

Executive Summary

The principal objective of this research was to identify and illustrate the health needs of Somali women and offer recommendations for service providers to implement change.

The project has been conducted by BRC (Bradford Resource Centre) on behalf of ELHFA (East Leeds Health For All) with funding from Leeds City Council Joint Planning Unit, Special Grant Programme.

The literature review section provides a context for the research detailing background data on Somali culture and clarifying the main themes and issues emerging from the research.

The report is structured in two parts. Part I incorporates a discussion of the Somali community groups and other agencies providing services to the Somali community. Part II details the research methodology, findings and conclusions and recommendations.

The methodology for the empirical research consisted of focus group discussions and qualitative interviews, carried out with Somali women living in Leeds. Furthermore, key service providers working with asylum seeker and refugee communities were consulted, along with Somali community organisations, to establish gaps in service provision and inform recommendations.

The report offers an insight into Somali community organisations, emphasising the benefits of community led provision and practical ways in which to sustain and develop these groups. The Somali community groups operating in Leeds are an invaluable source of advice and support for the community. However, their nature of functioning in isolation from mainstream agencies and often from one another prevents them from securing substantial long term funding. Part I of the research describes this in detail and suggests a framework for organisational development.

The majority of women who participated in this research were suffering from extreme trauma and isolation inflicted by their experiences in Somalia, separation from family, the strain of seeking asylum and settling into an alien society. This coupled with poor living conditions, the pressures of parenting and hostility from the indigenous population, has inevitably had an adverse affect on the women's physical and emotional well-being, with almost all the respondents citing the experience of stress. The main barriers preventing the women from accessing the appropriate health services needed were difficulties in communication, lack of knowledge about the institutions and practices existing in the UK and a lack of understanding amongst service providers of the specific health needs of the Somali community.

The main recommendations of this report are as follows:

- Improved cultural sensitivity and awareness of medical practitioners and service providers regarding the needs of asylum seekers and refugees.
- Ready access to language support within service provision.

- Wider availability of female doctors and interpreters, offered more pro-actively to Somali women.
- Improved support services to women who have experienced trauma.
- Greater awareness of stress-related symptoms amongst medical practitioners and a willingness to carry out thorough investigations, action prompt referrals and signpost Somali women to other relevant support services.
- Cultural sensitivity and greater awareness amongst medical practitioners regarding issues such as FGM.
- Wider provision of appropriate childcare to relieve pressure and prevent isolation amongst Somali women.
- Prompt and effective support for families experiencing racial harassment, and quick relocation when at risk. There is also a need for advocacy and increased awareness in relation to reporting hate crime.
- Signposting to the British Red Cross tracing and messaging service, detailed in appendix 4 for Somali women wanting to contact family in Somalia.
- Ongoing / improved support to Somali community organisations regarding development and funding.
- Increased awareness amongst agencies of each other's services to aid signposting.

Introduction

Impetus for research

This research project was commissioned by East Leeds Health for All (ELHFA), a voluntary sector organisation sited in Lincoln Green, Leeds, which aims to reduce the inequalities experienced by people from disadvantaged groups in inner East Leeds. ELHFA has worked with Somali women for three years, predominantly by hosting a weekly social and activity session. As the group, 'Wadajirke Dumarka', or 'women together' in Somali, progressed ELHFA invariably found that they had to deal with more complex health issues around specific psychological and physical needs. The organisation felt it necessary to explore these in more depth in order to make recommendations to healthcare providers for change.

Research aims

The aims of this research were:

To survey Somali women in Leeds to ascertain the most pressing health needs of themselves, their children and families, using a holistic model of health and to make recommendations for the development of work around Somali women's health.

Who was involved

The research project has been carried out by BRC (Bradford Resource Centre & Community Statistics Project), a voluntary sector organisation which supports community and campaign groups, and which specialises in community-based research. Partner organisations joined the steering group, and these include ELHFA, Refugee Council, Health Access Team, East Leeds PCT and Black Health Initiative.

Funding for the research was provided by Leeds City Council Joint Planning Unit, Special Grant Programme.

Project summary

The research was conducted during 2005. There were several strands to the project, details of which follow in this report. Firstly, we conducted a literature review, to identify what had been found elsewhere in the country, to familiarise us with Somali culture and experience in the UK, and to clarify some of the themes of the report. We carried out a number of interviews with agencies and community organisations, that are already supporting the Somali community in Leeds. The main thrust of the project was a series of focus groups and individual interviews with Somali women who are resident in Leeds.

This report is available electronically via www.brc-net.org.uk. A printed summary report can be requested from ELHFA on 0113 2484880.

Literature review

The following section comprises a review of existing research and other background literature concerning the subject area. The aim is to illustrate what is already known, the gaps in knowledge, and how this study contributes to the existing data.

Whilst we have been able to access some existing research about the Somali community in the UK and Somali culture, there is little material available in relation to the health issues and needs of the Somali community, in particular Somali women.

“Despite the importance of the issue, there are as yet comparatively few recent studies that focus exclusively on the topic of health.”

(Harris, 2004:p.53)

This study proves useful in that much of the research concerning the Somali community has been carried out in the South where there is a larger and more established population. Less consultation has been conducted in the North and consequently service providers are unaware of the issues and appropriate provision required, highlighting a demand for this type of research. It is also hoped that this research will draw the attention of and be beneficial to potential funder's, recognising the health inequalities amongst Somalis and the benefits of community led provision.

Many of the health problems for asylum seekers and refugees, identified in other research, will be synonymous to the findings of our research. However, our research also highlights areas of concern unique to Somali women because of their gender, experiences, culture, and religious beliefs.

(Harris 2004, Cole and Robinson 2003)

Patterns of migration

A recent study by the Institute of Public Policy Research identifies diversification of Britain's migrant population over the last fifteen years. The report, which analyses the Census and Labour Force Survey, highlights over 50 new countries and regions, which make up the new migrant communities in Britain.

The research findings show that Britain's migrant population has risen by 1,147,905 people between 1991 and 2001. In 1991 immigrant communities formed 5.7% of the countries total population, this increased to 7.5% by 2001.

The study also recognises a substantial growth in migration from 'non-traditional' countries, such as those of South Africa. The number of people migrating from South Africa and settling in Britain is said to have doubled.

(Kyambi, 2005)

Settling in the UK

The rapidly growing Somali community is largely concentrated in London with smaller communities emerging in Manchester, Sheffield, Leicester, Liverpool and Leeds.

“Historically, port workers from the then British colony of Somaliland first settled a century ago in Cardiff, Bristol, and Liverpool: Cardiff itself has the most people of Somali-lineage in Britain.”

(Kyambi, 2005: <http://www.ippr.org.uk/pressreleases/?id=1688>)

The 2001 Census counted 43,515 Somali people living in Britain. There is no comparable figure for 1991, but experts believe this to demonstrate a rapid growth. 1,479 of these people were found to be living in Yorkshire and Humberside. The majority of Somali people in Yorkshire and Humberside are known to be concentrated in Sheffield and Leeds.

“According to the Refugee Council statistics in 2001 there were 6500 applications from people with Somalia as their country of origin. “

(Cole and Robinson, 2003:p.ii)

Statistics from Leeds Refugee and Asylum Service show that there were 177 Somali asylum seekers resident in Leeds at the end of July 2005. The age and gender breakdown of this group is detailed below.

| Age | Female | Male | Total |
|--------------------|---------------|-------------|--------------|
| Under 1 | 0 | 0 | 0 |
| 1 -5 | 11 | 24 | 35 |
| 6 -10 | 18 | 9 | 29 |
| 11-17 | 18 | 12 | 30 |
| 18-24 | 13 | 13 | 26 |
| 25-34 | 18 | 15 | 33 |
| 35-44 | 12 | 5 | 17 |
| 45-54 | 2 | 1 | 3 |
| 55-64 | 0 | 1 | 1 |
| Age Unknown | 2 | 3 | 5 |
| Total | 94 | 83 | 177 |

Source: Leeds Refugee and Asylum Service

The rise in Somali migration to the UK is predominantly forced due to the civil unrest in Somalia, which began in May 1988.

Although there is no statistical evidence to support this, it is also believed that many Somali's who initially migrated to other European countries are also relocating to the UK.

“Immigrants who arrive by air gravitate towards existing communities of their own ethnicity.”

(Summerfield: 1993 p.82)

Over the last 20 years, UK's Somali population has both grown and diversified. The community was in the past one of seaman and family. This has since developed into a refugee community with a disproportionate number of women and children.

(Kyambi 2005, Cole and Robinson 2003, Harris 2004, Summerfield 1993, Leeds Refugee and Asylum service)

Eligibility for asylum support

For support purposes, an asylum seeker is defined as someone over 18, who has made an a asylum claim or a claim under Article 3 of the European Convention on Human Rights, in person, at a designated place, which has been recorded by the Home Office and not yet disposed of (Immigration and Asylum Act 1999 Part VI, "IAA")

Under S95 IAA, an asylum-seeker aged 18 or over can be provided with asylum support to cover both her own and her dependant's housing and living expenses. An application for either or both has to be made to the National Asylum Support Service, who will assess the needs of the applicant and then disperse them for housing and provide support at the rate of 70% of the income support applicable amount. Dispersal occurs without the asylum-seeker taking any part in the decision as to where they are sent. There is some guidance about assessing and responding to health care needs.

If the asylum-seeker is given refugee status, they will then be given limited leave to remain for four years. NASS subsistence and housing is withdrawn at short notice. The refugee is then allowed to apply for benefits and make a homeless application without restriction as to immigration status or habitual residence, but subject to all the other conditions.

A family refused asylum continues to receive support until they leave the UK (unless affected by S9 of the Asylum and Immigration (Treatment of Claimants etc) Act 2004.

Support for an asylum-seeker without dependent children ceases when the asylum claim (and any subsequent appeal) has been disposed of. If she is unable for any reason to return to her country of origin, this lack of support can leave her destitute. These failed asylum-seekers can claim S 4 IAA support, administered by a special NASS team. In order to claim S4 support strict criteria need to be met. (Legal Action Journal, January 2006)

Somali Culture, Religion, and Identity

Somalis are not just one homogenous group of people, there is both difference and conflict within the community. Important variables, which distinguish one Somali from another, include area of origin and clan affiliation, "*a form of social classification, ... in which kinship forms the basis of social, political and economic life.*" (Harris, 2004:p.67) (A map of Somalia and a diagram illustrating clan structure can be found at the end of the literature review section. This has been taken from Dirie, 2004)

Nonetheless, the community does appear to be unified in their commitment towards family, community, Muslim identity, and privacy.

'The Somali Muslim culture is not a confessional one; self-containment is valued and personal enquiry is seen as intrusive.' (Harris, 2004: p.15)

As with most migrant communities, there is a struggle in preserving the values, beliefs, and traditions relating to their culture and religion. This can be difficult as the community is torn between integrating and maintaining its identity. It is often the

elders who seek to safeguard their culture and religion whilst the children strive to adapt and fit into wider society.

Teenage rebellion is a common problem for Somali parents. Children and youth in the UK generally have much more freedom than those in Somalia and young Somalis are often left questioning,

“... their culture and the authority of the parents.”

(Farah and Smith, 1997:97 cited in Harris 2004)

Harris explains the rebellion in Somali youth as partly due to them not having role models, the community is not very well established in many areas of the UK and mainstream society is largely unmarked in terms of success stories for the community. The Somali Community is still very much ‘socially invisible’.

“But ‘culture’ is as ‘culture’ does. Culture is a fabric of actual lived experience, not a static heritage that can be meaningfully reproduced in any context.” (Harris, 2004: p.)

The role of women within the Community

“It is interesting that despite the stereotype of the subservient Muslim female, much of the material we have on Somalis shaping their own lives in the UK focuses on women. “ (Harris, 2004: 62)

In Somalia, women in both rural areas and within towns contribute towards earning an income for their family as well as having domestic and caring duties at home. Yet the overall control and dominance still resides with their husband or father. Although Somali women are still very much dominated by men in the wider Somali community, there is an increased sense of freedom amongst the women in the UK.

Summerfield describes the Induction of newcomers to the UK amongst Somali women.

“Whenever a Somali woman arrived, whether or not she had any kinship ties or was known to the women in London she would automatically go to the household of a resident Somali women.” (Summerfield, 1993:p.90)

“There is an extraordinary ‘sisterhood’ amongst Somali women (in common with other African women) which appears to be extended to any women whether she is Somali or not.” This has undoubtedly been our experience during the research process.

Summerfield also looks at the way Somali women are often hijacked by Somali men when it comes to Somali community organisations.

“The organisations, which are effectively in female hands, are often nearly emasculated by the internecine quarrels of men. ...when the women are asked why they allow men to take over they say, “it is our upbringing to defer to men. We know they are not as effective as us but what can you do?”

(Summerfield, 1993:p.95-96)

(Summerfield 1993, Harris 2004)

Women's Health: FGM

A key consideration in assessing the healthcare needs of Somali women is the issue of Female Genital Mutilation (FGM).

