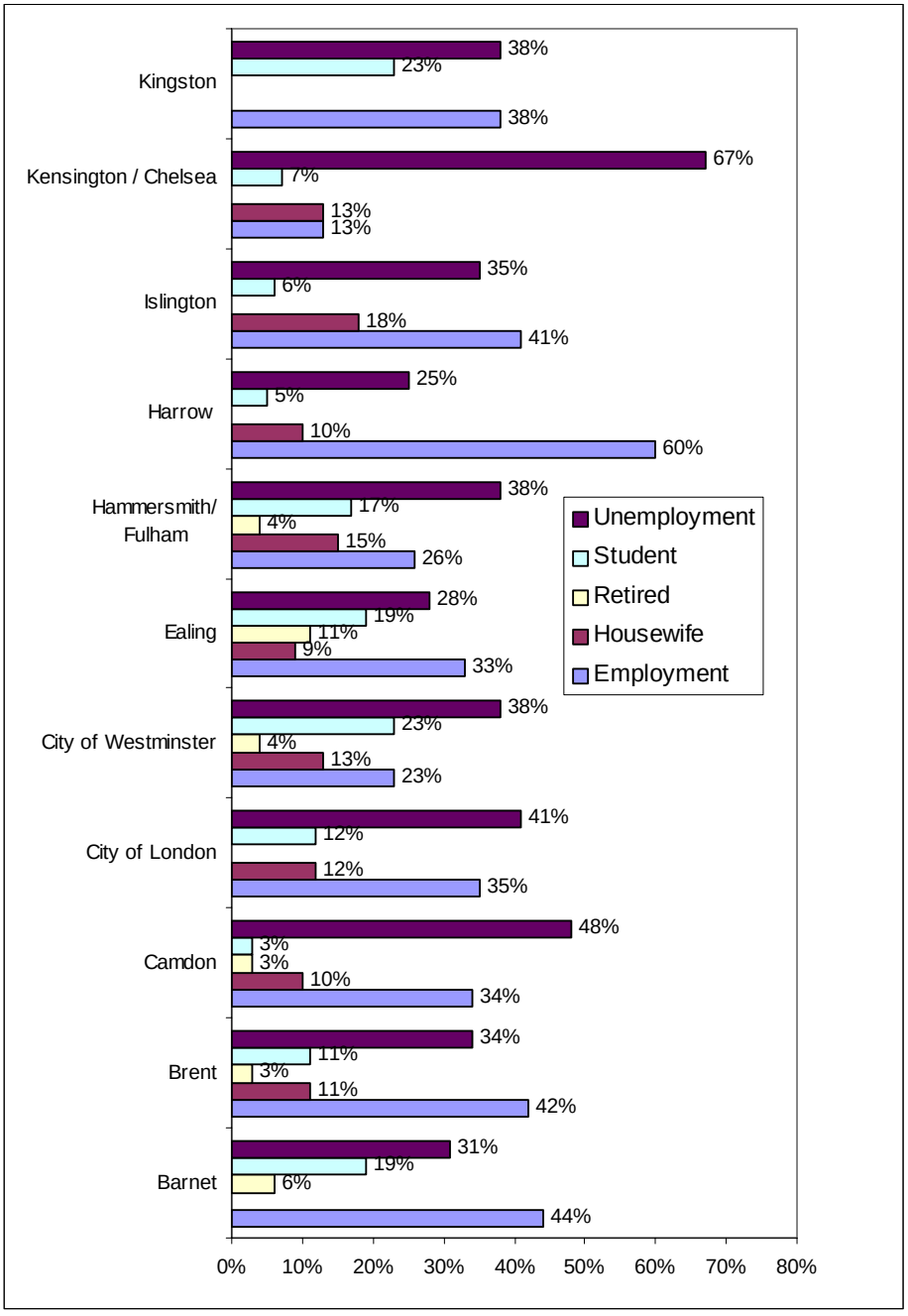
### *2.13 Employment Status within the Sample By Borough*

Figure 19 indicates that the highest proportion of unemployed respondents are living in Kensington and Chelsea Borough, with 67% of Kensington and Chelsea residents unemployed; the lowest figures were for Harrow, with 25% of Harrow residents unemployed. However, the overall figures for unemployment were high across all the London Boroughs surveyed. Figure 18 shows the high proportion of young people affected by unemployment, with 36% of 25-40 year olds unemployed; for 40-50 year olds, unemployment rates were still high, at 30%.

