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Perceptions and Attitudes of Black Sub-Saharan African
Migrants from War-Torn Zones towards Accessing Health
Services in England.

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seTitle: Perceptions and Attitudes of Black Sub-Saharan African Migrants from War-Torn Zones towards Accessing Health Services in the English West Midlands Region, UK

Background

Conflict and Displacement

Internal conflicts and violence often force large numbers of people to leave their homelands. The latest figures released by the United Nations High Commissioner for Refugees (UNHCR) show that there are 70.5 million forcibly displaced people worldwide, of which 41.3 million are internally displaced and the remainder are scattered as refugees and asylum seekers across the world (Janmyr, 2018). Some regions of the world have experienced more conflict and violence than others. Regions such as Central America, the Great Lakes region of Africa, and South-East Asia have witnessed numerous civil wars within several states leading to mass displacement of populations, whereas other areas such as Europe and the Southern Cone of Latin America have had a relatively low frequency of internal conflict (McCallin & Montemurro, 2009). Thus, many black Sub-Saharan Africans (BSSA) displaced by war and internal strife moved to Western Europe in the run-up to the new millennium. In the UK today the BSSA communities form part of the UK’s population demography (Heys, Martin, & Mkandawire, 2019). On arrival, it is imperative that these communities are integrated into the mainstream population, including access to services offered by the health system, as they often come with a wide range of health needs triggered by war and violence (van der Haar & van Leeuwen, 2019). Furthermore, these communities will also be having multiple needs emanating from their circumstances some of which may challenge their ability to navigate through the new health system(Mbalinda et al, 2021). It is therefore against this background that such communities may need a tailor made approach to make sure that they access the new health service.

Impact of Conflict on Communities

There is evidence that the impact of violent armed conflict is often strongly gendered (Ventevogel, 2014). This means that while men are more likely to be killed or maimed during battle, or exploited through forced conscription, women and children are more vulnerable to the impact of war thereby affecting their public health including their health-seeking behaviour. Among other things, rape and other forms of sexual violence are common in many armed conflicts, taking a toll on the health and well-being of women and children (Verelst, De Schryver, De Haene, Broekaert, & Derluyn, 2014). This is not only intended to harm the women and children but the men too, as women are seen as the reproducers and carers of the community. What this means is that when one group wants to exert control over another, they see raping and/or impregnating women as a way of destroying the

opposing community (Moffett, 2006) which ultimately tears apart the social fabric of societies (Winkler et al., 2015). This has come to be known as the weaponization of rape in conflict ridden communities (Nyashanu et al 2022). In turn, victims of rape and sexual abuse are invariably stigmatised by their own communities. A stark example is the famously documented incident of the Ecumenical Women at the United Nations who were rape victims in Darfur, Sudan and had to build their own huts outside of their family compound due to the associated stigma of being raped during the conflict (Zannettino et al., 2013). Apart from the aforementioned social implications, what is often neglected is the reality that sexual violence is a major cause of intense psychological trauma, the uncontrolled spread of sexually transmitted infections, unplanned pregnancies and lasting psychological damage for the affected individuals. The stigma associated with rape also has a huge impact on victims' health-seeking behaviour (Nyashanu 2017). Many men who experienced forced conscription at a tender age including violence can also present with post traumatic stress and other mental health problem which inturn affect their health seeking behaviour when they move to another country for refugee (Nyashanu et al 2022).

When health systems collapse in times of war and conflict, maternal and paediatric health indicators, which are often used as a measure of overall health system performance, can decline significantly (Khan et al., 2016). This has a direct effect on the health-seeking behaviour of the affected population. In many conflict-affected areas reproductive health services are almost non-existent, leading to increased infant and maternal mortality rates (Veling, Hall, & Joosse, 2013). In South Sudan, for example, the world's youngest country and a region blighted by decades of violent conflict, girls are more likely to die during birth than they are to finish primary school (United Nations Economic Commission for Latin America, 2004). Given this evidence, it is understandable that migrants from conflict zones come with complex health needs, which can negatively affect their health-seeking behaviour if they are not closely supported and empowered.

BSSA migrants from war-torn zones face numerous barriers in accessing health services in the United Kingdom. Some migrants in the UK have restricted access to health services during their asylum application process (Kohlenberger, Buber-Ennsner, Rengs, Leitner, & Landesmann, 2019). The majority arrive in the UK as asylum seekers going through the stressful process of regularising their stay. This legal process has enormous implications for their perception of what health services they can access even after being granted refugee status (Kohlenberger et al., 2019).