The origins of the tradition are unknown but it has been practised for centuries in many African countries and amongst Muslim communities in Asia though to a lesser extent.

“Women are seen as the repositories of family honour, and the rationale for FGM, beyond the weight of ‘tradition’ is the preservation of a young women’s purity – her virginity and her symbolic cleanliness.”

(Harris, 2004:65)

Women who have been subjected to this type of mutilation have often been socially conditioned to accept the distress and pain as simply a factor in the transition to womanhood.

The health complications of FGM may not manifest until a number of years after the circumcision, affecting sexual intercourse and childbirth. The severities of these implications are dependent on the type of circumcision endured and sanitary conditions of the environment in which it was carried out.

The most common affects amongst the women we encountered include urinary infections, pain passing urine, complications during childbirth and menstruation problems.

Those who believe in the practice of FGM frequently defend it as being a religious requirement, quoting ‘Hadithi’, which holds chastity and modesty as important qualities in women.

The Agency for Culture and Change Management include statistics titled “estimated prevalence of female genital mutilation in Africa.

The sources for these are given to be Amnesty international, World Health Organisation and Female Genital Mutilation Papers 1996.

Somalia is estimated to have 98% prevalence (4,580 women)

The agency for culture and change management set out a clear “frame work for action “to end the culture of female circumcision. [See appendices for further information].

(Agency for Culture and Change Management- Training Material, Harris 2004)

Mental health

“Mental disturbance is often somatised – anxiety and stress expressed in aches and pains. “ (Harris, 2004:54)

One of the key findings in our research was the number of women who complained of aches and pains mainly in the shoulder and back area. They also stated that

doctors were quick to prescribe medication without proper examination or consultation.

Somali Mobility and Mental Health research, looks at what extent the Somali population are affected by common mental health conditions and the level of geographical movement amongst the community.

The most common mental health conditions were found to be post-traumatic stress disorder, depression and anxiety disorders. Geographical movement is believed to be linked with these disorders.

(Cited in Harris, 2004: p.54)

(Harris 2004)

Khat

“In Africa, chewing the stimulant khat is generally harmless, recreational activity. But now that the drug is being sold legally in Britain, it is causing problems in many immigrant communities.”

(Prasad, 04/09/02: Guardian Society)

In Somalia the leaf form drug khat is a substance popularly used as a recreational pursuit. Men from all social backgrounds unite at the end of the day and chew together. When chewed for half an hour Khat has the same affect as drinking 10 cups of coffee in one sitting.

In Britain, the use of khat is associated more with social exclusion than leisure. It is chewed more often and mainly in isolation from others. Also, the Kenyan produced leaves available in Britain are far more potent than those in Somalia imposing a greater risk to the user's health.

“The misuse of Khat, many community members argue, is symptomatic of the social isolation of Somalis in Britain.”

(Prasad, 04/09/02: Guardian Society)

Consistent use of the drug can cause many adverse effects in relation to both physical and psychological health, disabling men (generally men) from work and family life, thus exacerbating the pressure of life on women.

There is also an increase in the use of khat by teenagers and women. Again social exclusion is a reason for this, but also because, women have a new found freedom in the UK and teenagers are trying to find a way in which to relate with the older generation.

(Harris 2004)

(Prasad, 04/09/02: Guardian Society, Harris 2004)

Housing and living environment

Housing is a key factor affecting health and well-being, certainly the cause of great anxiety and stress amongst the women we interviewed.

The research entitled 'Somali Housing Experiences in England' examines the housing situation of Somali families living in five key areas of the country, where there is a concentration of Somali people. These areas were Sheffield, Bristol, Liverpool, Tower Hamlets, and Ealing.

Commonly these five regions are tarnished by high levels of crime, poverty, and unemployment, coupled with a lack of or poor quality amenities and services.

"Despite these problems, respondents typically expressed a commitment to their local neighbourhood, underpinned by the benefits associated with living alongside other Somali households." (Cole and Robinson, 2003, p.ii)

Cole and Robinson (2003) found that this was mainly due to feeling safe and supported amongst people from their own community especially with informal advice and guidance from local Somali community groups.

Harassment from other people living in the same locality, accelerated by the recent demonisation of asylum seekers, was cited as a major area of concern by Cole and Robinson and a key finding within our research.

The quality of housing was also found to be a concern,

"... refugees often find themselves in the oldest accommodation, plagued by damp and vermin." (Harris, 2004: p. 53)

The Somali population are quite often subject to the problem of overcrowding. Firstly, the majority of British housing stock is not adequate for large families, common amongst the Somali Community and quite often Somali families shoulder the responsibility of housing extended family.

'Meeting Basic Needs', a study carried out in Leeds, states that Leeds City Council received 337 homeless applications in 2003 from refugees. The scale of the problem was believed to be a result of both a shortage of social rented accommodation and the unrealistic 28 day transition period given by NASS to those granted refugee status.
(Dwyer and Brown, 2004)

A study titled "Is it safe here?" explores how refugee women feel about living in the UK. The research found that 83% of recently arrived refugees feel obliged to live by a self-given curfew ensuring that they are home by 7pm.

Many of the women have lost or been separated from their families and are living in extreme isolation, making them increasingly vulnerable.

"The women interviewed in this research describe a life of loneliness, despair, and loss. Refugee women suffer from severe stress, yet trying to communicate their needs is problematic." (Dumper, 2002:p.1)

(Cole and Robinson 2003, Harris 2004, Dwyer and brown 2004, Dumper 2002)

Communication and language barriers [understanding UK institutions]

The 'Report on Somali women's experience of maternity services' highlights the shortage of interpreting services available to Somali women, the lack of understanding regarding policies amongst Somali women especially in relation to issues such as FGM, and the lack of care and sensitivity they feel was given by maternity staff.

'Important areas of antenatal care which require communication, such as options for pain relief in labour and the management of female genital mutilation were rarely discussed.' (Bulman, 1997: p.6)

In Britain, asylum seekers and refugees in theory have equal entitlements to healthcare as the native population, but it is their lack of understanding of the institution and systems in the UK, which prevents them from accessing the same level of care and service.
(Harris 2004)

Dumper states,

"Being able to communicate in English is recognised by nearly all the women as a prerequisite for survival in this country." (Dumper, 2002:p.1)

The commitment towards improving language skills was also evident from our research. Participants perceived learning English as central in achieving their full potential in the UK especially in terms of gaining employment.

It is however, knowing where to access English Language Classes and often the provision of childcare, which prevents Somali women from taking up these services.

(Harris 2004, Bulman 1997, Dumper 2002)

Introduction to Part I

This section attempts to bring together various perspectives on provision for the Somali community in Leeds, many of which are personal views and experiences. There are different sides to the story from each agency we spoke to, and we have only a partial understanding of the history of many of these groups. We have tried to represent the different views objectively and as they were expressed, though these may be contradictory and sometimes critical. We hope readers and agencies will not take offence or judge the Somali groups, but will look to constructive ways forward which will build on the good work and benefit the whole Somali community in Leeds.

a) Somali community organisations in Leeds

We identified three Somali community organisations currently operating in Leeds (Little London, Iftiin Welfare Association, Lincoln Green women's group), and one which serves the wider African community (ESSCA). The Lincoln Green women's group is discussed separately in section b) below, as we were asked specifically to identify ways forward for the group.

We established initial contact by telephone with Little London, Iftiin and ESSCA, having been given contact details by a community development agency. We then visited each group and met with a coordinator to discuss their group and introduce the research project. In all cases we were getting background information on the group from their own perspective, as well as requesting help in identifying and contacting women who could be research participants. Supplementary phonecalls were made to discuss the compilation of this section of the report, and to request ideas for collaborating with other Somali groups.

The Somali community organisations identified in Leeds are as follows:

Leeds Somalia Community

At the time of completing this research Leeds Somalia Community, had recently ceased operation, despite securing a substantial funding grant.

Iftiin Welfare Association

Iftiin runs its own premises in Harehills and provides activities for young people including computing, Koranic instruction, study support and sports, sometimes using other local venues. The group also provides advocacy and support around housing, benefits etc.

Iftiin has been in operation for about one year, and appears to be quite well established. The coordinator said they had learned lessons from other Somali groups where questions have been asked about organisational practice, so they are very transparent with finances and strong on policies. A registered charity, Iftiin is generally self-funding and self-sufficient, and has received small grants for sports and education projects. The group appears to be well used by young people (and appreciated by the mothers we encountered), makes good use of small premises and has a good range of activities. In terms of supporting Somali women, Iftiin's main

approach at present is to look after their children and assist with their education, activities and religious instruction, thereby reducing pressure on the mothers. However the coordinator told us they would like more women to be involved in the organisation, by joining and running committees etc. This is already happening: at the AGM in December 2005 two women joined the new management committee. The coordinator said he was unclear about other Somali groups in Leeds and what they are doing.

Little London (Leeds Somali Community Association)

Leeds Somali Community Association operates from a flat in the Little London area, which has an office and meeting space/kitchen. They provide advice and practical help with housing, asylum, solicitors, benefits etc, as well as educational support and trips. The group has been running for about 3 years, with some changes in leadership.

The group has had some success in gaining funding, and is run by committed volunteers in basic premises. They are exploring use of other venues to address problems around accessibility and transport. Little London group is strong on advocacy/practical support for Somali families, despite operating with no practical resources and no money, and provides some trips and education work where funding allows. They have more than 20 female members from various areas in Leeds, but at present run no activities as such for them. The coordinator described the women as largely housebound looking after children, and advocated childcare training so they could be training/working whilst their children are looked after too, as well as the need for women-only cheap leisure facilities. The women we met were happy with provision at Little London but echoed their isolation and childcare responsibilities. The coordinator described the Somali community as tightly-knit: *"we all know each other, everything is word of mouth"*, and had a good knowledge of the other Somali groups in Leeds.

Eastern Sub-Sahara Community Association (ESSCA)

ESSCA is a general community association for African communities, mainly Somali but also Ugandan, Sudanese etc; it has an open constitution to all African communities. The group is newly established, has no premises as yet and is looking for funding; it has partly emerged from the aftermath of Leeds Somalia Community. The coordinator said that ESSCA wants to cooperate with other groups and for women members to take a stronger leadership/managerial role. Currently women meet on weekends to read Koran.

Comments made by Somali group coordinators about other Somali groups

We were told by other agencies and from background reading to expect to encounter some conflict and rivalry between some of the Somali community organisations. Groups have come and gone, and sometimes the same people will coordinate subsequent organisations after one has closed down. When questioning the group organisers about ways in which the groups might work together, it was evident that they still viewed each other with some suspicion and criticism. The concerns raised included:

- That approaches should be made through agreed channels to group leaders with clear proposals for any joint working.
- That groups should be transparent, professional and clearly benefiting the Somali community in tangible ways.
- That tribalism was a big part of life in Somalia, but should not be echoed here in the UK.
- That different Somali community organisations have different aims and priorities
- That any new Somali community organisations should only be founded by people with significant local knowledge/history of Leeds and with clear consultation processes to establish needs.
- That any group leadership or committees should be elected democratically

Conclusions and recommendations arising from the work with Somali groups

Before making recommendations about collaborative working, it should be recognised that there are reasons for a number of Somali community organisations to co-exist with minimal collaborative working. Clan divisions are deeply embedded in Somali culture an issue, which has emerged throughout the research. Women we interviewed (in the research in Part II) have expressed some preferences between the Somali organisations they have used, and indeed they should have a choice which one/s to use. For many women without access to personal transport and with several children to look after, services need to be locally based. The growth and demise of various Somali groups over time has also had some impact in keeping track of what else is going on in Leeds, and rumours about bad organisational practice has made some community groups defensive.

According to the agencies interviewed in section c) below, all three Somali organisations have received community development support, and are also active in Leeds Refugee Forum. These links seem to be very positive, and we recommend they continue.

While all the Somali groups are functioning with some effectiveness, this could be enhanced with greater promotion of their services and, more relevant to this research, with creative ways of reaching and involving women.

Little London group and ESSCA could clearly do more if they had funding.

At this early stage in the group's history and without further information, it is difficult to comment on ESSCA. It is hoped the organisation will encourage female involvement and will effectively cater for the needs of the wider African communities in Leeds.

b) Lincoln Green women's group (Wadajirke Dumarka)

Wadajirke Dumarka is a women's group, which is hosted and facilitated by East Leeds Health for All (ELHFA), meeting weekly in Lincoln Green. The group emerged after one Somali woman sought help from ELHFA with housing and advocacy. She wanted to meet with other Somali women and later brought some friends, and the group developed from there. It has accessed several small grants and receives ongoing funding from Leeds University Lifelong Learning Department for a sessional worker and crèche worker. The women agree their own programme of activities which include sewing, massage, trips and healthy eating. They have produced a

banner, photographic display and book on low cost days out with children, and will soon be publishing a book about their memories and experiences of living in Somalia. Members have adopted a constitution in English and Somali, and are keen to become self-servicing and in the long term to gain their own funding and manage a building.