**(Figure 18) Employment Status within the Sample by Age**



**(Figure 19) Employment Status within the Sample by Borough**



**(Table 16) Employment Status within the Sample by Borough**

| | Employed | Housewife | Retired | Student | Unemployed |
|---|---|---|---|---|---|
| **Barnet** | 44% | 0% | 6% | 19% | 31% |
| **Brent** | 42% | 11% | 3% | 11% | 34% |
| **Camden** | 34% | 10% | 3% | 3% | 48% |
| **City of London** | 35% | 12% | 0% | 12% | 41% |
| **City of Westminster** | 23% | 13% | 4% | 23% | 38% |
| **Ealing** | 33% | 9% | 11% | 19% | 28% |
| **Hammersmith / Fulham** | 26% | 15% | 4% | 17% | 38% |
| **Harrow** | 60% | 10% | 0% | 5% | 25% |
| **Islington** | 41% | 18% | 0% | 6% | 35% |
| **Kensington/ Chelsea** | 13% | 13% | 0% | 7% | 67% |
| **Kingston** | 38% | 0% | 0% | 23% | 38% |

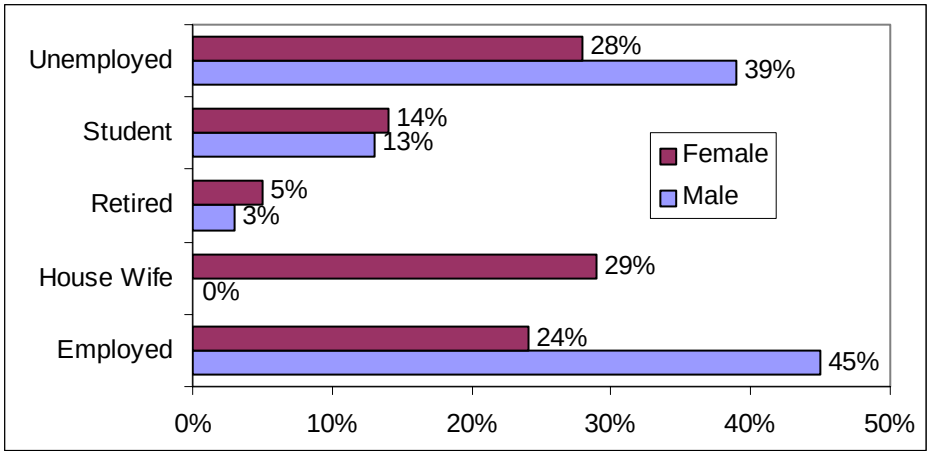
## *2.14 Summary of Employment Status of Adults by Gender, excluding under -18s.*

A total of 158 adult respondents said they were working - 38% of the survey population. Once analysed according to gender, substantial differences emerged. Women were much less likely to be employed (24%).
39% of the male population were unemployed, and 45% were employed. Results therefore indicate that men have more opportunities for seeking and finding work, with women having far fewer opportunities for employment. Behind this lie two main factors: firstly, women are likely to have a lower standard of education than men; secondly, women's much greater role in childbearing and childcare within the community makes job seeking/returning to work much more problematic.

**(Table 17) Summary of Employment Status of Adults By Gender, Excluding Under -18s.**

| Gender | Employed | House Wife | Retired | Student | Unemployed |
|---|---|---|---|---|---|
| | | | | | |
| Male | 45% | 0% | 3% | 13% | 39% |
| Female | 24% | 29% | 5% | 14% | 28% |

**(Figure 20) Summary of Employment Status of Adults by Gender, excluding under -18s.**



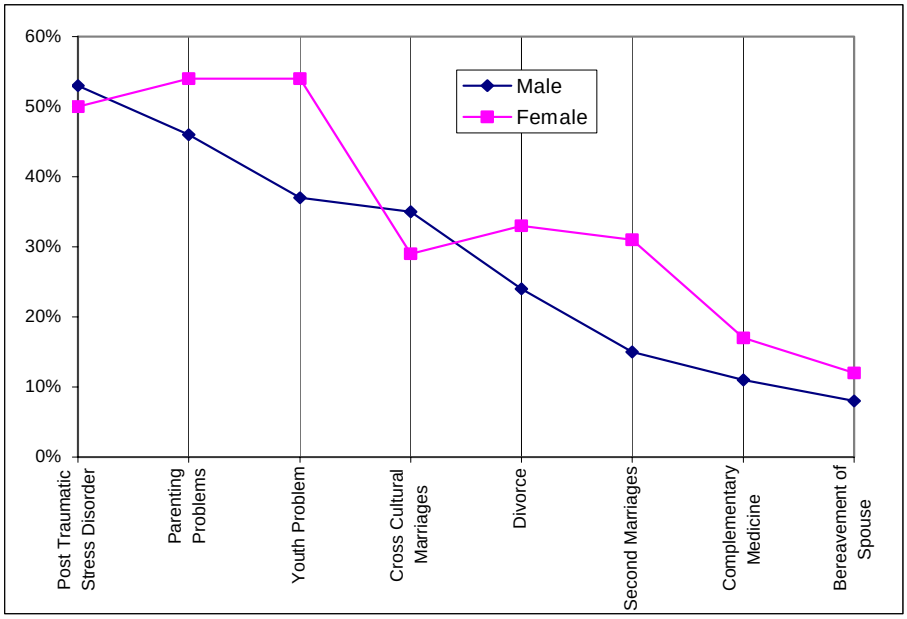
## *2.15 Social Issues of Concern to the Community*

