Improving health outcomes for Syrian refugee women and children: an Appreciative Inquiry study on the role of the health visitor

Kathleen Mary Clarke

Doctor of Nursing

University of Stirling

Faculty of Health Sciences and Sport

February 2021

Declaration

I declare the work in this thesis is entirely my own unless otherwise acknowledged.

KMClarke

Kathleen M. Clarke

Date: 28th February 2021

Copyright

Abstract

Syrian families can have poor health outcomes and face challenges accessing care. Few studies have considered the health visitor role in improving the health and wellbeing of Syrian women and children. The health needs of the women need to be understood within their cultural context, but these may not be familiar to health visitors.

A two-cycle research study using Appreciative Inquiry was undertaken in Scotland. Twelve Syrian women from two support groups participated in Cycle 1 interviews and in co-creating a vignette that was used in Cycle 2. Eleven health visitors from three Health Board areas contributed to Cycle 2, participating in a telephone interview.

Thematic analysis generated six themes related to the lived experience of Syrian women: 'rabbits in the headlights', 'loss of home', 'reclaiming home'; and health visiting practice: 'thrown in at the deep end', 'above and beyond', and 'you don't know what you don't know'. A range of health concerns and challenges impeded access to health care. These include complex systems, unclear professional roles, appointment delays and transport. Despite experiences of multiple loss and social isolation, the women showed resilience, although the language barrier often hampered integration.

Health visitors had not been included in pre-arrival meetings for Syrian families and usually had limited knowledge of Syrian society and culture. As well as facilitating access to health care, through 'bonds, bridges and links', health visitors potentially could promote Syrian women's 'belonging' and wellbeing. Training for health visitors should draw on an intersectionality framework in order to challenge homogenous and stereotypical notions of what it means to be a Syrian refugee woman and meet their care needs.

This research may provide a constructive route for health visitors to better contribute to improved health and wellbeing for Syrian women and children and will inform health visitor education and practice.

Acknowledgements

Contents

Glossary of Abbreviations and Acronyms Used

CHI .... Community Health Index Number

EPDS .... Edinburgh Postnatal Depression Scale

ESOL .... English for speakers of other languages

FGM/C .... Female Genital Mutilation/Cutting

GIRFEC .... 'Getting it right for every child'

GP .... General Practitioner

HV........................ Health Visitor

HVs....................... Health Visitors

NHS .... National Health Service

HVP .... Universal HV Pathway in Scotland (Scottish Government 2015)

NICR .... NHS Invasive Clinical Research

NMC .... Nursing and Midwifery Council

PND .... Post Natal Depression

RCN..................... Royal College of Nursing

RCT .... Randomised Controlled Trial

SVPRS .... Syrian Vulnerable Persons Resettlement Scheme

UK........................ United Kingdom

UNICEF .... United Nations International Children's Emergency Fund

UNESCO .... United Nations Educational, Scientific and Cultural Organization

UNHCR................. United Nations High Commissioner for Refugees

Codes used in data collection:

HVQ .... Health visitor questionnaire

HVIV .... Health visitor interview

SWIV .... Syrian woman interview

SWCCG .... Syrian woman co-creation group

List of Figures

List of Tables

List of Photographs

Prioritise People

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

Nursing & Midwifery Council (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. London: Nursing & Midwifery Council.

Chapter One: Introduction

This thesis is a study of one aspect of health visiting (HV) practice where I recognised that there may be a need for additional research and education. HV practice has continuously responded over the years to meet policy and legislative changes, as well as to the demands of casework. This has been, for example, evident in recent years, with increasing numbers of refugee and asylum-seeking families from areas in the world where their lives are at risk.

This chapter introduces the study, starting with the aim, and provides the background with an overview of Syrian people's situation with their heath and cultural considerations. The role of the HV is explained, as are some pertinent terminologies.

HVs are predominantly women and will be referred to using female pronouns. This does not underestimate the value of men who are HVs, who form a scarce resource. Furthermore, the study will mainly refer to Syrian refugee women as Syrian women, their foremost identity.

1.1   Study aim

Millions of Syrian families are dispersed throughout the world and a large number now live in the UK. These numbers grow as people continue to escape the Syrian civil war to begin new lives. The Syrian Vulnerable Persons Resettlement Scheme (SVPRS) (Home Office 2017) provides a safe route of entry to the UK that, in collaboration with United Nations High Commissioner for Refugees (UNHCR), grants leave to remain in the UK for 5 years. The *Home Office (July 2018, p. 32) funding* scheme prioritises:

> *women and girls at risk; survivors of violence and/or torture; people with legal and/or physical protection needs; people with medical needs or disabilities; children and adolescents at risk; persons at risk due to sexual orientation or gender identity; and people with family links in resettlement countries*

It could therefore be assumed that many people arriving would be in need of health care. Access to healthcare is an essential human right that each person needs in order to optimise their health and wellbeing. Where English is not the refugee's first language, this can be challenging, and even more so for refugees who have additional burdens, such as safety concerns, to cope with. Refugees can have complex health needs and there may be a poor uptake of health services as, to access services, they face many challenges (Soares and Tzafalias 2015).