The research was commissioned by ELHFA, who run the Lincoln Green women's group. We were given background information by the sessional worker and project manager, and observed the group in operation 8-10 times, whilst on an introductory visit, conducting three focus groups, meeting the women for 1:1 interviews, and giving feedback on research findings. While some of the questions within the focus groups and interviews asked about the women's experience and opinions of the group, they were not asked directly about how the group should develop. This would have been a separate piece of work.

We were asked specifically to make some comments about the future of the Lincoln Green group. This has been running for three years, with an average attendance of 10 women, and up to 70 women and children at special events. We understand that at times there have been major clan rivalries between group members, which has led to some women leaving. We have also been advised of, and witnessed to some extent, growing frustration amongst some group members, which again apparently for some has been a reason for leaving. The women are still dependent on ELHFA workers who facilitate sessions, do administration/publicity for the group and provide childcare and some funding. This is unsustainable as ELHFA's own funding is not fully secure. Some group members want to become an independent organisation and ideally to run a community building which is solely for their use. Group members, and a community development agency interviewed for Part I, told us they did not wish to collaborate with other Somali groups as they felt the men in the community would take control.

ELHFA have attempted to describe and facilitate the various stages of constituting a group, setting up a bank account and applying for funding etc, sometimes by inviting other agencies such as Resourcing the Community to assist. However this has been difficult to implement as there have been some heated discussions and not always a shared understanding or commitment amongst group members to go through the various stages.

Conclusions and recommendations arising from observations of Wadajirke Dumarka

Wadajirke Dumarka has had something of a difficult history and some personal clashes in trying to move forward as envisaged by some of its members and facilitators.

A fresh approach may be helpful. We have witnessed a number of new members join the group during the course of the research, who have not inherited historical arguments about the future of the group, and indeed may have new ideas. There may be scope to build on the momentum and interest in the research, and we would advocate an external facilitator to help the group to agree and devise a development plan. Women could be encouraged to implement certain aspects, build their confidence and enthusiasm, and set up small working parties to address the issues they have identified. Women could be asked to prepare and present their own

ideas/plans for the future and how the group could go about this. With effective community development support, stages in developing the group could be timetabled within the programme of activities.

Research with the other Somali groups, and with the women, has shown that the group's profile could be improved. Wadajirke Dumarka could be better promoted, by using a larger mailing list arising from the research, developing stronger links with Iftiin, Little London and ESSCA. Women from Lincoln Green could go out to visit other groups, set up exchange visits within a programme of activities or invite women from the wider Somali community on trips out.

One of the research findings (from Part II) is the desire to have more practical help from the group, eg advocacy, advice and access to telephones. Apparently some of this is in place (provided by Ebor Gardens Advice Centre) – but is perhaps not fully known, so needs better promotion. The group organisers should look at how housing advice, dealing with crises etc could be built in to the activity programme, as well as ways of securing practical donations for women and families living in poverty.

Within the women's research (Part II) some women have described receiving a less than warm reception towards new members. This was not witnessed by us, when new women have arrived they have been welcomed, and this may have been a historical problem. However this always needs to be borne in mind, both by existing group members and other Somali women who could try the group out now.

Lincoln Green women's group could join the Leeds Refugee Forum, to develop stronger relationships with the other Somali groups, refugee communities and agencies which can offer further community development support, and bring Somali women to the table. However there may be gender issues if this is a male-dominated group, which would need to be addressed by the forum.

c) Findings from agency interviews

Agency interviews were completed face-to-face with Resourcing the Community, Health Access Team, Leeds Asylum Seekers Support Network, Black Health Initiative, Refugee Action and by telephone with the Refugee Council in order to explore some of the current provision for the Somali community in Leeds. The topics used for the interviews, plus contact details and short service descriptions, can be found in appendices 3 and 4. Supplementary phonecalls were made to some agencies, to clarify what had been said or explore ideas for ways forward. This is not a comprehensive survey: several agencies such as Positive Action for Refugees, and Refugee Education and Training Advice Service were unable to take part, or did not work sufficiently with the Somali community to have much to say. East Leeds Health for All also provides services to the Somali community, which were discussed in section b). The website www.refugeeaccess.info provides a searchable database of service providers which work with refugees, and lists some 33 such projects in Leeds, though many serve a wider range of client groups and issues. Unless otherwise stated all the following observations came from one interviewee.

Observations about the Somali community groups

- The groups are there to help Somali people settle in the UK, access services and claim benefits. The main aim of each group seems to be setting up a community centre.
- The Leeds Refugee Forum, formed in August 2003, now has the active involvement of three Somali community groups: Iftiin, Little London and more recently ESSCA. Though conflict between the groups has been evident at some meetings, relationships appear to be becoming more settled. The Forum members have recently adopted a constitution and elections for the executive committee which will be held in February 2006. There is scope for the Somali groups to use the Forum as an umbrella body under which to jointly apply for funding for common projects which will benefit the wider Somali community.
- One Somali community group was working in schools to become more familiar with the UK education system, and was relaying this back to the Somali community.
- A lot of the Somali community appear to have refugee status and are a much more settled community.
- One worker observed that men tend to take control of groups and do all the talking. Another agency had done community development support with several Somali groups and found gender to be a sensitive issue within the Somali community, to which groups were responding to different degrees. Though the groups may have women members the worker felt they are still male-dominated; the women may be quiet and have to gain permission from their husbands to participate, or the group leaders may be reluctant to address women's issues or let women take a lead in this. The worker has spent some time encouraging the groups to address this, in particular as funders will be reluctant to fund groups who do not acknowledge women and women's issues.
- We were told that gender differences have also led to conflict between groups. One Somali organisation invited a women's group to meet in their space. The women's group refused, saying they had been dominated by men for too long in Somalia, wished to be independent and take forward their own issues, and felt sure that the men would try to take control of their group.
- One worker observed that because the Somali community is relatively small (estimated at 500 people in Leeds) funders are reluctant to fund individual groups; therefore the groups need to work together but could still maintain their own identities. Another agency also wished to see the Somali groups working together.
- However one worker described how attempts to coordinate meetings between the different Somali community groups have failed. The plan was to include input from community organisations and funders who would be able to help the different Somali groups. The worker explained this lack of success as following a history of conflict and clan rivalry in Somalia, which remains whilst living in the UK. Another worker described fragmentation among the Somali groups, as individuals identify themselves and others on clan heritage. The differences between clans were seen as greater than the similarity of being Somali.

Observations about Somali women and their needs

- Two agencies observed there are many Somali women *"suffering in the background that no-one has a clue about"*.

- One worker observed that roles have reversed for many Somali women; in their home country they would be supporting men, while in the UK they were more likely to be head of the household and more in charge. This brought both more rights and more responsibilities. As the main applicant for support it brought economic power: women often get all benefits in their name and manage their own money.
- Two agencies identified high incidences of mental health problems and trauma amongst Somali women, along with more general health/women's health issues. Another agency identified sexual health issues, isolation and problems in accessing services. One worker felt that Somali women were likely to have significant psychological/emotional needs due to their experiences of torture and rape. However these needs may be masked because of women's feelings of shame, and because Somali women come over as strong personalities who are very focused on looking after their families.
- Anxiety was common due to practical issues such as uncertainty of asylum applications, the asylum process, problems with representation from solicitors, and women coping on their own with children.
- One worker said Somali women commonly experienced flashbacks, resulting in them not wanting to go out and keeping their children off school. Social services have not been interested in the women's health, just focus on the fact that the children have been kept off school.
- Another agency identified problems with schooling. In common with other refugee communities, Somali people found it hard to access schools, there was a shortage of spaces and often no other Somali children at school. This raised problems of integration and was a cause of concern for mothers too. Somali children identified with neither white nor Asian children who make up the other main ethnic groups in schools.
- Further integration problems were raised. One worker felt that as Somali people did not identify with other ethnic groups, adults also found it more difficult to access community and social groups. The worker had been told by Somali women that they felt neither black nor Asian, but because of their skin tone could be mistaken for either, and they felt their culture and individual needs were not understood.
- One agency received lots of enquiries regarding housing. Asylum seeking women were often housed in very deprived areas, where there were existing social problems, absence from school, crime and drugs. This raised problems of isolation and discrimination, while the housing itself was often in a very poor state of repair.
- One worker talked about Somali men using khat (stimulant), spending all their money on this and sleeping all day. This meant that men were not available to work or help their family, putting more pressure on the women.
- One worker talked of increased fear of racial hatred amongst refugees following the London bombings in July 2005.
- Meetings concerning the formation of a new group Eastern Sub-Sahara Community Association had highlighted the needs of the Somali community as health problems for both genders (mainly around accessing services), concerns over racial hatred and adult education. Also a need has been identified for a women-only gym accessible to Somali women, and for raising awareness around healthy eating for the Somali community, possibly including home gardening projects.
- One agency had previously carried out research with black women in Leeds, including Somalis; this identified a need for talking therapies. The worker was

also keen that the agenda for this research should focus on what the women say they want, and that the women should be involved in the follow up.

Observations about service provision for the Somali community in Leeds

- One agency worker felt that there aren't really any services or organisations that address the specific needs of the Somali community. Another felt there was a general lack of statutory and voluntary groups working with refugees, in areas such as support, advocacy and integration. A third worker felt that there was a lack of specific services to deal with trauma issues, ie counselling, therapy, other support services.
- Language barriers were identified as an issue for service provision, as many Somali women have broken or no English. However it seems they are quickly able to access informal language/advocacy support from within the Somali community, and usually present at appointments with a friend or family member.
- GP services are supposed to be more effective/accessible due to services such as the Health Access Team; however problems still exist. Asylum seekers may be discriminated against and prevented from registering with a GP. Doctors often lack understanding about Somali culture, trauma and the background of many asylum seeking/refugee communities. Attempts to run information sessions with GPs often received poor attendance from doctors, or only from GPs who already had good awareness of issues affecting refugees. Difficulties in gaining accurate statistics of refugees and asylum seekers makes it hard to measure uptake of services. GPs often explain gaps in services for asylum seekers as a result of where they are housed; in inner city areas there tends to be a shortage of GPs and health providers are over-stretched. Women who become more isolated due to mental health difficulties are less likely to be aware of services.
- One agency felt that all organisations should look at availability of female interpreters, practitioners and staff, as well as increasing their understanding of culture, religion and family structure of asylum seeking communities.
- Two agencies said they were not seeing as many Somali women as before; numbers had reduced in the last six months or 2-3 years respectively. One worker described the Somali community as quite self-sufficient; this led to low take-up of services and made it more difficult for service providers to access and engage with such communities. Another worker observed that Somali women appear to be very strong and assertive, very good at finding out what their rights are, and very protective of their families and children. The worker felt that without an understanding of Somali culture and body language the women could be seen to be aggressive, but actually these were very positive aspects.
- A multi-agency forum exists on the subject of female genital mutilation. After it was established nothing was happening in Leeds to address the issues. FGM was described as a "hidden issue". The forum has devised guidelines and training for health workers, community workers and the child protection team, to make them more aware of FGM and to provide contacts for advice.
- One agency commonly encountered destitute asylum seekers. Another agency had developed specific new services in response to this, ie a hardship fund and emergency accommodation in volunteer's homes.
- One worker advocated clearer lines of communication between communities and providers of health services, i.e. better service promotion and feedback about community needs. Another worker described the importance of knowledge of services and agencies signposting to each other. One worker spoke of the need to make mainstream providers aware of Somali women's health needs –

particularly as the conflict within the Somali community hinders a united approach from within the community to address the problems themselves.

Conclusions and recommendations arising from the agency interviews

The difficulties in bringing Somali community groups together are real; there are particular conflicts relating to gender and clans. It is apparent that such groups are receiving good community development support. While this will hopefully assist the organisations individually, it is unlikely that groups will attract large funding grants or be able to develop their own premises if they are unwilling to collaborate with each other. However the Leeds Refugee Forum seems to be bringing the groups into dialogue and hopefully further collaboration, and offers the opportunity to submit joint funding bids. Lincoln Green women's group (Wadajirke Dumarka) should consider joining the Forum.

Both community development workers and funders should recognise that Somali community groups may have different needs to other funding applicants. They are not just an immigrant population who are familiarising themselves with life in the UK, but are also totally unused to having a government or any kind of statutory infrastructure. Additionally there are crisis issues within their own community, which require speedy and flexible interventions, together with strong cultural values that differ markedly from other populations in Britain. This may go some way to explain the apparent resistance to conform with agencies' visions of how groups can develop, and errors made in organisational practice. A fuller, culturally appropriate, explanation of group development, funding applications, monitoring and accounting may resolve some of the historical issues and enable these groups to become more sustainable and credible.

While community development support seems to be fairly well coordinated between agencies, there is some lack of awareness between other agencies within this small survey regarding what services are available to the Somali community.

The agency workers have identified a definite need for support for women regarding mental health difficulties and trauma, dealing with practical issues that cause anxiety, and breaking down their isolation.

There is an identified need for greater awareness amongst medical practitioners and other agencies to ensure that services are sensitive and responsive to the needs of asylum seekers and refugees. This includes consistent provision of appropriate language support.