According to Trends (2017), there has been a recent increase in the number of refugees. In 2015 the city of Birmingham in England had 18,607 migrant GP registrations (Munro, 2017). However, this number does not account for the undocumented individuals with no recourse to public funds (Trends,

2017). The majority of migrants live with poor resources. Furthermore, their legal status of having “no recourse to public funds” presents a major barrier for failed asylum seekers to access health services (Galloway, Duffy, Dixon, & Fuller, 2017). Hidden health-care costs such as transportation costs also act as a barrier to migrants in accessing health services (McKeary & Newbold, 2010).

There is extensive research demonstrating increased psychological ill health such as post-traumatic stress disorder among migrants (Bogic, Njoku, & Priebe, 2015; Porter & Haslam, 2005). Brief structured psychotherapies are effective in the short term for various traumatic stress responses (Silove, Ventevogel, & Rees, 2017). However, migrants from Sub-Saharan Africa may find it difficult to benefit from these services due to cultural practices and beliefs (Kohlenberger et al., 2019). Some migrants with immigration issues may be reluctant to access health services due to fear of deportation and re-traumatisation (Kohlenberger et al., 2019). Miller and Rasmussen (2014) argue that trauma among asylum seekers stems not only from prior exposure to traumatic experiences but also from social ecology and displacement-related stressors.

New Communities and Access to Health Services

Cultural differences, implicit biases and discrimination pose significant barriers to migrants trying to access health services (Kohlenberger et al., 2019). Socio-cultural barriers could also arise from the internalised stigmatisation of mental illness in the country of origin and this may contribute to restricted access to health services (Silove, Steel, McGorry, Miles, & Drobny, 2002). Steel, Liddell, Bateman-Steel, and Zwi (2011) believe that HIV and mental health stigma can manifest through stereotyping, separation, loss of status and discrimination. Cultural competence is the ability of a professional to effectively work in cross-cultural situations (Tol et al., 2011). The combination of a perceived lack of cultural competence, unconscious bias and discrimination can form a monumental barrier, resulting in migrants being reluctant to access health services (Kohlenberger et al., 2019).

More importantly, there is a need for the local health system to provide services that are friendly and inclusive of the new communities to enhance positive health outcomes for all. In doing so there are challenges which may include, among others, strain on the already existing health system alongside ballooning of the health bill (Trentacosta, McLear, Ziadni, Lumley, & Arfken, 2016). While these challenges are acknowledged, it is important that the health needs of migrants from conflict zones are addressed within a suitable time frame to prevent a long-term negative impact on their health and well-being.

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3 Considering the above assertions, this paper sets out to explore the experiences of BSSA migrants
4 from war-torn zones in accessing health services in the West Midlands region of the UK. This may help
5 to inform on factors influencing the uptake of health services for new migrant communities.
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8 9 **Methodology**

10 11 ***Research Design***

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13 This study explored the experiences of BSSA migrants from war-torn zones in accessing health services
14 in the West Midlands using an explorative qualitative approach (Neumann, Anderson, & Denich, 2018).
15 Exploring lived experiences required a phenomenological approach whereby participants were given
16 the opportunity to recount their experiences, allowing things that were of impact to them to unfold.
17 This approach gave the researcher an opportunity to “enter the research participants’ world”
18 promoting a deeper understanding of their experiences as perceived by them (Charon, 2008). Ten
19 focus groups made up of seven participants each were utilised and followed up with 3 in-depth one-
20 to-one interviews from each focus group using a conversational approach where research participants
21 were encouraged to direct and shape the discussion in accordance with their own experiences, views
22 and particular concerns (Kvale, 1996) as opposed to responding to a pre-determined agenda.
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31 32 ***Conceptual Framework***