Health visitors (HVs) are registered nurses or midwives with additional public health education who have responsibilities for the health and wellbeing of children and families;

they oversee child development in the early years and work closely with families, supporting their parenting. HVs fulfil the key role of the Named Person, as advocated by Scotland's 'Getting it right for every child' (GIRFEC) policy (Scottish Government 2020a), delivered through the Universal Health Visiting Pathway (HVP) (Scottish Government 2015). They have the advantage of visiting families with children under school age in their own home. Many refugees are young adults, predominantly women with children, who are entitled to receive this universal HVP service. The health and wellbeing of the women and children may partly depend on the HV identifying and understanding their needs, but these health needs and their cultural preferences may not be familiar to the HV.

The role of the HV in providing support for Syrian women and children has not been adequately explored to date. This study considered these issues. The aim of the study was: *To explore the health visitor role in improving health outcomes for Syrian refugee women and children.*

1.2   Background

My current professional role is as an educator within a health visiting programme. Previously, I was a lead nurse for child welfare and protection and a HV. I am also a registered adult and mental health nurse. I approached this study with knowledge and experience of the HV profession. Further, I recognise the valuable support that HVs provide to families, communities, and to future generations.

During 2015–16, I was privileged to be in contact with a large number of HVs across Scotland undertaking a Continuing Professional Development (CPD) programme funded by the Scottish Government to support the implementation of the new Universal HVP (Scottish Government 2015), and the introduction of the Children and Young People (Scotland) Act 2014. I was in clinical practice and a teacher on the CPD programme.

As part of the programme, a short session on cultural awareness was delivered, following which most HVs indicated this was an area of practice they knew little about. Many HVs were unaware that they may need additional education until this session. They stated that the mandatory equalities training that they had attended had merely raised awareness on discrimination policy and legislation regarding disability, diversity, gender, sexual orientation, race, beliefs and religion. Knowing more about the heterogeneous nature of the groups with whom they were working was raised as an area for education, including refugees and asylum seekers. Most relied on a telephone handover from a midwife following a new birth, passing on cultural facts, such as where interpreters may be needed or times to avoid

visiting, information they regarded as relevant to the family. However, frequently the HVs found this information to be incomplete.

The HV caseloads were increasingly culturally diverse; a number of families had arrived from Eritrea and others were beginning to arrive from Syria, with more expected. Some families presented with particularly challenging situations for which HVs knew little about. The HVs worried about the effects of traumatic wartime experiences of those on their caseload, and how they as HVs might care for them. Furthermore, the HVs had little time to research the relevant cultural information.

1.3 Syrian refugees and the context of migration

Having discussions with resettlement officers, HVs and the Syrian women, over time, it was revealed that the distressing drivers for migration experienced by the Syrian families often shape their experiences and their health and wellbeing. For instance, experiences such as having been forced from their homes, fleeing bombings, shootings, sexual assaults, and rape. Mental and physical trauma from the hazards and risks from mines and chemical warfare can also feature (Jabbour et al. 2018). On leaving their homes, many have left their possessions behind. Their families can be separated, their communities have been disintegrated, and some have lost close family members. Many faced difficult journeys to reach Scotland; parents carried their children and precious few belongings to neighbouring refugee camps, where many remained for months and even years.

The protracted Syrian civil war, of almost ten years' duration, has meant that some children were born during conflict. Families initially live in shanty towns and camps following dispersal, where staying alive is the first and principal objective. The sanitation is poor, food is scarce and of deficient quality, and disease spreads readily. Children suffer from a lack of healthy nourishment, which has an impact on their growth and development. Modigell et al. (2020) reported that 4.6 million are suffering malnutrition, and 74% of these are children. This is severely impacting on children's growth and development, with 137,000 under-fives affected by wasting, and one in eight children having stunted growth. Furthermore, one in three pregnant women are severely low in iron and other essential nutrients, which poses a serious risk to the development of a healthy foetus. Moreover, pregnant women often feed their children before themselves. Some of these pregnant women will have been raped and go on to have babies (Azizi et al. 2017). Around 248,000 (4%) of the women who have fled to adjoining camps are pregnant and require immediate care and medical attention for themselves and their new-born babies (Modigell et al. 2020).