The reduced 'take-up' of services amongst Somali people should be investigated through improved promotion of services and stronger liaison with Somali community organisations.

d) Methodology

Personnel

The entire project was conducted by two female researchers with no prior relationship with the women or the Somali groups, and was mainly done with both researchers present. Both researchers are from BRC (Bradford Resource Centre & Community Statistics Project), and have a working background in community development and conducting research along related principles. Previous projects include a disability and employment survey carried out by disabled researchers, assessing need for housing and support for vulnerable people and community profiles for neighbourhood action groups.

Research methods and question design

The practical research took the form of focus group discussions and interviews.

The research questions sought to gather data on general health as well as on other aspects of the women's lives that could potentially affect their physical and psychological health. A key consideration in the design of the questions was the language used. We were conscious of the language barrier and consequently aimed to construct questions, which were clear and appropriate for translation. The focus group questions were around general topics whilst the interview questions were more in depth and personal.

We conducted three focus groups, which were held at the Lincoln Green women's group, within an established weekly session and as an agreed part of the programme for activities. These were semi-structured and lasted approximately one hour; the list of questions / topics are attached in appendix 1. At the point of devising questions for the third and final focus group, most of the group participants had stated they were not interested in doing an individual interview. This is why we chose a number of interview questions to repeat in the focus group. In fact most of the group participants changed their minds and went on to do an interview as well, therefore they were asked some of the same questions twice.

The interviews were semi-structured (using the questions listed in appendix 2), and lasted between 10 and 40 minutes, depending on how much the participants had to say. Interviews were mainly conducted at the premises of the Somali groups, or less often in the women's homes, depending on their preference. As we were often reliant on an interpreter the actual question wording may have been different, reflecting the choice of words/understanding of the interpreter. 15 interviews were conducted via an interpreter, 8 without. Additionally where the interpreter or participant did not understand the question we rephrased into simpler English. In these cases it was more difficult to avoid leading questions. The design of the medical appointment question raised some confusion; participants found it hard to choose a single example rather than a general answer.

Terminology

The headings listed in the question schedules (appendices 1 and 2) and within the findings in section e) are working terms to aid structuring of the interviews and the

report. The terminology used in speaking with the women was sometimes different, for example what we describe as 'FGM' here was called 'circumcision' during the interviews, reflecting the women's own choice of words for this issue. Again, 'women's health', 'stress' and 'racism' are working headings; the interview questions began with a simple explanation and examples of what we were referring to.

In addition to the empirical research, we also carried out a review of existing research and background information relevant to the research (see literature review in Part I).

Data collection

At the first focus group we requested permission to record on tape and a significant number of the women refused. This meant that the data was recorded manually, and for consistency we adopted the same method throughout all the research. Though this may have slowed the interviews down occasionally we made efforts to record direct quotes. It is likely too that sound quality and content would have been lost due to use of an interpreter or several people talking at one time in a focus group.

During the focus group sessions, we each monitored the responses of different women and where possible we tried to conduct the interviews in pairs so that one person could concentrate on taking notes.

Translation

Many of the women that we met spoke very little or no English. The main language of the women who participated was Somali. At the beginning of the research, we had arranged interpretation via Language Link. The idea was to have a female interpreter who was neutral, not part of the women's group or immediate Somali community. Language Link put us in contact with a translator from Sheffield who was able to speak Somali, the main language of the group. This translator was present for the first focus group but was unable to attend any further sessions. We struggled to get another interpreter via Language Link and, as we often required an interpreter at short notice to coincide with when the women were available for interview, using an interpreter from Sheffield was not practical. We subsequently were reliant on a few of the women we met via the Somali organisations, who agreed to help with interpreting.

Sample

We made contact with the participants through the various Somali community groups that operate in Leeds, namely Iftiin Welfare Association, Little London, Eastern Sub-Saharan Community Association, and Lincoln Green women's group (Wadajirke Dumarka). Iftiin and Little London invited women to their premises at an agreed time to meet us. East Leeds Health for All sent letters, translated into Somali, to all the Somali women on their mailing list inviting them to participate. We encouraged the participants to tell their Somali friends, and this may have contributed to the increased attendance at focus groups. Little London also gave us names and addresses of women to visit, though this was ineffective despite several attempts to find them. The women had often moved on, showing the transient lifestyle of asylum seekers. We did locate one woman at home, who had limited English, and though she was pregnant and appeared interested, her husband wanted to discuss men's health and said she did not want to take part.

We were aiming to make contact with 50 women from the Somali community; however, as a result of time and access constraints we were unable to do this. The total number of participants was 27. A total of 15 women took part in one or more focus groups; 8 in the first one, 9 in the second and 14 in the third, with 4 women attending one focus group, 6 attending two and 5 attending all three. 23 women completed individual interviews. The breakdown in terms of participants from the Somali community groups was as follows: 18 from Lincoln Green Group; 5 from Little London; 4 from Iftiin Welfare Association. No participants came forward from Eastern Sub-Sahara Community Association.

One woman lived in LS2; 3 came from LS7; 8 from LS8; 14 from LS9; one from LS11. The weighting towards east Leeds can be partly explained by the decisions of housing providers and partly by the large proportion of women we met via the Lincoln Green women's group (Wadajirke Dumarka).

Attempts were made to attract as wide a sample of Somali women from Leeds as possible, varying in age, origin, area, and experience. We contacted all the Somali/sub-Saharan organisations we knew to be in operation, in various areas of Leeds.

The age ranges of the respondents were; 12 participants aged 18-24; 8 aged 25-34; 3 aged 35-44 and 4 aged 45-54. No women 55 and over took part. Though some of the teenage girls we met wanted to take part, we set a lower age limit of 18 years.

There may be some inaccuracies with the ages recorded in the research. Somali families do not always record date of birth, and this may only be estimated at the point of seeking asylum. One of the participants laughed and explained to us that many asylum seekers claim to be 18 at the time of their asylum application, so their "age" is 18 plus the number of years in the UK. This may reflect that the asylum seeking process demands all applicants are at least 18 years old. Another woman disputed this notion, saying that parents usually know the true year of birth of their family members.

We did not request information on disability, though one participant was profoundly deaf.

Ethics

Confidentiality

The women who participated in this research were very candid and bravely spoke of traumatic and deeply personal experiences. We have tried to present their stories accurately and with sensitivity. However, we are also very conscious of confidentiality, as the Somali community appears to be small and tightly knit. We explained confidentiality as recording the answers in full, without naming anyone in the final report. However we were reliant on an interpreter throughout the research and cannot guarantee that the confidentiality was fully understood by all the women. Some of the women confided in us things that they had apparently not shared with their husbands or families, and we feel a duty to protect those confidences. Therefore, some details have been removed where it would be very easy for the

relevant individuals to be identified within the community, and we have instead tried to focus on the underlying issues.

Psychological effects on participants

Based on our early familiarisation with the Somali way of life, the main issues we did not want to cause additional distress around were separation from family/death of children, and female genital mutilation (FGM). Therefore we designed these questions to be as non-intrusive as possible around these issues, grouping FGM with other women's health concerns, and not asking about children who did not live with their mothers here in the UK. In gaining information about the sample we did not ask directly about date of birth, feeling this would mirror the bureaucracy the women would experience regularly in the UK and in seeking asylum, instead asking women to choose which age category they fell within. Again we did not ask directly about asylum/refugee status, as this would have been intrusive and not a direct research topic. However we were able to gather from the data several indications of asylum status as well as difficult experiences of the application process.

This approach may have had some impact on the results. The subject matter for the research was very personal; we were asking the women to share details of various aspects of their private lives. The results reflect the extent to which they wanted to talk about personal issues, as well as the research design. We were conscious of ethical issues of not raising anxiety and flashbacks without adequate support for the women.

When questioning the women about FGM, this was often met with laughter and in the focus groups with intense discussion with each other in Somali. The interpreter would then give us very brief answers. Combining this behaviour of the participants with background reading and the prevalence of urinary/gynaecological infections we feel there was probably more personal experience of FGM than was disclosed.

From background reading and completing interviews with agencies, and questions designed to minimise intrusion, we also feel there was more experience of trauma, e.g. rape and murder in Somalia, than was disclosed in the interviews.

Payments

As a thank you for their involvement in the research the women were given retail vouchers of a nominal value. This did seem to act as an incentive in that the women who initially refused to take part in an interview changed their minds once they realised there would be a form of payment. The women we met were always pressured for time and living in extreme poverty so even the small payment for their time would have made some difference to their lives. Those who helped with interpreting received additional vouchers.

Interventions

On two occasions we felt obliged to take action to support the women, regarding the problems they had brought up at interview. Where one woman was living with death threats to herself and her children from neighbours, we gained her consent to speak to her housing caseworker and ensure they were trying to move her swiftly. Another woman was living in extreme poverty and an overcrowded household, in which case

we spoke more to her and her family to ensure the relevant statutory agencies were aware of the problem. Both these women have since moved home.

Analysis

The research methods chosen were designed to gather qualitative data, i.e. an illustration of the range of personal experiences and opinions through the women telling their stories. Numerical analysis of these findings is not always possible, and the sample size does not warrant this. The numbers of the sample for both interviews and focus groups has already been clarified above.

Statistical analysis of the focus group data was difficult. This was because at all group discussions we were receiving input from one or more interpreters, who simply summarised the group answers without indicating who or how many women had stated that, while other group members who could speak English would add their own views. We recorded all the answers given, where possible noting when more than one woman appeared to be agreeing.

As the interviews were semi-structured, of different length and usually via an interpreter the actual question wording differed slightly between participants. We were responsive to what and how much the women wanted to tell us under different subject headings. All answers have been recorded in full, the range of which is shown in section e) research findings, with illustrative quotes.

To process and analyse the data we typed up transcripts swiftly after the focus groups and interviews, comparing notes with each other where we had both attended the same session. For all focus groups we each had notes to ensure as much data was captured as possible from the multiple discussions taking place in the group.

We initially divided the analysis work by looking at results to each question in isolation, producing summaries of all comments made and grouping these by range of responses with illustrative quotes. Data from the focus groups and interviews that related to similar questions or themes was then pooled, which we have identified in the findings section as arising from the different methods.

After initial analysis the focus group and interview data was summarised, and we held a feedback session, via an interpreter, with the women at Wadajirke Dumarka. We explained what we felt had been said in the focus groups and interviews. Although that afternoon had been a busy and difficult group session the women were keen to hear what we had to say and said they agreed with our initial findings.

We looked at the initial findings again and began to compare/combine the results from each question, looking for links. From this process a couple of extra relevant themes emerged, which were not actual or key questions, e.g. the role of religion and the experience of seeking asylum.

The conclusions and recommendations arose from latter stages of the data analysis, as well as some input from the project steering group, and comparison with the results of Part I. The observations from Somali community organisations and other service providers suggested key recommendations, which support and complement the findings from Part II, which surveyed the Somali women.

e) Research Findings

To best display the crossover between research methods the following findings will be presented by theme, showing whether the data was gathered through focus groups or interviews. The related questions are also listed here, while the full list of questions for focus groups and interviews can be found in appendices 1 and 2.

As explained in the methodology, numerical analysis of this type of research is not always possible. This relates to the sample size and the semi-structured nature of the interviews; women were not asked identically worded questions, and may have given supplementary answers. There were other inconsistencies due to translation into Somali and the general flow of the interview. However all findings reflect the inclusion of comments from 27 different women. Focus groups had between 8 and 14 participants; there were 23 individual interviews.

Introduction

Question: How long have you been in the UK? (interview data)

8 respondents had been in the UK less than 6 months, 3 of which had only been in the UK 3 weeks.

5 respondents had been in the UK 1 or more year but less than 2 years.

6 respondents had been in the UK 2 or more years but less than 3 years.

1 respondent had been in the UK 3 or more years but less than 4 years.

1 respondent had been in the UK 4 or more years but less than 5 years.

2 respondents had been in the UK 5 or more years.

Over $\frac{3}{4}$ of the interview sample had lived in the UK less than 3 years, with $\frac{1}{3}$ less than six months.

Although we did not directly ask the respondents whether they had lived in any other UK city, 5 of the participants mentioned that they had lived in other cities in the UK.

1 respondent said she had lived elsewhere in Europe for 12 years before moving to the UK.

Question: Who did you come to the UK with? (interview data)

9 of the women came alone.

7 came with their child or children.

3 came with their mother, father and siblings.

2 came with their children and husband.

1 came with a friend.

1 came with her grandma.

The majority of women interviewed came to the UK alone or as the sole adult with their children.

Healthcare

Question: What is healthcare like in Somalia? (focus group data)

The nature of healthcare in Somalia was described as follows:

All healthcare is private in Somalia, and also expensive, *“not very expensive but people are poor”*. However free immunisation is available and is administered by a mobile nurse. More medicines are available over the counter in Somalia

Less technology is used in Somalia, and traditional medicine is an alternative if you have no or little money. It's cheaper and can sometimes be free. *“Traditional medicine is made from food and herbs. It's a bit like Chinese medicine.”* Traditional medicine is also important as some people don't believe in drugs, and many elderly people don't believe in technology. Some older people would often argue that, *“people have used traditional medicine for years and it has worked.”*

Self-medication and treatment is common in Somalia for the reason given above: *“I saw a girl with a sore stomach – they heated the stick and burned her tummy – in a few days she felt better.”*

“If you have an infection, for example in the leg. Then you treat it yourself. You cut the infection out with a razor and pour some hot oil on it to take away the bad blood.”