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34 This study was guided by the Silences Framework (Serrant-Green, 2011). This framework is ideal for
35 researching sensitive issues among marginalised communities. The method was originally used to
36 study the decisions and silences of black Caribbean men in England in relation to sexual health,
37 considering the importance of gender and ethnic differences in this context. It resulted in the
38 development of the Silences Framework guiding research on sensitive issues and the health care of
39 marginalised communities (Serrant-Green, 2011). Similarly, this research set out to study the
40 sensitive issues concerning access to health services by BSSA communities from war-torn zones in
41 Sub-Saharan Africa presenting with stigmatised conditions. The utilisation of the Silences
42 Framework in this study aimed to challenge the view that people should adopt specific behaviours
43 when accessing health services without consideration of other historical, social, cultural and
44 economic influences. The Framework is supported by anti-essentialist standpoints, which challenge
45 the idea that the world is constituted of a single reality which is unchanging and without it such
46 things would cease to be what they are (Pinafi, 2015). Anti-essentialism questions essentialist
47 theories and their conviction in the determination of being, and belief in the biological paradigm as
48 being the determinant of the subject’s essence. In this sense, anti-essentialism counters the
49 existence of binarism, constituted in superiority terms of the first in relation to the second. This
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allows exploration of the experiences of people who are marginalised and voiceless in society, suggesting that things are not always as they seem to be. The essentialist view of the world is evidenced in the way migrants from conflict-ridden zones struggle to access services when settling in new communities. These social situations often make the migrants invisible, with “silences” around their situation little explored. The Silences Framework also provides a 4-phase method for the data analysis to enhance credibility.

Identification and Recruitment of Research Participants

The research participants were recruited through community organisations and faith groups for BSSA in the West Midlands region. In the first instance the researchers sent letters to community organisations and faith group leaders inviting their members to take part in the study. Only those members who had agreed to take part in the study had their names and contact details passed to the researchers. All the potential participants were given an information sheet prior to taking part in the focus group discussions and one-to-one semi-structured interviews. Venues for the focus groups and interviews were secured in local community centres. Before the focus group discussions and interviews, the researchers went through the information sheet and gave the participants an opportunity to ask questions about the study. All the participants completed a consent form prior to taking part in the study. The research team was made up of 3 women and 1 man. The presence of women and a man made it possible for both female and male research participants to feel comfortable taking part in the interviews.

Table 1 below shows the profile of the research participants:

Seven focus groups comprising 10 people each and 18 one-to-one interviews were conducted. Research participants were considered eligible if they met the following criteria:

- a) Originating from one of the above-mentioned countries
- b) Left their country of origin following violence or conflict
- c) Aged 18 years and above
- d) Had used health services in the West Midlands

All the interviews were conducted in English as all the research participants were able to speak English.

Data Collection

seven focus group discussions with 10 participants each were used to collect data from research participants in the first instance. Each focus group discussion was followed by 3 one-to-one follow-up interviews. The purpose of the follow-up interviews was to explore further all unexhausted issues during the focus group discussions.

Focus Group Discussions

The focus group discussions were conducted in places where BSSA communities normally meet, including African restaurants, faith buildings and community centres. The researcher would begin the focus group discussions with an open question such as “thinking back to when you visited any health service, can you tell me everything that happened”. An interview guide with prompts was also created to support this process, for example prompts such as “tell me more” and “how did you feel about it”, “is there anything specific you can remember” were utilised in order to elicit more detailed and clear responses where this did not occur naturally from the conversations.

It was important that issues of potential bias within the research process were considered, for example the balance of power in the relationship between the research participants and the researchers (Kendall & Halliday, 2014). Considering this, the focus group discussions were conducted in places where the research participants felt comfortable, and the researchers kept field note diaries to note down thoughts and feelings in order to support ongoing reflection. In addition, a distress protocol was available to support the research participants who became distressed during the interviews (see more under ethical considerations).

One-to-one Follow-up Semi-Structured Interviews

Following the focus group discussions, an interview guide for the one-to-one interviews was developed to further explore outstanding issues from the focus groups. Two interviews were held following each focus group discussion.

Data Analysis

Both the focus group discussions and the one-to-one interviews were transcribed verbatim. NVivo was used to organise the data. The transcripts were analysed using thematic analysis, facilitating exploration of how the participants ascribed meaning to their experiences in their interaction with the health system, according to their needs (Gill, White, & Cameron, 2011). The data from the focus group discussions and interviews were analysed together. The analysis started at the focus group and interview stage, with the researchers keeping field notes on thoughts, feelings and emotional responses emerging from the interview process and discussed content. The analysis was carried out

in 4 key phases (Serrant-Green, 2011) to make sure that the researchers were fully immersed in the data while confirming the meaning accorded to it by the research participants and other associated groups that mirrored the research participants.