Survival is extremely challenging; food and humanitarian aid gets through sporadically, and water and food, as well as clothing, are regularly in short supply. There is a psychological burden of hopelessness which resonates throughout the camps, and huge risks are regularly taken by some to move on to a desired better life. Hebebrand et al. (2016) noted that, in 2015 alone, 5000 shipwrecks were recorded, and where, of the 89,000 people who were rescued, 69% were from Syria. As I write this thesis, the COVID-19 pandemic has spread around the world, causing a vast number of deaths and severe illness. It is taking hold in the refugee camps where the measures to manage it are limited.

Glasgow was the host city in Scotland for the initial Syrian arrivals, as it had the most experience with other refugees and asylum seekers and had built up a wealth of knowledge and expertise on such groups. All 32 Scottish authorities have since followed on, with each now willing to house Syrian families.

1.3.1 Syrian refugee health

The health of Syrian refugees is a major public health concern (Orcutt et al. 2019). It was recognised that many people arriving from Syria could present with a number of health and social concerns (Orcutt et al. 2019). It is possible, however, that some of these initial health issues could be addressed before arriving in Scotland.

Health issues are known to include infectious diseases such as tuberculosis, cholera and polio. These spread throughout the camps with high numbers of fatalities due to poor sanitation. Chronic conditions, such as diabetes, arthritis, exhaustion, and parasitic infections, are prevalent (Orcutt et al. 2019). Inclement weather, along with malnutrition, had an additional impact on health, exacerbated further by inadequate clothing and poor shelter. Some families have to sleep in the open when the camps are full, increasing ill health risks (Modigell et al. 2020). Mental ill health, including post-traumatic stress disorder (PTSD) symptoms, depression and anxiety, are prevalent (Killian and Agathangelou 2018).

Women and children can be extremely vulnerable. Many women have not received health care during pregnancy. Hence there is a high infant mortality rate (Higginbottom et al. 2020). Scott (2016) also noted that many women became pregnant within a year of migrating to New Zealand and presented with complications. Some had never received previous maternity care. Female genital mutilation/cutting (FGM/C), a traditional practice prevalent on women from the Middle East, further complicates pregnancy and childbirth. There may also be honour-based violence, modern slavery, and radicalisation, where disaffected young people in particular can be influenced by extremist influencers and go on to engage in terrorist activity (Christmann 2012); and human trafficking, each adding further layers of

complexity. Child protection issues with sexual abuse and exploitation prevail (Mercy Corps 2021; Reid 2020).

Immunisation is another major health priority, and with unavailable or inaccurate records, makes the task extremely challenging to deliver. Furthermore, the storage of vaccines is far from satisfactory, so many, if received, could be ineffective.

Women and children can form a high percentage – 80% – of these migrants (Modigell et al. 2020), and HVs are a key profession to make early contact with the families following their arrival in Scotland. They can help to facilitate registration and engagement with health services. HVs therefore need appropriate education to meet Syrian people's health needs, and ensure that they receive person-centred care that is commensurate with their ethnicity and vulnerability.

1.3.2   *Syrian Vulnerable Persons Resettlement Scheme*

The Syrian families come to the United Kingdom (UK) through various routes and most journey on to Scotland under the Syrian Vulnerable Persons Resettlement Scheme. This scheme was introduced to the UK in 2014, intending to transport 20,000 Syrian people most in need of medical care and relief from torture, to be re-homed and receive the care needed (Home Office 2017). This plan is an addition to those plans already in place to support vulnerable children and asylum processes. The UK government provides support in many forms to people affected by conflict in Syria, and to neighbouring countries such as Jordan, Lebanon, Turkey, Egypt and Iraq. Of the more than 7,000 Syrian people who have already arrived in the UK, over half of them are children (Home Office 2017), and over 3,200 Syrian people have now arrived in Scotland by 2021 (MacKinnon 2021).

1.4   Terminology

Confusion and misunderstandings exist with regard to the terminology used to describe migrants, asylum seekers and refugees. The following definitions, used by the New Scots Refugee Integration Strategy 2018–2022 (Scottish Government 2018, pp. 79-81), will be adopted in this thesis.

An *asylum seeker* (or person seeking asylum) is someone who has lodged an application for international protection under the United Nations 1951 Refugee Convention (UNHCR 1951) or Article 3 of the European Convention on Human Rights (1953) and is awaiting a decision from the (UK) Government.

A *refugee* is a person who, 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' (UNHCR 1951).