In Somalia it is the same doctor for everything. Doctors are only available at the hospital, there are no surgeries. Those who practice medicine in Somalia are not always qualified as a doctor. It could be *“someone with experience who is wise”* or *“...may not be a proper doctor but his father was and he has learnt from him.”*

Question: How is it different here in the UK? (focus group data)

The women felt that in some respects healthcare was better in the UK. The NHS provides free healthcare, there is an ambulance service, and better doctors.

“Not very good doctors in Somalia, e.g. kidney problems, can't get a good doctor, have to stay in the house, can't afford doctor, so will die.”

However other aspects that the women found frustrating:

You may attend several appointments before you are prescribed medicine in the UK; in Somalia you are given a prescription straight away.

“You have to wait a long time in accident and emergency, sometimes four hours!”

“The doctors in the UK always tell you to drink more water and take paracetamol!”

The women also felt their lifestyle in Somalia had been healthier than here in the UK:

Life is less active in the UK, felt healthier in Somalia.

"People are more active in Somalia. Over here we are always in the house and don't get a lot of exercise. We walked everywhere in Somalia. Sometimes people walk from Sheffield to Leeds just to get some exercise."

"It would be better if there were gyms for women."

"I suffer more with headaches, back pain, pain in the knee, more than I did in Somalia."

Question: Tell us about a time you went for a medical appointment

Was it at the GP's, hospital or somewhere else?

Was it for you or your child?

**What was it like? / Tell us what happened / did you get what you needed?
(interview data)**

GP / Hospital

For this question, 20 of the respondents referred to a medical appointment with their GP. 2 of the respondents talked about a visit to a Hospital. 1 respondent spoke of an appointment with a midwife. 1 respondent spoke about an appointment with a nurse at her GP's surgery. 1 respondent spoke about a medical instructed by the Department of Work and Pensions regarding an Income Support claim. Some women mentioned more than one medical appointment.

Reason for appointment

Of those women who stated their reason for the medical appointment the variety of ailments are as follows:

3 stated feeling sick / vomiting

2 stated headaches

2 stated menstrual problems

2 stated loss of appetite

2 stated pain in leg

1 stated stomach pain

1 stated a high temperature

1 stated problems with hearing

1 stated sleeping problems

1 stated back pain

1 stated pain in shoulder

1 stated aching all over

1 stated pain in one side of the body

1 stated itchy eyes and nose

9 respondents spoke about aches and pains in various parts of the body; which could be a symptom of stress and anxiety. Often psychological issues manifest in a physical form. [See literature review: mental health section]

Outcome

The women were asked whether they were satisfied with the level of care and service they received in relation to the medical appointment they had described.

14 of the respondents said that they were satisfied.
"They help me always, I don't have any problem." "They helped OK."

4 respondents stated that they were unsatisfied.
*"Coming to the UK you are hoping, you don't get what you are hoping."
"They check everything and say no problem" – but she is still feeling unwell."*

3 of the respondents stated that they were sometimes satisfied with the level of service received and sometimes not.
*"Sometimes I say it's not good but it's OK." "They help most of the time but some of the time they don't give medicine."
"They don't help so much ...they don't seem to care."*

4 of the women talked about reoccurring pain / symptoms that they felt have not been dealt with / investigated fully. They felt that doctors frequently prescribe paracetamol or advise weight loss without considering any other underlying causes.
*"Used to go everyday."
Sleep problems –"thinking"
"Doctor told me to take paracetamol, it doesn't help me. ... I would like them [doctors] to do something more."*

1 respondent stated that she was not satisfied with the healthcare her children had received.
"The problem still there, my baby vomiting, I'm really worried about."

Frequent medical appointments

6 of the women spoke of having lots of medical appointments
"Even tomorrow I have appointment." "Too much, too much."

The women explained this, as being partly due to medical care not being readily available or free in Somalia and also as a result of their health becoming poorer since moving to the UK.

*"In Somalia pay for an appointment." [focus group]
" **Visit the doctor more in the UK, because health is worse.**" [focus group]*

Also in Somalia if they were to visit the doctor, they would see one doctor for everything and receive a prescription during that visit. However in the UK there are more departments and specialists increasing the waiting time and delaying diagnosis.
"Sometimes in the UK you have to have more than one appointment before the doctor gives you medicine. Sometimes you have to go for blood tests. In Somalia they give you a prescription straight away."

Need for an interpreter

3 women cited language barriers and the need for a Somali interpreter at medical appointments.

Quite an extreme case highlighting the need for an interpreter, but more importantly the need for an appropriate interpreter, concerns a woman who was sent for a medical by the DSS regarding an income support claim. Prior to the appointment she stated that she would need an interpreter. However, when she went for the medical

she was told that there was no interpreter available. This was also the case when a second appointment was arranged. On the third occasion the respondent arranged for a friend to translate on her behalf but was told that this was unacceptable and that she would have to communicate via an interpreter the DSS had organised. The women explained,

“...They bring the man, I want the lady. They bring the religious man, the religious one who’s praying, I can’t tell him anything.”

Her medical problem related to a urine infection and other menstrual problems.

“I want this girl, the lady said go, she can’t do it for you and we cut your benefit too. (Benefit was stopped) I was there for one hour begging her, saying please let this girl do it for me and she said no.”

The respondent had to pay her own travel expenses on three separate occasions and also experienced delays in receiving benefit.

One of the women we interviewed was unable to effectively communicate what she needed to the GP due to being deaf and the need for a Somali interpreter. The woman had been deaf for the past three years (without medical attention) and had been in the UK less than a month. She had been to the doctor to try and get a referral to a specialist and the GP told her he was too busy and would get back to her. The respondent was extremely anxious and frustrated as there was no one to advocate on her behalf because she had refugee status and consequently wasn’t entitled to support from a NASS caseworker.

Another respondent talked about her experience in Denmark where she had lived for 12 years prior to moving to the UK:

“Can’t speak Danish but there is no interpreter. They like to speak Danish not English. I felt bad cause I was pregnant, but I couldn’t tell them – had only lived there for 3 months. I’m vomiting, can’t eat food. He understands but treats me like someone who is nothing. So I became seriously angry. I come to see you several times. I can’t stand up, I feel like I’m going to die – he wrote me the medicines, but couldn’t tell me what it was for. Became little better, stopped vomiting...in England - easier, I can understand what they are saying, if difficult I take an interpreter.”

2 respondents mentioned taking an interpreter to medical appointments.

Access to a woman doctor

2 participants stated that a female doctor wasn’t always readily available. This was more of an issue in relation to women’s health needs.

Women’s health

Question: All women sometimes get health needs related to being a woman, e.g. periods, giving birth, infections, and circumcision.

Is this something that affects you?

How is it for you in the UK when you are trying to get help with these needs? (interview data)

11 respondents, almost half of the sample, said they had been affected by women’s health issues. The main issues cited by the women were urinary/gynaecological infections and menstrual problems.

*"My periods are after 3 or 4 months, I feel sick, I don't know why, I'm feeling well, backache. Its coming little bits but its not coming normal, maybe I'm sick."
"Even now infections in urine."*

Only 3 women spoke directly about FGM in the interviews. We were conscious that the issue was a taboo subject and wanted to respect the women's privacy so did not ask directly about the practice unless mentioned by the respondent. Although, it was seldom stated it is likely that many of the women were experiencing infections and increased menstrual pain due to female circumcision.

"Lots of women have problems about raping and circumcision."

One woman spoke at length about FGM stating,

"When a women is circumcised difficult to get periods, have children. Period cannot come out. There are three types of circumcision; one is when they cut some bits, one is when they cut all off, one is when they cut then sew you up. Women who sewed difficult with period. When I was a girl I was very bad, urine, period, kidney. Lots of Somali women have these problems. Easier since I have children."

The respondent asked us whether circumcision happened to white women; this may indicate a lack of awareness as to whether FGM is a universal practice. We explained that women in UK would only be cut if necessary during childbirth and generally not for any other purpose.

We asked if her children had been circumcised, she replied,

"My children not circumcised, I know the problems. It's not something with religion it's culture. Can't give my daughter problem like the way I have been having problem. There is some people who still do. Different world, different culture now."

When asked if it is happening less now, she stated

"yes happening less now, not so much now. Both in Somalia and in other places."

Another woman bravely spoke of her trauma in suffering repeated rape in Somalia and the health problems caused by circumcision. She explained how she had been raped several times, sometimes three times a day for a period of six years, men "using" her and "taking" her. She also stated that she was only 15/16 when she was first raped and this caused health problems due to being circumcised.

"I feel problem now... need to tell GP... forgot to tell last time. I think infection now...pain. Two times I went to GP... but I feel shy. My doctor is a man, last time was a woman. I need to tell them."

6 respondents stated that they had not experienced any women's health problems but would not have any problem in going to the doctor with such a complaint.

"never even if I get baby."

2 of the women said that they were OK now but in the past had experienced such problems and felt fine about seeing the GP.

2 women explained that they go to the doctors as required and there is a female doctor available if needed.

"Can see a woman doctor always and give me what I need. It's good place really, good health centre."

2 women didn't comment on this question.

5 respondents stated that they were not satisfied with the response they received from their doctors and would like them to do more.

"...Maybe sometimes you are weak, you need iron, but they don't help so much. I'm feeling that problem up till now. They don't seem to care."

"They just gave medicine without even taking urine. "

4 women said they would prefer to see a female doctor.

"Better than a man... good to talk with women."

"I need sometimes a woman doctor. I'm feeling shy to talk to a man."

One woman went to the doctors wanting to talk about gynaecological problems

"white water in women's place", but because there was no female nurse/doctor available she said that she had a headache. "If had English would have asked for nurse".

Question: We understand circumcision is common among Somali women. What would you like to tell us about that? (focus group data)

As explained in the methodology, when we questioned the women about FGM this was often met with laughter and lengthy discussion with each other in Somali. However when the interpreter summarised the responses these were very brief.

The women acknowledged there was some practice of FGM amongst Somali women, but said it was becoming less common, over the last 15 years or so. One woman said lots of research and discussion had happened about FGM, and that it had stopped in Sudan.

"We don't have to do it, it's old fashioned. We don't do – it's changed"

"At the moment we don't do that in our country. It was before, now girls don't do that."

It was also stated that the practice of FGM was, *"...only culture" and "... not part of religion"*.

They acknowledged that FGM caused problems for women:

"Having a baby is difficult, intercourse it's a problem."

Question: In the UK we have family planning clinics [explain family planning clinics].

What can you tell us about family planning and contraception within the Somali community? (focus group data)

The women said that use of contraception among Somali women has become more accepted:

"Some things preventable"

"Haram [things which are forbidden; opposite of halal] in Islam says no contraception – but because children are more expensive you do regulate"

"Some people use it – if feel sick"

However it was clear from the data that many of the women have several children, and we were also told:

"Our religion says have to have another child after two years."

Khat

What can you tell us about Khat? (focus group data)

As explained in the literature review, khat is a stimulant commonly used in Somalia, particularly by men. More recently women in the UK are beginning to use it too.

Khat did not appear to be a major area of concern in the lives of the women we encountered. The issue was discussed within a focus group but was not mentioned by any of the women during interview.

The comments made in the focus group are as follows:

- *“Drugs – if you eat you feel everything – but it’s not good. I know some women chew. If you chew you feel you can do anything but you can’t. It makes you sleep. It’s like drugs. It’s your husband, it’s his problem. If sleep all day he won’t see his family, his children”.*
- *“I have no idea because I never had anyone near to me have it. When they use it they listen music and drink more tea. Feel more imaginative.”*
- *“When people eat the khat they are happy, they feel that they can do everything, they clean house, wash things, women not men.”*
- *“It’s a rubbish thing, we don’t like it”. “It’s like a mint, a green leaf, I hear it’s not tasty.”*

Do people use it here in England?

- *“Yeah, If you told me before I would bring it for you!”*

Is it expensive?

- *“Not that expensive. Can eat £20 worth. It will be hard because you can’t save money for family and future”*

Do your husbands/menfolk use it?

- Some of the women said their husbands used it in Somalia but not here.

Stress / emotional difficulties

During a focus group session the women were asked about keeping healthy and factors that made it difficult for them to stay healthy. We explained the holistic model of health adopted for this research and asked them about sources of worry. Initially we were not sure if the women would understand the terminology stress. However, the women appeared to have a clear understanding of what we meant by stress and frequently used the term to define how they felt.

“We are stressed and confused – our health is OK – we are just thinking, thinking, thinking.”

“I don’t know what to do, I’m confused just living with stress all the time.”

Question: Sometimes people feel ill, tired or sad because they are worried about things or have too much to do. Does this affect you? (interview data)

Of the 23 women interviewed, 22 said that they had some experience of stress.