The focus group discussions with the research participants lasted for 1 hour while the one-to-one follow-up interviews lasted for 30–45 minutes. **All the focus group discussions and interview data were subjected to the 4 phases of the Silences Framework (Serrant-Green, 2011), the analysis method used for the qualitative data, as follows:**

Phase 1: Following transcription, the output from the interviews and focus group discussions was analysed by the researchers, and recurrent themes were identified as the preliminary findings from the study.

Phase 2: The preliminary findings from phase 1 were reviewed by the research participants in the presence of the researchers, who noted down any comments and reflections. These were used to enhance further critique, confirming or refuting the findings from phase 1. **A discussion of the findings was formulated and moved to phase 3 for further analysis.**

Phase 3: Further analysis of the findings from phase 2 was undertaken by social networks of the research participants. The participants in this phase were drawn from the BSSA communities and had not taken part in the focus group discussions or interviews. The aim was to consolidate the findings from phase 2 with a critical indirectly associative eye.

Phase 4: Finally, the researchers reflected on the findings from phase 3, revisiting, reviewing and developing emerging themes, which formed the final output of this study. **Fig 1 below shows the four phases of data analysis as explained above.**

Fig 1 The four phases of data analysis.

Source: Green (2011)

Ethical Considerations

All the research participants were given an information sheet to read and signed a consent form prior to participating in the study. They were furnished with information about supporting organisations. For example, if they took part in the study and got affected, they could access help

from these supporting organisations. The researchers also enlisted the services of a post-trauma counsellor to support the research participants during the focus group discussions and interviews, in case they were affected by taking part in the study. The research study was approved by the research and development unit at the Heart of England Foundation Trust (NHS) and the ethics committee at the University of Wolverhampton.

Results

Following transcription, coding and analysis of the focus group discussions and follow-up interviews, the study found that perceptions and attitudes of BSSA communities in accessing health services included **difficulties in navigating the health system, intrusive and embarrassing questions from clinicians, stigmatisation through offering an HIV test, culturally unfriendly counselling support, unconfidential services, and episodes of trauma flashbacks.**

Theme 1: Difficulties in navigating the health system

Difficulties in navigating the health system were evident for 63 of the 70 research participants. *"I couldn't figure out where to get sexual health services and maternal services as I was pregnant and not feeling well following sexual and physical abuse in Goma,"* expressed a 36-year-old woman from DRC. The woman felt dejected and frustrated. Most of the research participants appeared to be confused by the set-up compared with what they were used to back home. Some felt that there was not enough information to guide service users on the whereabouts of different health services. This tended to limit the number of people from the BSSA communities who engaged with the services. A 40-year-old man from Sudan said *"Surely the whole set-up confuses me and there are no clear directions showing how you can access these services. I think there is need for the National Health Service to induct new service users on where different services are located and can be accessed."* There was a clear feeling among the research participants that the system took it for granted that all people could use resources such as the Internet to find out more about the available services, but many from BSSA communities had no access to the Internet due to their socio-economic status (settling refugees and asylum seekers).

Theme 2: Intrusive and embarrassing questions from clinicians

Of the 70 research participants, 60 felt that the questions they were asked while accessing services were at times embarrassing and intrusive in nature. Most of them felt uncomfortable being asked intimate questions or regarding issues to do with their sexual history, especially by a member of the opposite sex, which is normally regarded as a sensitive issue in their own culture. Some research participants said that, given the choice, they would not use the services again. A 40-year-old man

from Sudan said *"Honestly, I felt that this female nurse's questions were intrusive and embarrassing. She asked me the number of times I'd had sex in the last month before my arrival [in the UK] and whether I had suffered from STIs. Given the choice, I won't come back"*. The same sentiment was expressed by a 45-year-old woman from Sudan who said *"I don't like the idea that when you go into the clinic a man asks you some questions which are so intimate and at times embarrassing. My cultural values do not approve such conversations with a man, surely this is discouraging a lot of women from accessing these services."* Clearly the research participants struggled to engage with health professionals of the opposite sex when discussing sensitive issues such as sexual health.