The office of the UNHCR, also referred to as the UN Refugee Agency, works internationally to support refugees and works with the Home Office as part of UK refugee resettlement programmes.

The UNHCR (2018, p. 2) adds the following definitions:

> *Displaced person*: 'A person who has been forced to flee their home and has crossed an internationally recognised state border'.

> *Internally displaced people*: those who have not crossed their country border.

> *Migrant*: the term 'migrant' does not exist at the international level. 'Migrant' is an umbrella term to cover both migrants and refugees. Migrants may move across international borders to improve their lives by finding work, or in some cases for education, family reunion, or other reasons. People may also move to alleviate significant hardships that arise from natural disasters, famine, or extreme poverty. Blurring the terms 'refugees' and 'migrants' takes attention away from the specific legal protections that refugees require.

1.5   Health visitors

Health has been defined as a 'state of complete physical, social and mental wellbeing, and not merely the absence of disease and infirmity' (WHO 1946). HVs are in place to support maximum health outcomes for families, with a clear focus on enhancing health rather than treating disease. They are highly trained specialist public health nurses who provide a universal home visiting service in the UK to families with children under school age (Smith 2017). Four founding principles remain central to HV practice:

- ❖ *The search for health needs.* This provides the framework for an ecological health assessment, action and review.
- ❖ *The stimulation of an awareness of health needs.* This principle aims to inform and support individuals, families and communities to improve their health.
- ❖ *The influence on policies affecting health.* To be active in informing policy progression from an evidence base.

❖ *The facilitation of health-enhancing activities.* Supporting activity towards making positive health improvements in communities, for families and individuals. (Nursing and Midwifery Council (NMC) 2004).

The key purpose of these core principles is to improve health outcomes through addressing health inequalities. HVs promote health and wellbeing, taking a health-enhancing 'salutogenic' approach from the individual's own world. This is central to the approach that health visiting takes to the Syrian refugees in meeting their health and cultural requirements while valuing their coping strategies. This means that practice is orientated to a 'strengths' or 'assets-based' approach, with a focus on health promoting. Originating from Antonovsky (1996), salutogenesis explains how some people respond well when coping with stressors in their lives, in contrast to those who struggle. He recognised that people's situation has an impact on their ability to be well and considered health promotion from a holistic perspective. People's ability to cope is central to salutogenesis. Mittlemark and Bull (2013) suggest that the time has arrived for his concept to be stretched to encompass wellbeing, not just the prevention of disease. To enhance wellbeing, HVs empower people to make healthy choices, and take into consideration family resources and strengths on which to build capacity, with the aim of reducing health inequalities (Cowley et al. 2013; Doi et al. 2017). Furthermore, HVs help to educate and prepare people for becoming parents. They support and guide parents with their children's health and development. Fundamental to HV practice is engaging early with families, preferably in the ante-natal period, following the birth of a new child, or when families move into their area, which is important for building trusting partnership relationships (Doi et al. 2017). These relationships are essential to support family uptake of services and improve health chances (Cowley et al. 2013). Home visiting is a key factor in establishing these positive relationships (Doi et al. 2017). Following implementation of the Universal HVP in Scotland (Scottish Government 2015), which offered additional home visits, mothers have felt more able to build reciprocal trusting relationships. Key to the success was familiarity, having the same HV to confide in, and offering consistent advice (Doi et al. 2017).

Families possess a wide range of cultural and ethnic backgrounds, and HVs are pivotal in helping families who come to the UK from elsewhere to settle, access health care and integrate within their new communities. In recent years, many Syrian refugee families arriving in Scotland have young children, and many women are pregnant or become pregnant following arrival, and it makes sense that HVs are equipped to provide these families with optimal care as they may be in early contact with them from arrival, and need to be able to communicate effectively and facilitate support for their healthcare needs (Drennan

and Joseph 2005; Burchill and Pevalin 2012; Baldwin and Johnson 2017). Furthermore, the women may be dependent on them recognising and responding to their health needs (Quickfall 2014; Baldwin and Johnson 2017). Yet, little preparation for these skills may be included in their training (Malone et al. 2016). Further, HVs may be unaware that they have a deficit in knowledge and skills and may lack understanding of what is required. Faced with language barriers, HVs are then less likely to devote time to establish the positive relationships that are needed to offer an effective service (Malone et al. 2016).