19 women stated that they suffered with stress and anxiety.

3 of the participants said they have felt stressed in the past but are no longer suffering from it.

"Yes, when I first come, because I don't know anyone or any places. This time it OK. I was worried about language, if I want to go somewhere I needed someone to take me and help me."

"Before I have stress because I didn't get papers to remain UK."

1 woman said that she was not affected by stress.

Factors which are both the causes and symptoms of stress were described as follows:-

Separation from family

11 women, almost half the research sample, cited stress caused by separation from family members. 9 of these women had family in Somalia and one had siblings in the UK that she had lost contact with. Many of the women who had family in Somali did not know the whereabouts of their loved ones or whether they were still alive.

"Sometimes I worry about my brothers and sisters. They are in the UK but we lost the contact."

"Yeah I think about my family - Mother, brother and sisters in Somalia. If I think about my family, how can I bring them here?"

"Yes – Africa, my family, my husband, no peace [in Somalia]."

"All my family are not here, they are in Somalia in the war"

"3 of my sister, my brother – killed in Somalia"

"Sometimes I worry, they are my family, I miss them, I don't know where they are. I can't do anything for them."

"I think of my husband, left in Somalia – nothing else I am worrying about, only my husband."

Uncertainty of Home Office decision

The insecurity of being granted refugee status was a grave cause of concern for at least 5 of the research respondents. We did not ask directly about asylum / refugee status therefore it is possibly an issue for more than the number stated. This issue is discussed in more detail in 'experiences of asylum seeking and moving to the UK', later in the findings section.

"The Home Office says maybe you never come from Somalia"

"About this country to stay, I get the letter to stay, I'm OK now."

Isolation

4 of the women spoke about feeling isolated, mainly through being at home all day with their children. 3 of these women were single mothers and 1 had a husband who

worked long hours. Other factors which contributed to their isolation were not being near other Somali families; not being able to go out to work and meet people; being in an alien country and experiencing hostility and sometimes harassment.

"I feel stress. I'm feeling very lonely here. My husband is working he's not with me all the time. I'm feeling a bit of isolation. I'm feeling bored"

"Feeling lonely, my husband not here. There is not even a neighbour who is Somali."

Another woman had come to the UK alone and did not have any family here.

"Being on my own, I don't know what to do. Sometimes you are thinking, thinking, thinking without result. "

Housing / Overcrowding

4 of the participants suffered from overcrowding. Many of the women had large families in relation to number of children. Yet as with many asylum seekers and refugees they were accommodated in some of the smallest and poorest condition housing.

"problem... don't have a house [lives in a tower block]...too small, 3 children"

"I'm OK, but live in flat – one bedroom, 12 people. Only problem is house.

Before, my dad was here and living there alone. Then my mum and all children came. All came to same house." This family has now moved.

Exhaustion

2 women felt tired because they each had 6 children to look after. One was told by her doctor she was tired because of this. The other woman had just visited a specialist, feeling pain in the chest and shoulders, and wanted a massage to help with the pain.

Homelessness

The women we met often had insecure housing situations. During the course of the research several participants moved home.

One woman stated,

"Yes – am homeless, got extra priority but am homeless. I think where can I find a house, go to housing everyday and ask them. I hope to get a house soon – baby coming."

Trauma

One woman gave a particularly harrowing and candid interview, frequently breaking down in tears as she recalled her life in Somali, experiencing repeated rape and witnessing the murder of her brother.

"Yes because I have stress. When I was born I lived me and my brother and my mother – my brother and my dad is passed away... My brother was killed..."

Ill health

1 woman was stressed and anxious due to ill health. She had lost all hearing and was struggling to get a referral to a specialist.

The question of stress highlighted the vicious cycle of causes and symptoms in relation to health. The overwhelming strain of stress that many of the women we met were faced with undoubtedly had an effect on their health.

"I'm sick sometimes, I got asthma, sometimes headache."

"I feel ill, tired, I worry a lot"

"Got depression – all of time at home caring for children, no work to go to – it's stressful"

Question: What kind of things do you worry about? (focus group data)

Additional comments made within the focus groups were:

- Being alone / without family / homesick
- Everyone being a stranger
- Not being able to speak English
- Homelessness
- Home Office decision

"Stress in mind more than physical problems – always feel tired, thinking all the time, feel down."

"if you don't get exceptional leave to remain, you don't get anything, no home, no college, no help and you can't go home..."

Question: How do you cope with stress? (interview data)

4 women said that they coped by talking to their friends and family.

"I told my auntie and some of my friends my problem"

"My husband helps me."

3 women stated that they went to sleep.

"I can't do anything about it. Sometimes when I feel so much I just sleep."

2 women said they tried to relax by soaking their feet or taking a shower.

"I just relax and forget everything. When I am stressed I take shower and forget about it."

2 women said that they prayed.

"Pray to God and read Holy Koran"

2 women said they didn't know what to do.

"I don't know what to do, I'm confused – just living with stress all the time"

I never talk about it – don't see people

2 women said they felt they couldn't do anything.

"I don't do anything, just wait"

"It's very hard."

1 woman said she comfort ate, consequently she was very self-conscious and unhappy with the weight she had gained.

1 woman said she cried.

"I cry sometimes, I worry."

1 woman said she went for a walk to cope with stress.

1 woman said she coped with help from the Somali community.

Question: What do you do when you are stressed and worried? (focus group data)

Responses in the focus groups to this question were as follows:

- *"read the holy Koran and pray to God"* – this sentiment was echoed by several women
- Talk to friends and other Somali people: *"many don't have family here"; "helps by talking... calms you down"*
- Cry

Relationships and Support Networks

Question: Who do you live with? (interview data)

4 women lived alone

6 lived as the sole adult with their children, of whom there were between 1 and 6

2 lived with their husband

6 lived with their husband and children, of whom there were between 2 and 10

3 lived with their parents and siblings

2 lived with a friend, one of whom was getting a new house on her own very soon

2 women were pregnant with their first child

Though not all the married women mentioned their husbands, 2 said their husbands were in Somalia. 1 was separated from her husband who lived elsewhere in Leeds

10 women, almost half of the interview sample, lived alone or with sole responsibility for their children.

12 women, over half of the interview sample, were mothers, while another 2 were expecting their first child.

Question: Who helps you or gives you support? (interview data)

5 women stated they were without any support:

"We don't have anything, nobody helps us... I do what I can do, but lots can't do with them [children]"

"If I am sick there is no-one"

"One day we go to church, they give us food. Second time we go there they say 'we know your dad is working, we can't give you anything'."

One of the women described the extreme pressure her family was under without support: a family of 12 living in a one-bedroomed flat, without money. Her children

shout all the time because their home is too small. Neighbours complain about the noise and bring bullies, who say 'you have to go'. They have nowhere to go – housing workers say they have to wait. There is no washing machine, the fridge is too small, just for one person. They don't have clothes for the children, or uniform for their 7 children who attend school. Children attend three different schools, their parents have to take them and come back, but don't have money for bus pass or for food. This family has now moved, into privately rented accommodation rather than waiting indefinitely for adequate council housing.

3 said they had received support but this had ceased; in two cases this was the NASS caseworker being withdrawn on achieving refugee status, and in one case where Somali neighbours had moved away.

Of those who received support, they identified the following sources:-

7 women mentioned friends, of which three were said to be Somali - *"other Somali women help when they can"*. 1 woman had more friends in London, where she lived before.

4 said their husband, though in one case *"most of the time he works"*

2 said their children and husband

1 said children

1 woman said her older children, aged 16/17 helped, while another pointed out *"we have different culture. Baby of 4/5 years can help her mum. But our culture boys don't do anything only girls, it's not good."*

4 said they received support from the Lincoln Green women's group, while another non-member said she was interested in joining.

2 said their NASS caseworker, and 1 said NASS helped with *"housing and money every week"*

2 received financial support from the jobcentre [benefit payment]

1 said her sister, sometimes

1 said her neighbour (Somali woman) and her two older boys helped with errands etc, and would help with her baby when it was born

There were 17 references to informal support networks, eg family, Somali friends, and only 8 to support from agencies and professionals. The role of friendships and groups was especially important, especially where these were Somali and female. One woman said support was kept within the Somali community, from *"only ourselves"*, adding, *"if woman can understand each other problem is good. Need to listen to each other. Woman's group is good"*. However even where these support networks were in place, women still experienced isolation. One said she hadn't got any friends, just people who come to the group at Lincoln Green. Another woman said she has friends at the group and in the area where she lives. They sometimes help her *"make conversation, talk, but [with] your own problems no-one can help you"*.

Question: Who do you have to look after? (interview data)

Only 3 mothers and 1 of the daughters directly answered this question. However it was implicit that all the women who were mothers had to look after their children, often with minimal support: *"my mum has to look after everybody"*. The parenting section describes this in more detail.

The women did not mention looking after their husbands or friends.

Question: How do you feel about the people around you? (interview data)

1 woman said she found it difficult and was lonely.

4 women said they were content with their domestic situation and support network

Children and Parenting

Question: How is it looking after your children here in the UK, compared to Somalia?

What do you think it's like for your children, living here in UK?

How do you feel about bringing them up here? (interview data)

7 respondents had no children; 2 were pregnant with their first child; 1 was unclear. 2 respondents had one child; 1 had 2 children; 1 had 3; 1 had 4; 2 had 6 children; 1 had 7; 1 had 8; 1 had 9 children. 1 respondent said 3 of her children had died and one lived elsewhere in Europe. 1 lived with an adopted child as well as her own children.

3 respondents had some of their children born in Somali and others born in UK. One had her children born in UK; 8 brought all their children with them from Somalia. One said she travelled to the UK without her child, who followed a year later.

The breakdown above demonstrates that some mothers had no experience of bringing up children in Somalia. Others had experience both in Somalia and UK. Two women were expecting their first child to be born here in the UK. The ages of the children were also factors in how much the children were aware of their changed environment.

Parents described life in the UK as both harder and easier than in Somalia:

3 respondents talked of having support from extended family in Somalia, regular visiting and help when the parents were sick. This is not the case in the UK and puts increased pressure on the parents, especially when sick. One woman described parenting as *"here more work, harder here"*.

2 respondents described British weather as colder; this impacted on children by making them more prone to illness.

Some women spoke of increased freedom and opportunities for their children in the UK: *"they like this life very much, a free country."* Another said her children's minds were *"open to new things, new world, so they like here better than Somalia"*. Two described Britain an opportunity for a better life, as life in Somalia had been hard. In one family the children were able to be educated and choose different careers; however *"they are feeling free here, I can't control them so well here like my parents. Sometimes children speak bad language, I say not in my house. I give them chance – if I force them they will be out of the house."* One mother described the differences in social life for her children – discos in the UK for young ones and swimming in pools instead of lakes/ rivers. She also said *"girls can put on their trousers without expecting violence."*

One woman was living in poverty and an overcrowded household. Despite her stress she was hopeful for the future: *“Children like it here... Children don’t see everything – they going to school and come to new country – mother and father thinking about the children. In here can get the school – I like it. They’re my children and they can learn. I hope when they grow up they will get the good life, better life – good job, if they learn. At the moment because of house and no money – bit worried - maybe in future it will be better.”*

Education

4 respondents felt very pleased at the education their children could receive in the UK. One said her children had not been to school in Somalia but could attend here in UK; another said her children had gone to religious school in Somalia.

Child safety was a key area of concern. 4 women described how in Somalia children could be left outside unaccompanied and go to school alone. This may reflect Somali culture of a community responsibility towards children. Having to take children to school in UK places increased pressure on parents. In one family the parents had to escort 7 children to 3 different schools. Parents also worry about their children in the UK: *“I’m afraid if I leave them outside I won’t see them again – maybe someone will take them.”* Another woman commented, *“Here it is safe, not worrying about the war. If they late coming back home, I am worrying, I have to call them and say ‘where are you?’”*

Child safety in Somalia is also an issue for different reasons. Two women talked about shootings occurring while children are travelling to school, one mimed her daughter crawling home after some fighting.

Growing up environment

Whether children had lived in Somalia or UK, or both, was a big factor. Some children were already grown before arrival in the UK: *“he’s OK, he’s doing everything well. He control himself. Now he his own man, not teenager anymore.”* Another woman said, *“Back in Somalia it was hard. Long time it was good when I got my first daughter... Then it got bad.”*

One woman spoke of the stark contrast in bringing up her child in UK after some years in Somalia. *“Somalia is no good for him. Here is good for him – going to school, learning quickly, is good. We happy here, he got friends. He learn bad things in Somalia – guns. A man taught my son to use a gun... They don’t care – they don’t think this is baby – don’t encourage [children to use guns]... [in] Somalia 10, 5, 6 [at these ages] they have pistol.”*

One woman’s children were born in the UK, they were too young to know the difference. She said *“it’s OK to bring them up here – we are not going back.”* A woman pregnant with her first child stated *“it’s not my country”*. She feared the loss of Somali culture and language, but felt overall it will be good to bring her child up here. Another pregnant woman felt there was no problem having her baby here, no difference.