Theme 3: Stigmatisation through offering an HIV test

Of the 70 research participants, 63 expressed concerns about being asked whether they had been to Africa and being offered an HIV test if they indicated that they had. They felt that the service was stigmatising them. A 34-year-old woman from Rwanda said, *"I felt stigmatised when the nurse asked me 'have you ever been to Africa?' In addition, when I said yes, she immediately offered me an HIV test. Honestly, what does this mean? It made no sense to me but to suspect that the service was stigmatising."* Some felt that there was discrimination, based on their experiences of colonialism in Africa, as they could not understand why such questions were being put to them. A 69-year-old man from Northern Uganda had this to say in reference to the colonial days: *"Honestly this brought back some memories of 1960s colonialism, as I thought that this was pure discrimination because I am from Africa."*

Theme 4: Culturally unfriendly counselling support

There were 62 research participants who felt that the counselling services were culturally unfriendly as they were used to being counselled by a person they knew and who would spend a lot of time with them at home. A 37-year-old man from Burundi expressed the following: *"It was so difficult for me to turn up in a room and open up about my problems to a stranger who is not even a friend or a relative, moreover you have time allocated to say all that is troubling you. This was honestly not helpful for me."* Some research participants expressed concern over the language the counsellors used, for example telling the service users to ask for any help if they needed it. This offer of help was often mistaken for material support, when in fact it only referred to social and counselling support, as explained by a 32-year-old man from DRC, *"I was so confused when the counselling services told me that if I needed any help I should contact them, but when I contacted them asking for material support they could not help. Honestly, they need to use plain language that we can all understand."*

Theme 5: Unconfidential services

A total of 68 research participants felt that the health services somehow showed no confidentiality. They were concerned about seeing different practitioners to talk about their health issues. A 42-year-old woman from Sierra Leone said *"Every time I visit the clinic I am seen by a different person reading all my private information from the screen. Back home I am used to one nurse whom I know personally. I honestly question their concept of confidentiality."* Some of the participants indicated that they were used to one professional they would confide in and talk about the issues that may be affecting them. Some research participants were also worried that some members of staff who came from their own communities would divulge some of their issues to the communities and were therefore uncomfortable, in the absence of a personal reassurance. A 45-year-old man from Rwanda said *"More so, there are other staff members who are part of our community. They can easily take that information back to the community and you know how our community is when they get such information. Honestly, there is need for personal verbal assurance that this service is safe and confidential"*.

Theme 6: Episodes of trauma flashbacks

All 70 research participants were concerned that whenever they were attended to by a new member of staff, they would be asked questions that linked to their previous experiences of trauma, leading them to experience flashbacks. A 50-year-old man from DRC said *"Sometimes I felt that I would not fancy going back to the clinic, as new staff will continue to ask me about the traumatising incidents I experienced, causing me to have some flashbacks."* Some research participants felt that keeping quiet when you were asked a question was being rude in their culture and were therefore forced to talk about some uncomfortable issues that brought back old traumatic memories. A 50-year-old woman from Burundi said *"Sometimes these clinicians want to hear all the details of your experiences. I find it so draining and very depressing to talk about such experiences. Sometimes I feel like keeping quiet and decline to say anything but again this is not acceptable in my culture as it is regarded as being rude."*

Discussion

The research participants expressed both cultural and experiential concerns about accessing health services as most of the **research participants had experienced problems in navigating the new health system**. Access to health-care services depends in part on ensuring that people have a usual and ongoing source of care and support (that is, a provider or facility where one regularly receives care). People with a usual source of care have better health outcomes, fewer disparities and lower costs

(Starfield & Shi, 2004). Navigating the health system and being able to locate the different health services available is essential for new communities. It is important for the National Health Service to consider the diversity of new communities and provide alternative methods of directing people to different health services. The BSSA communities have a culture of mainly depending on word of mouth for new information (Brown, Barry, Dacin, & Gunst, 2005). Most of the participants had no access to a computer and tended to be living in social security housing provided for asylum seekers and refugees. **Their socio-economic status made it difficult for them to access information about health facilities on common platforms such as social media and official websites for health services.**

The research study revealed that BSSA communities were sensitive to questions that touched on their sexual practices, which was likely to discourage them from accessing the services. When new communities come to a country, they bring with them different cultural practices that may affect their health-seeking behaviour (Obot, 2012). The BSSA culture is very sensitive to explicit questions of a sexual nature especially when asked by a person of the opposite sex (Ojua & Omono, 2012). This is the reason why some research participants were not comfortable with direct questions of a sexual nature. When such questions are asked among BSSA communities, they normally use more subtle language. Although there are restrictions on consultation time, clinicians should consider explaining the rationale for such questions to new communities in order to contextualise the situation. This may prevent a good number of new communities such as BSSA from disengaging from services.