The issue of greatest concern and interest to the community, according to the findings of the survey, was Post Traumatic Stress Disorder. Most respondents expressed a need to have further information and support on this issue. Currently the Health Resource Centre refers appropriate cases on to the Medical Foundation for the Care of Victims of Torture, or otherwise deals with them by providing informal counselling and support. However the HRC is in great need of additional resources to develop services in this and many other areas. Day-to-day experience, combined with feedback from the survey, also highlights the need to develop services to support self-help community groups working with young people, single parents, women, the elderly, and others.

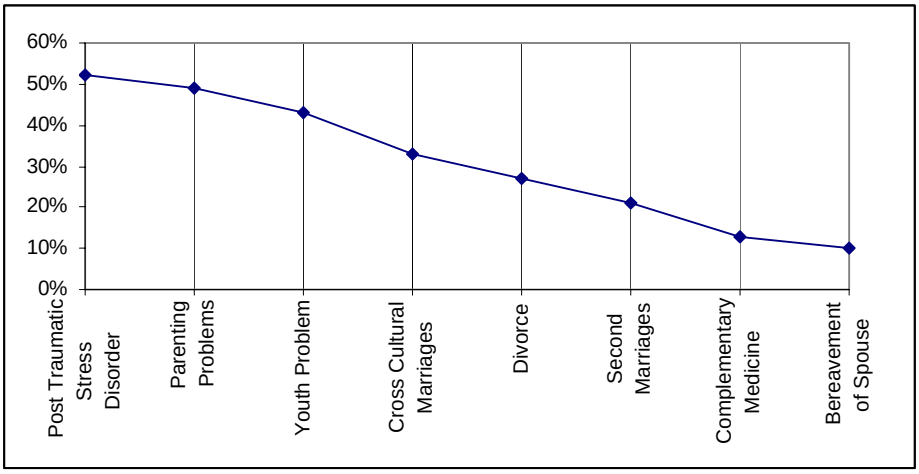
**(Table 18) Social Issues of Concern to the Community**

| | Male | | Female | | Total | |
|---|---|---|---|---|---|---|
| | (No) | % | (No) | % | (No) | % |
| Post Traumatic Stress Disorder | 142 | 53% | 76 | 50% | **218** | **52%** |
| Parenting Problems | 124 | 46% | 82 | 54% | **206** | **49%** |
| Youth Problems | 99 | 37% | 82 | 54% | **181** | **43%** |
| Inter-Cultural Marriage | 94 | 35% | 44 | 29% | **138** | **33%** |
| Divorce | 64 | 24% | 50 | 33% | **114** | **27%** |
| Second Marriage | 40 | 15% | 47 | 31% | **87** | **21%** |
| Complementary Medicine | 30 | 11% | 26 | 17% | **56** | **13%** |
| Bereavement of Spouse | 22 | 8% | 18 | 12% | **40** | **10%** |

**(Figure 21) Social Issues of Concern to the Community by Gender**




**(Figure 22) Social Issues of Concern to the Community**



# CHAPTER THREE

**3.1 Conclusion**

**3.2 Recommendations**

**3.3 List of abbreviations**

**3.4 References**

## *3.1 Conclusion*

The findings of this survey provide us with useful information about the health needs and problems of the Iraqi community in London. Of particular significance is the lack of availability of information in community languages, and the lack of interpreting and advocacy services; these factors are currently leading to unsatisfactory standards of access, diagnosis, and treatment. The need for Arabic language health promotion and information leaflets, for health information hotlines, and for Arabic speaking health workers were all needs described by many of the survey respondents.

Although the survey found a high percentage of respondents to be registered with a GP, other findings suggest that women, particularly of the older age group, are increasingly worried about their health yet feel unable to talk about their health problems. At the same time the findings suggest a relatively low uptake of screening programmes such as Cervical and Breast Screening. Although the survey did not ask directly about screening programme invitation and recall, a number of the survey respondents highlighted this problem.