Children's experiences of harassment

One woman described how her children were subject to racist attacks, people hit the children and were verbally abusive. Another mother was told her children couldn't talk or cry – they should be silenced, while another woman's children were told they would have to leave their home because they were too noisy.

Racism

**Do people in the UK treat you differently or badly because you're Somali?
If Yes please tell us more about that / give example.
(interview data)**

12 respondents answered "no" to this question, saying they had not experienced any racism:

*"Most of the time [I am] in the house, there's not much problem with that."
"I didn't see anything – for me it's OK. We live good, good person here"*

4 women said they had received occasional racist comments but were unconcerned:

"Sometimes children say 'who are you? Which clothes are you wearing?' Because it's children you can't say anything... I think this country's not bad, it's OK."

1 woman didn't comment

5 of the women made philosophically accepting comments about racism:
3 of the women observed that there are both good and bad people: *"a lot of Somali people bad. You grow up in good family, you good"; "you meet two people, one is nice, one is rude, brother and sister"*
*"If people say anything to me I just take it like a story."
"I'm human being, same like them"*

This approach was also echoed in the focus group.

It may be the case that their traumatic experiences in Somalia were much worse than the racism they may have encountered in the UK.

Though the majority of the participants said they did not experience or feel concerned about racism, several women reported some more extreme racist incidents and fear of racism.

3 women said they had not had problems with racism in Leeds but elsewhere: 1 in Birmingham, 1 in Ethiopia and 1 experienced a particularly intimidating incident whilst in London:

*"Last week I was in London, in underground. Someone came near me. I was waiting for train. [The man said] 'you and your dress, f*** you'. I was afraid. The other people looking, no-one talking. I say 'if he push you underground you will die. Today is the last day of your life' I say to myself. I was shocked. When he gone, there was a lady beside me, she said 'are you OK?'"*

2 women spoke of increased worries about racism since the London bombings (July 2005):

1 said that when the bombings happened Somali people were scared about the backlash against them, but *“why would we come to Christian country if we hate the Christians?”*

1 woman had been shouted at by a passing motorist while she was wearing Hijab; he had been abusive and knew she was Somali but it was not clear what had been said. She associated this with the bombings and prejudice towards Muslims, saying *“Somali people didn’t do it. I don’t like to kill people, it’s rude. We are not like [other] Muslim[s].”* She had been distressed by the incident: *“already he is gone, I didn’t do anything, I was walking in street and he shout me”.*

Within the focus group this was also commented on: *“Especially since London bomb and 9/11 – they look to you as a bomber.”*

2 women and their children were suffering severe racist harassment at home:

“The area I am living now, neighbours are very racist. They say to me ‘your children can’t talk or cry, they should be silenced’. They put a picture of fire on front of door. It’s very dangerous. They write letter saying they will kill me and my children.” The woman was very distressed and worried; when questioned further she said she had already reported the problem to the GP, owner of the house, housing people, who didn’t do anything. She said *“If I get a new house today, I would move – but I can’t. Who else can help me?”*. This woman has since been rehoused, but had been living in fear and under attack for some time.

The other woman said *“there are bad people in the area, they knock on the door, they throw stones, they hit the children. It a problem. I don’t know what they want. They are British people, white people. They say ‘f***ing black’. I don’t know why they are doing that.”*

Role of religion

The women we met were devout Muslims; Hijab was commonly observed (covering the head and body), and in the women’s group members regularly left the main activities to pray.

Question: Can you tell us about how religion is a part of your life? (focus group data)

Participants described their faith as *“extremely important”*, *“my life is from my religion”*. They made statements about Islamic principles – *“we all believe in 5 commands – 1/ only one God, 2/ pray, 3/ Hajj [pilgrimage to Mecca], 4/ fast – Ramadan, 5/ give to charity if you can afford, Hajj if you can afford”* – as well as talking about being practising Muslims, reading the Koran regularly and praying 5 times a day: *“I feel happy talking to Allah – it’s important”*. In practical terms it was harder for the women to practise their religion in the UK; several women said there were more mosques and places for Koranic instruction in Somalia. One woman said

she “*can’t hear call to prayer (Azan) here – can’t hear when sleeping, morning especially*”.

While only one focus group question asked directly about religion, the women’s Islamic faith was a recurring theme elsewhere in the interviews and focus groups.

Several women in the focus group said they prayed and read the Holy Koran when they were stressed and worried: “*any problem give Allah*”; “*we pray – it’s good, it helps*”. Two women echoed this at interview; one laughed self-consciously and said it was a secret.

Islam was also important for the women’s children. Within the focus group women said their children had attended (free) Koran school in Somalia, where children learn Arabic so they can study the Koran. Another woman said at interview that her son attends Iftiin for Koranic instruction.

Other comments made regarding religion was men that they married didn’t have to be Somali but had to be Muslim. Other comments were that the practice of female genital mutilation was cultural, not part of their religion. The women also told us in a focus group that contraception was “Haram” (forbidden) under Islam, and that their religion dictated they should have a child every two years.

Experiences of asylum seeking and moving to UK

While no direct questions were asked regarding the process of seeking asylum in the UK, both the focus groups and interviews gave some insight into how the women have been affected by this. This section will collate references made to asylum seeking within the other questions and discussions. A summary description of the asylum seeking process is included within the literature review, which may aid understanding of this section.

From the interviews it would appear that at least six women had successfully achieved refugee status. A further five had been unsuccessful or were uncertain: two had NASS caseworkers, one was waiting on news regarding her papers, one had been refused three times, and one had been asked to return to Somalia but was appealing. Despite living in the UK for 2-3 years, a number of women were still uncertain whether they would be allowed to stay, while one woman was unable to move house because she did not have the required Home Office paperwork. Other women expressed the desire to work, which they could not do without permission.

Separation from family was a common experience of the women, many of whom had left husbands, children and other family members in Somalia. Some women travelled to the UK alone, to join their husbands and families who had come first. Many of the women had no contact with their family in Somalia and no news of their welfare; worry about their loved ones was common. In choosing three things that would improve their lives, 11 women in their interviews spoke of their wish to be reunited with their family. In a focus group having no family in the UK was described as a source of worry.

One woman spoke, both in focus group and interview, of how her family had become fragmented since moving to Britain. She has a half-brother and half-sister in the UK

whose mother is white; she has not seen them for over a decade and wanted advice of which organisations could help her trace them. Not seeing her family and worries about her brother were a significant cause of stress for her.

Anxiety about Home Office decisions was repeatedly cited in focus groups and interviews as both a source of stress and a difficulty in staying healthy. The women were well aware of their limited options and the implications of the outcome of their applications: *“We can’t go back – the situation there is the same. We are asylum seekers – deal with Home Office – if you don’t get exceptional leave to remain, you don’t get anything, can’t live.... you can’t go home – home country has a lot of problems.”*

Successfully achieving refugee status did not resolve all the women’s problems, they are often still without their family and experiencing related stress and isolation: *“Even if we get exceptional leave to remain – we still need to bring our families [to UK] and can’t do it”*. The research also showed instances where gaining residency placed financial burdens on both individuals and families. In one case the father had gained refugee status and was in paid employment. However his large family were then dependent on insufficient earnings while the mother was unable to work. This left them living in poverty. Another woman described her asylum application being refused, and whilst outside the home office system for several weeks being left without any accommodation or money. The abrupt withdrawal of NASS caseworkers on achieving refugee status also created problems; in one case a woman was left with significant health problems and difficulties communicating, with no-one to advocate on her behalf.

Two women spoke of traumatic experiences of the Home Office process:

“When I come here, they say I’m not Somali – because I have lot of problem. They interview me and make me feel bad... When they interview me I can’t think... can’t talk to Somali interpreters. Lots of women have problems about raping and circumcision, can’t talk about it.” She described how Somali culture prevented her from telling a male interpreter about the trauma and abuse she had experienced in Somalia.

The other woman had been asked by the Home Office to return to Somalia. She said that the Home Office employed staff from Somalia, who had left the country 25 years ago, and that asylum applicants can tell by accent that interpreters are from different tribes: *“they are enemy – they will lie. When I come first day they ask me 98 questions – there is interpreter and one person (judge) – they take what interpreter say. I can’t understand what they say. They ask interpreter whether it’s true or not. After one week they send me refuse, I don’t know why. That person never see the war, but they ask him.”*

In the focus groups, women were asked to describe difficulties in staying healthy. Their answers included nervousness about arriving in the UK, not knowing English, homesickness and that *“everybody here is a stranger”*.

Use of Somali and other groups

Question: Which, if any, of the Somali groups do you use?

What for?

What do you think of them?

Do you go anywhere else outside the Somali community for help? (interview data)

The methodology section describes the groups through which we met the women.

From the interviews 6 women said they used Little London group, 7 used Iftiin for themselves and/or their children, 15 used Lincoln Green. Four women said they used more than one of the Somali groups. We did not encounter any members/users of the Eastern Sub-Sahara Community Association, or anyone who had used the now defunct group at Harehills Tradex.

Little London users

2 women were happy with the support they received from Little London:

“They help so many people here - Home office affairs, advice, job search.”
[They are] “helping me with everything I need – they will help or send somebody”.

2 women were interested in the Lincoln Green women’s group

For one woman it was her first visit to the group, she didn’t have chance to get out much because of looking after her children. Another woman who came to be interviewed was delighted to meet other Somali women there at the same time – she said *“I feel free!”*

Overall, from their comments in other interview questions, the women we encountered at Little London seemed significantly more isolated than those involved in the Lincoln Green women’s group. For example they identified less sources of support and less knowledge of other organisations.

Iftiin users

3 women said they received a range of advocacy and practical support from Iftiin:
“They are helping, benefits, reading letters, can use telephone, children use computers, every problem they help, different activities for children, the house [premises] is only little but we come here.”

2 women who used other Somali groups as well had specific reasons for using Iftiin:

“Sometime I go Iftiin, I speak my language but I can’t write... It’s good”
“My son, learning Koran. Iftiin is good, they care for my children”

1 woman said she just used Iftiin; another said she didn’t know about other groups.

Lincoln Green users

5 women made positive comments about Lincoln Green group, enjoying *“talking, eating, sewing, dancing”*, having a meal and receiving vouchers for participating in the research. One woman had been helped with furniture. Social aspects were very

important: one liked meeting her friends and some new people; another said she *“was feeling happy when I saw lots of Somalian women together”*.

1 Lincoln Green user viewed other Somali groups in Leeds with some suspicion: *“My idea – if there is another Somali group, they are not doing anything, they are not helping us. I know from Somalia they are not helping each other, here I don’t know.”*

2 women identified the need for more practical support from the group, as well as access to a phone: *“We need help with advice, Home Office etc”*. During the interview several women asked us directly for practical help, with housing, seeking asylum, financial and medical issues. While some advice workers are available to offer this support (from Ebor Gardens Advice Centre) this is not as well known amongst users as it might be.

Within the focus groups at Lincoln Green women were also asked about the group – all present agreed it was important to them. When asked why, comments were *“when we come here we come out of house and talk to each other”*; *“because we come together, everyone talks and relaxes”*.

Users of more than one group

1 woman from another Somali group had visited Lincoln Green before and said she was made to feel unwelcome. Another comment made about Lincoln Green was, *“one women’s group was giving bus money – there was massage and dancing – the bus fares stopped. Woman are saying ‘why have they changed their face?’ It is hard for some of the people”*. In this case funding appears to have run out, a fact either not understood or fully explained to the women, who have taken some offence.

1 woman said she had attended another group in Beeston; we were unable to identify which group this was.

Some women at the Lincoln Green focus group said their children went to Iftiin, for help with various school subjects. They said that Lincoln Green was the only women’s group in Leeds.

Users of non-Somali groups

17 women interviewed did not use non-Somali groups. One said she doesn’t go, *“don’t know their language”*. The woman who only took part in the focus groups did not use non-Somali groups.

Resourcing the Community was used by 3 women, SureStart by 2, Refugee Council by 1, Asha women’s group by 1, a Sudanese group by 1, and an Asian group by 1.

1 woman said *“I go where I want... so many places you can go if you understand each other... If they invite me I will go. It was boring staying in the house. They send me letter so I go. There is a community – all good. Lots of Somali women.”*

Hopes for the future

Question: What three things would make your life here in the UK easier? (interview data)

We asked this question to summarise the main issues affecting the women's quality of life and well-being, but also because we wanted to end the interview on a positive note, leaving the women hopeful for the future.

The main responses were as follows:

11 respondents said to be with their family or have all their family together.
"My family – in Somalia, have a son there"; "Someone who will take my husband here with me"; "My family – I am desperate to get my family"; "To get my family together is the highest"; "Main thing I forget, to see my family."

10 respondents stated good health.
"Good health better than everything, only that"; "Health first"; "To be OK, my health"
One respondent said, *"My husband is stressed, so he would be good, to be well."*
Another said, *"My stress to come down – to forget everything"*

8 respondents replied to have better housing (poor condition and overcrowding were cited as being the main problems in terms of housing).