The study revealed that the research participants were also very sensitive about being offered an HIV test. HIV is a sensitive subject among BSSA communities (Nyashanu & Serrant, 2016) including questions being asked pertaining to HIV testing. More importantly, most of the research participants had experiences of colonialism, which affected the way they viewed issues that tended to single out the continent of Africa as causative of a stigmatised condition such as HIV. The research participants could not comprehend why they were being asked if they had visited Africa, before being offered an HIV test. A professional would know that the question was to establish whether they had been to a high HIV-prevalent place, but this is more contentious for a layperson from the African community with negative experiences of colonialism. It may therefore be useful to explain to individuals accessing services why certain questions are being asked by clinicians, to foster a better relationship and prevent suspicion caused by ignorance of the reason for the questions.

The study also revealed that the research participants were not happy with the counselling models they were receiving in the health facilities. Traditionally in BSSA communities, counselling and support for a distressed individual would involve a close friend or relative who would spend time with the affected person, giving support (Mpofu, 1994). It was difficult for many of the BSSA research

participants to open up to a new person they had never met before. There was also the expectation that the person who was going to help them through their difficult experiences would spend more time with them. Some of the research participants felt that they were not being given enough time and were made to confide in a stranger, which is not common in their culture. In light of this, culture-friendly supportive counselling interventions should be considered for BSSA communities as a way of showing inclusivity and increasing cultural competence among staff working in health and social care.

The research participants felt that the services at the health facilities were not confidential, according to their definition and understanding of the term. Confidentiality is a key aspect in either encouraging or discouraging people in the use of health facilities (Reddy, Fleming, & Swain, 2002). However, the concept of confidentiality can vary according to the cultural meaning given to it by a group of people. One of the key factors raised by the BSSA research participants was that they did not have confidence in the confidentiality protocols followed by the health services they accessed. Back home, the BSSA communities were used to accessing a service manned by a person who belonged to their community and whom they had known for years. This generated confidence to trust the person and feel that whatever they shared with them would be kept in strict confidence. This situation was contrary to what they found in many health services in the UK, as so many professionals who were not known to them operated the services. This may have caused the BSSA communities to exercise caution with potentially helpful clinical information, thereby negatively influencing their recovery rate (Kripalani et al., 2007). Considering this, new communities should be made aware of how their information is kept confidential. More importantly, professionals working with new communities need to understand their concept of confidentiality in order to effectively address their worries about accessing health services.

The study revealed that some research participants were affected by flashbacks of past trauma as a result of talking about their experiences to the practitioners. Post-traumatic stress disorder (PTSD) is a type of anxiety disorder which develops after being involved in, or witnessing, traumatic events (Javidi & Yadollahie, 2012). The condition was first recognised in war veterans and has been known by a variety of names, such as "shell shock". However, it is not only diagnosed in soldiers. A wide range of traumatic experiences can cause PTSD. The BSSA research participants reported that they were not comfortable with being asked about their past traumatic experiences, which often happened when a new professional attended to them, thereby causing them to experience flashbacks. While it is important for clinicians to understand the experiences of the patient that caused the illness (McElroy & Townsend, 2009), there is a need to assess the impact of bringing up past traumatic experiences the patient has undergone in light of their state of health. Furthermore, individuals from war-torn zones attending treatment centres in host countries should be identified for treatment for post-traumatic

stress when they show signs of being affected (Airhihenbuwa & Webster, 2004). Clinicians should therefore consider lighter tones of conversation with individuals from conflict zones who are accessing services. Other forms of information-seeking, for example through records, could be utilised to prevent patients from having trauma flashbacks.

Recommendations and Implications for Future Practice

The NHS needs to consider other methods of communicating with diverse communities about the different health services available. New methods such as the use of social media and word of mouth within communities should be considered. Cultural competence in the delivery of health services is key to inclusivity and maximum utilisation. Training in cultural competence for health professionals should be considered, as well as ensuring that new communities are informed about the culture and practice within the NHS when accessing services. More importantly, BSSA migrants need to be made aware of the rationale for questions they are asked. The concept of confidentiality is complex and culture-bound. It is therefore imperative that new communities such as BSSA migrants are reassured that the confidentiality protocol is safe, in order for them to trust the services and use them effectively for their positive well-being.