The findings of this research also point to unemployment, poor housing, social isolation, and language problems as factors contributing to the physical and mental ill-health of the sample group. All these factors need to be taken into account by service providers involved in the planning and delivery of healthcare services.

The research also highlighted the need to develop care for the elderly, both in the form of Residential Homes and Day Care Services.

Above all, what is clear is that the purchasers and providers of healthcare services need to enter into a consultation process with appropriate community groups and individuals. The differing needs of various communities can then be incorporated into the planning and delivery of health services; any changes to current healthcare provision requires joint action: from individuals, organisations, communities and government.

### *3.2 Recommendations*

Recommendations arising from the survey findings can be summarised under the following categories:

**a) Development of Health and Social Services**

1. To establish a centre to provide comprehensive and ongoing research into the health and social needs of the Iraqi and Arabic speaking communities, highlighting the underlying factors contributing to their ill health e.g. high levels of unemployment, poor housing; and to make recommendations and develop services to tackle these problems directly.

2. Development of Counselling Services within the Health Resource Centre. Large numbers of our communities suffer from unresolved Trauma Related Psychological Problems, consequent to their experiences of flight, loss, torture and persecution. There is a great need for counsellors from the same communities who share an in-depth knowledge, understanding and awareness of the trauma that their clients have experienced.

3. To establish a Residential Home and Day Care service for Iraqi Elders. The findings of the survey highlight the new and increasing problem of isolated and vulnerable elders in the community, and the need to develop Day Care and Residential services accordingly. The concept of support for the elderly coming from outside the family unit is a new and difficult one for our communities to accept, however the reality of the present day situation of the elderly members of the community means that we have no choice but to address this problem. Given this background, it is more important than ever that the services that are developed are appropriate to the cultural, religious, social and practical needs of the community.

4. Development of Family Therapy Services within the Health Resource Centre. Feedback from the survey and from the day-to-day work of the Health Resource Centre highlights the increasing problem of family breakdown and communication breakdown within families. Inter-generational conflict, stress and trauma arising from refugees' experiences of flight and persecution, pressures created by inter-cultural marriages, young people's isolation and inability to integrate into their new environment, all these are issues adding to the pressure on families and causing them to break down.

5. Provision of a centre-based meeting-place and platform for social events. A large number of respondents reported our community association to be a place where they felt safe and confident, and isolated members of the community, particularly women, found it a place where they would like to meet others. However the lack of space at the community association currently prohibits the provision of these kind of social and drop-in services.

6. To develop services to support self-help community groups working with young people, single parents, and women's groups, as well as to provide technical aid and support to professionals within the community.

7. To secure funding to appoint a fully trained Community Health Worker, offering comprehensive health advice and information to the community.

**b) Development of Access and Advocacy Services**

1. To develop an Arabic-language information pack with details of all health and social care services/resources available throughout London.

2. To develop an Interpreting, Translation and Advocacy Unit which could provide Arabic language translation and interpreting services to all health and social care sectors throughout London with minimum notice.

3. To translate Health Promotion and other leaflets currently on display in GP surgeries into Arabic.

4. To establish a comprehensive database of all Arabic-speaking doctors and health workers throughout London.

5. To work in partnership with statutory and voluntary organisations to provide the Iraqi and Arabic-speaking communities with improved information and access to healthcare services.

6. To work with GPs and health and social care workers providing services to Iraqi and Arabic-speaking communities, with the aim of increasing their awareness about the cultural, social and ideological background of the community in general and of refugees in particular. Such networks would also facilitate health workers' awareness and use of our interpreting and advocacy services.

7. To develop a long-term strategy to improve access to services in general, particularly in the fields of social and primary health care services and housing. Equally, to ensure that the services available are appropriate to the needs of a multicultural community e.g. by the more widespread provision of female doctors.

**c) Training**

1. To train our community health professionals to work within the National Health Service, for example in GP Surgeries that have a high concentration of Iraqis and Arabic speaking communities.

2. To make training/employment facilities and ESOL courses widely available, especially for women with childcare responsibilities. There is the need for work training programmes and professional accreditation for those qualified in their home country, so that their skills can be updated, recognised and used.

3. To run in-house volunteer training courses on Health Advocacy issues, so that volunteers can be used as an additional resource to staff the Interpreting, Translation and Advocacy Unit.

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### *3.3 List of Abbreviations*

**ICA** - Iraqi Community Association
**HRC** - Health Resource Centre
**PTSD** - Post Traumatic Stress Disorder
**STD** - Sexually Transmitted Diseases
**HRT** - Hormone Replacement Therapy
**TRPP** - Trauma Related Psychological Problems

## 3.4 References


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