1 woman said she didn't know what to do, she had children and her house was without heating:

"If I get something else I can move, but can't do it. Weather will change now it's September"

Another woman said,

"House, if I can get my house, live with other ladies, they have another culture, another language. They are from Ethiopia."

One of the women asked,

"If I could say my house is little would you help me?"

6 respondents stated being able to work / finding employment

"Would like to get a job – then I can help other people – sometimes my people/relatives in Somalia are dying – would like to send money."

"I want work, first thing." She was interested in interpreting, packing, anything.

6 respondents said living in peace and being safe.

"Live here without problems, peace"

"To get safe...to stay somewhere safe, not like Somali – is not safe"

3 respondents said to be granted residency in the UK

"For me stay country.", "Letter from home office, my life would be very better."

2 respondents stated to learn English

"If I could learn language, I would be very happy to learn English language."

Other responses included,

"If I could get childcare, it would affect me so much, I could do so many things. What's making me stay at home is the babies. I could work. I studied in Somalia. I taught in Somalia."

“Would like to live in Harehills, near to Iftiin. Would be very happy”

“We need some exercise, gym, swimming, social gathering.”

“I’m feeling happy today because we meet.”

“My children have good education – I want the best, that’s why I come from Denmark, to learn English”

“A place to pray – one place, meeting place, children to learn culture – good culture and bad culture. Somalia is good and bad culture. Some people born here, don’t know Somalia. Big Somali community.”

“If I go Somalia one day”

“To start a new life – to forget my bad life”

(focus group data)

Although most of the women in the focus group either didn’t understand what we were asking or didn’t want to name three things, they made similar comments:

- *“Health”*
- *“Stay with your people, if you have family”*
- *“you have peace, without worry”*
- *“...place for women to enjoy ourselves”*
- *“...have gym/swimming just for women”*

f) Conclusions and recommendations

Recommendations from Part I

The main recommendations arising from Part I, Provision for Somali community in Leeds, which related to the Part II themes were as follows:

- Improved cultural sensitivity and awareness of medical practitioners and service providers regarding the needs of asylum seekers and refugees.
- Ready access to language support within service provision.
- Improved support services for women who have experienced trauma.
- Raised awareness amongst agencies of one another's services to aid signposting.
- Ongoing/improved support to Somali community organisations regarding development and funding.
- Improved promotion of Somali community organisations, particularly the Lincoln Green women's group to women currently unaware of it.
- Practical support to be more fully incorporated into the Lincoln Green women's group.

Conclusions and recommendations from Part II

Any recommendations made should be culturally sensitive. The women we encountered were devout Muslims, and there are distinct gender boundaries and clan divisions within the Somali community. Most of the women we encountered had several children to look after, while their husbands are in Somalia or busy working long hours. They may be forced to move home frequently based on decisions regarding their housing or asylum applications. Whilst the women are under considerable stress of living conditions, settling into an alien society, poverty, seeking asylum, separation from family and recovering from trauma, they are warm, proud and resilient characters who look after their own people and make clear decisions. The recommendations therefore should be appropriate and supported by the women, ideally providing the Somali community with greater support to effect change for themselves.

Introduction

The majority of women had been in the UK for less than 3 years, and many for less than 6 months. Most of them had come alone or as the sole adult with children.

Healthcare

There are considerable differences in healthcare between Somalia and the UK, and for women moving to Britain this is a major cultural shift. This lack of knowledge of institutions and systems prevents the women from being informed consumers of services in the UK, which is further exacerbated by language barriers and apparently poor cultural knowledge amongst medical practitioners. Though the women often stated they were generally happy with medical services here, it may be that their expectations are low. To assess the effectiveness of services the results from this

survey would have to be supplemented with information about what other ethnic groups have experienced.

It has emerged from the data that the lifestyle in Somalia is far healthier than in the UK, especially in terms of regular exercise and access to fresh food. Changes to diet and level of activity, as well as a high prevalence of stress related symptoms and adjustments to the British climate, make for increased medical needs and frequency of appointments. Somali women living in the UK will not have the same access to traditional medicine, so will have a greater reliance on primary healthcare.

Recommendations:

- Language support needs to be consistently available, including female interpreters
- There is an ongoing need for greater cultural awareness amongst medical practitioners, using support available through agencies such as the Health Access Team (see appendix 4)
- Medical services specifically for black and minority ethnic communities should be promoted more widely within the Somali community, for example Haamla. This also applies to community health projects such as the Black Health Initiative. (Details of both these agencies are in appendix 4.)
- Somali women need access to women-only facilities at gyms and swimming pools, at low cost.
- Medical practitioners need to identify stress-related symptoms more readily, carry out more thorough investigations, make prompt referrals and signpost Somali women to other support services

Women's health

Problems relating to urinary infections and menstruation were common. We received some comments about personal experiences and the effects of FGM, which included problems regarding infections, menstruation, pain, and childbirth. From the prevalence of urinary infections as well as the lengthy discussions in Somali and laughter amongst the women, we feel it is likely that FGM was more common amongst the women than has been disclosed. Given the design of the research and short-term interaction with the women this is partly to be expected. As Harris is quoted in the literature review, *"The Somali Muslim culture is not a confessional one; self-containment is valued and personal enquiry is seen as intrusive."*

There was some use of contraception amongst the women, while large families were still common.

Although the research question listed childbirth as an example of a women's health issue, we received no comments about maternity services. Other research, such as Bulman's report in the literature review, has found poor cultural awareness and language support amongst maternity services. We have not found any evidence regarding maternity needs, but have already recommended above that Haamla should be better promoted amongst Somali women.

Recommendations:

- Medical practitioners need greater awareness and cultural sensitivity regarding FGM, which can be provided through the Health Access Team's FGM forum (see

appendix 4). This should be identified as a potential issue if other symptoms, e.g. urinary infections, are presenting, and appropriate signposting made.

- Female medical practitioners and female interpreters should be more widely available, and offered more pro-actively to Somali women.

Khat

Though this arose in the agency interviews as a common issue within the Somali community, restricting the presence and support of men towards their wives, the women we met in the research were not concerned about use of khat.

Stress/emotional difficulties

There was a huge problem with stress, with almost all the sample saying this affected them both emotionally and physically. Separation from family, applications for asylum, housing problems and childcare responsibilities led to exhaustion and ill-health. The women were often caught in a vicious cycle, unable through their isolation and practical constraints to take many positive steps to deal with their stress. Many had identified some ways of coping with stress, with a clear emphasis on informal support networks and their religious faith.

Issues regarding trauma were not generally drawn out, again this may reflect both the Somali culture of self-sufficiency and the research design. However some women spoke of rape, murder and violence in Somalia. Within the agency interviews several workers said they encountered traumatised Somali women more frequently, and that related support services and therapeutic interventions were inadequate.

Recommendations:

- As already stated, medical practitioners need to be more pro-active in identifying stress-related symptoms and signposting appropriately.
- Lincoln Green women's group already provides stress management support such as massage workshops, and social interaction with other Somali women. This needs ongoing provision and funding, as well as promotion to a wider range of women in need.
- Services and therapeutic interventions for Somali women experiencing trauma need to be improved, culturally sensitive, free of charge and widely promoted. If there is scope for Somali women to learn counselling skills and offer this on a peer or group basis, there is likely to be higher 'take-up', as the women clearly prefer to access support within their own community. Mental health professionals also need to increase their cultural awareness of this client group.
- Women most at risk of stress are least likely to be isolated and not accessing services. Agencies and community organisations need to offer outreach or more women's meeting facilities where childcare and possibly transport is provided. It is likely that such approaches need to be quite pro-active and will take some time to gain trust. If Somali women can do the outreach it is likely to be more effective.

Relationships and support networks

Almost half of the sample lived alone or were head of the household, while over half were mothers with up to 10 children. There were clear needs for practical and emotional support, but in many cases this was absent or had ceased. There was a far greater reliance on informal support rather than from agencies and professionals.

Recommendations:

- The reasons for lesser reliance on agency services may be cultural or related to appropriateness, knowledge, preference or availability. However all agencies could improve their own promotion of services, as well as raising awareness of each other to promote signposting.
- Appropriate childcare should be provided as widely as possible.

Children and parenting

The women generally had significant caring responsibilities, often as the sole adult with several children to look after. This situation was exacerbated by practical problems such as their children attending different schools, living in poverty or poor housing, having to travel frequently. While childrearing may be easier in the UK in some respects (lack of war, better opportunities etc), it should be recognised that women are also more isolated, fear loss of their culture and have to supervise their children more closely than in Somalia. Many of the women were happy with the opportunities available to them and their families in the UK, and generally adopted a positive attitude though this could be quite challenging.

Recommendations:

- There are clear practical issues that the women need help with. This includes a more efficient system where their children can be placed at the same school. Problems of wholly inappropriate housing and racist harassment need to be followed up swiftly, through advocacy and agency liaison. Agencies and community organisations also need to offer benefits advice, donations of clothes, food and household items, and help with travel expenses.
- Interaction with other members of the Somali community is a vital way of preserving Somali culture, especially as the women's children are growing up in the UK. The Lincoln Green group's work on a book of Somali culture is clearly a positive way of supporting women to remember and celebrate their way of life; this project can be emulated within other organisations.
- Women's groups such as Lincoln Green, as well as less formal networks, need to exist so that women can receive practical and emotional support from other Somali mothers.

Racism

Though a large proportion of the sample said they had not experienced racism, this was countered with numerous comments of acceptance or unconcern. The women did not let minor incidents or racist comments affect them. The women's clothing, visibly identifying them as Muslim, attracted some racist behaviour. However, there were much more serious incidents of racism, including death threats and harassment from neighbours and strangers. Women in these situations seemed completely isolated and unsupported. Racist behaviour was often apparently caused or exacerbated by recent terrorist events, Islamophobia and anti-asylum sentiment.

Recommendations:

- Families experiencing racist harassment in their homes need swift and effective support, and often to be re-housed quickly where they are at risk. There is a need for advocacy and awareness raising about reporting hate crimes.

- More general anti-racist work within schools and communities in Leeds should raise awareness of refugees and asylum seekers.

Role of religion

Muslim faith was very important to the women, a source of personal strength and a unifying factor within the Somali community.

Experiences of asylum seeking and moving to UK

Seeking asylum raised significant practical and emotional concerns for the women. The process was often traumatic and bewildering, resulting in symptoms of stress and swift changes of circumstances. It appears that Home Office interviews completely fail to acknowledge the gender and clan relationships within Somali culture, as shown by choice of interpreters. Positive outcomes in achieving refugee status were combined with separation from family left in Somalia and being without adequate housing, support or money.

Somali women living in the UK also have to make significant adjustments in becoming familiar with British culture and language. They have come from a country at war and without any government or infrastructure, to unfamiliar systems around asylum seeking, education, housing and medical care. These adjustments are further complicated by ignorance and negative views of asylum seekers amongst some British residents and professionals.

Recommendations:

- The need for practical support, benefits advice, donations, advocacy and anti-racist work have already been highlighted above.
- There appear to be a good range of services in Leeds for refugees and asylum seekers, both within and outside the Somali community. All support agencies such as Refugee Action, Refugee Council, Leeds Refugee & Asylum Service, British Red Cross need effective promotion, including making visits to community organisations which represent the refugee communities. The Somali community organisations also need to be promoted widely, as contact with fellow Somalis has been shown to be vital to the women seeking asylum in the UK.
- Home Office procedures should accommodate differences in culture between refugee communities, and where possible provide interpreters of the same gender and clan.
- A new Home Office service, SUNRISE, is being piloted in Leeds which gives practical caseworker support to applicants who have achieved refugee status (see appendix 4). The pilot needs to be effectively implemented, with as many eligible refugees as possible referred for further support, and efforts made to ensure this or a similar service is implemented on a more permanent basis in Leeds.

Use of Somali and other groups

Because we met all the women via Somali groups we have no way of establishing how many other Somali women are not aware of or accessing Somali community organisations. While there could be greater awareness of what is on offer, partially

achieved through carrying out this research, the women we met were generally happy with the support they received from the Somali groups. Some participants lacked contact with other Somali women, while others attended the women's group but wanted more practical help. 'Take-up' of services outside the Somali community was far less common.

Recommendations:

- All Somali community organisations could raise their profile and develop stronger relationships with each other to aid signposting, including joint events and visits to each other.
- The Lincoln Green women's group needs clearer promotion or signposting to practical assistance.
- The other Somali organisations – ESSCA, Iftiin and Little London – all need to provide more services for women, as indicated earlier in this report.

Hopes for the future

The most common aspirations raised were reunion with family left in Somalia, better health, better housing, opportunities for employment, living in peace, achieving residency in the UK, and learning English.

Recommendations:

- Recommendations regarding health have already been made above, including greater cultural awareness amongst medical practitioners and provision of women-only exercise facilities.
- The British Red Cross offer a tracing and messaging service, detailed in appendix 4. Somali women in Leeds need to be signposted to this service, where a Red Cross worker can visit them to fill in the forms and try to make contact with family in Somalia. This seems to be a relatively straightforward process, which can easily be actioned by all the Somali community organisations in Leeds.