Limitations and Future Research

There were some limitations with the sample and methodology utilised in this study. For example, the participants were all drawn from the West Midlands region so the results may have been influenced by the health service set-up in this area which may be different from other areas such as London or Greater Manchester. A high proportion of the research participants (60 out of 70) were women, who are normally more receptive to health messages compared with men. It is therefore likely that the experiences would have exposed more challenges if an equal number of men and women had been involved in the study. The methodological approach was qualitative in nature and therefore did not consider representativeness in terms of the findings. For future similar research it might be useful to utilise a mixed method approach to enable generalisation of the findings to the wider BSSA migrant community in the UK.

Concluding Comments

The experiences of BSSA migrants who sought health services in the West Midlands in the UK demonstrated important implications for future practice and informed service delivery. There is a need to consider cultural education for both BSSA migrants and health professionals to enhance understanding and trust between the groups. Basic professional training for health professionals should also encompass the needs of the growing ethnic populations in the UK.

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Fig 1 the four phases of data analysis

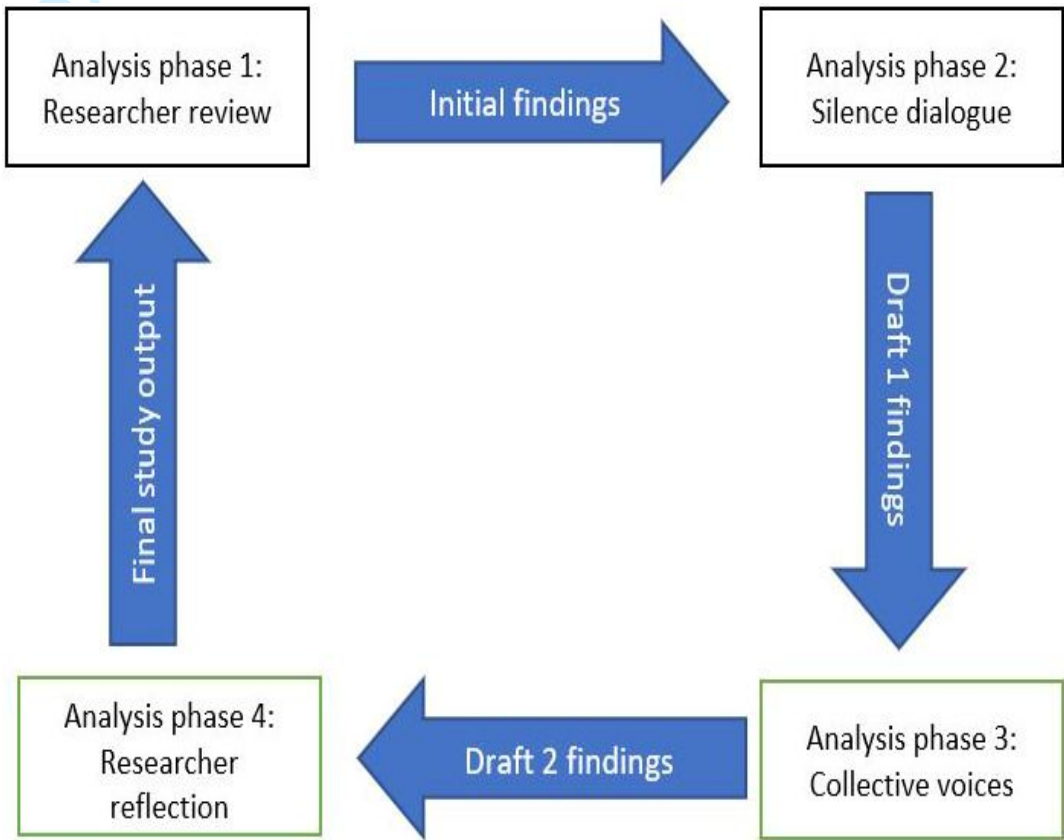


Table 1: Profile of research participants

Country	Male	Female	Age range	International language spoken
Democratic Republic of Congo	1	10	25–60	English, French
Uganda	2	10	35–60	English
Sierra Leone	1	10	30–55	English
Sudan	2	10	28–59	English, Arabic
Liberia	1	10	30–58	English
Rwanda	1	5	29–70	English
Burundi	2	5	32–58	English
Total	10	70		70