1.6   Cultural considerations in health care

For this thesis, the definition of culture, drawn from UNESCO (1982) (as cited in The Universal Declaration on Cultural Diversity (2002), p. 18) is adopted:

> *a set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and […] that encompasses, not only art and literature, but lifestyles, ways of living together, value systems, traditions and beliefs.*

In this study, it was important to understand how groups such as Syrian women and children related to and accessed health care because Scottish roles and services may be different to their previous experiences. Their own beliefs and values would very likely influence how and when health care is accessed in the UK. Understanding beliefs regarding illness, causes, and notions of wellbeing, with the value placed on specific types of care, is crucial for health care provision and to ensure that the correct help and support is available when needed. Some Syrian families, for example, may play a major role in caring during times of illness. Different mental health beliefs and emotional pain can further complicate care delivery, for example, when the stigmatisation of mental illness is a barrier to understanding in some cultures (Altschuler 2013). Similarly, the spiritual and religious practices connected with health and illness need to be incorporated in assessments to provide holistic person-centred care. In providing health care, Walton et al. (2014) suggest being cautious against making assumptions based on country of origin or religion, without communicating effectively with the recipient. For instance, issues such as touch can be particularly sensitive and difficult to negotiate without some understanding of its underlying meanings and explanations.

1.7   Cultural practice

Ethnocentricity, the concept of viewing the world from one's own cultural stance, can result in errors in judgements, and decisions may not be made by practitioners in the person's best interest (Altschuler 2013). This can lead to restricting people's care without taking

cognisance of individual cultural requirements. Sensitive cultural practice, often referred to as cultural competency in the literature, is the ability to deliver care with dignity and respect, to meet traditional, spiritual values and beliefs. For example, ensuring culturally suitable hospital gowns are available when attending for procedures. HVs should aim for cultural sensitivity and awareness (Baldwin and Johnson 2017). The language supporting cultural practice is often used interchangeably, as with cultural sensitivity, competence and safety, which are not always explicitly defined and can be confusing (Sharifi et al. 2019). Cultural 'competence' as a concept may in itself prove to be problematic. To be culturally aware and build that awareness into practice is to understand as well as to have the ability to communicate with a wide range of people, from different backgrounds, ethnicities and race (Leininger and McFarland 2002; Gerrish and Papadopoulos 1999). However, this notion is challenged by Heaslip and Smith (2016), who acknowledge that, due to rapid globalisation, it would be impossible to have this ability for the many people with whom they are in contact. Instead, a more organic approach, where the practitioner gains an understanding of differing values, beliefs and traditions, recognising differences is more realistic. Furthermore, the concept of cultural competency is becoming an outmoded concept. Intersectionality is the more current, nuanced and preferred term, which recognises ethnicity and 'culture' as aspects of multiple identities, including gender, age, social class or caste (Crenshaw 1989). So, these intersect in particular ways and would avoid homogenising 'Syrian women' to only one group, class/caste, geographic area, religion, education, aspect or experience.

Cultural knowledge and practice are increasingly prominent and influential in nursing (Markey and Okantey 2019), although the UK lags a little behind other countries, such as Australia and USA. For instance, those responsible for preparing the revised NMC standards for HV practice, due in 2021/22, are only now planning to explicitly include this aspect, however, more recent content is included in key textbooks (Baldwin and Johnson 2017; Condon and Thomas 2021).

Despite this, there is a dearth of literature to underpin education programmes and to facilitate HV practice to meet patient-centred care in a culturally sensitive way (Lawrence 2014). Education programmes designed to challenge biased attitudes and behaviours lie at the centre for developing a workforce that is sensitive to patients' requirements, whatever their ethnicity. This will avoid misunderstanding the needs of people, which could be unintentionally discriminative, and is essential (Narayanasamy and White 2005). For HVs, there is a need for greater knowledge and understanding to ensure that they show respect in people's homes, and do not become embarrassed, or cause embarrassment, through ignorance. Piacentini et al. (2018) highlighted that the topic of cultural exchange when

delivering health care in the home is an under-researched area. Furthermore, HVs need to be able to distinguish between traditional cultural parenting practices and safeguarding the wellbeing and protection of children (Quickfall 2014). Providing accurate and relevant advice and guidance, such as with infant weaning, is essential for HVs. Otherwise, their service lacks credibility and respect for the people they serve. Cultural education is not yet aligned within all programmes of nurse education in the UK, however, and wide variations exist with the interpretation and delivery of this topic.

I was interested in education for HVs and considered their approach to cultural needs within the intersectionality framework to underpin the study. Understanding people's cultural needs requires HVs to have the knowledge, skills, capacity and positive attitude to deliver culturally appropriate and compassionate person-centred care. This requires a holistic assessment to include cultural needs and is an absolute necessity in the foundation for health care planning (Leininger 2002).

1.8 The role of the interpreter

The interpreter is important for both communicating between the researcher and the Syrian women, and also for facilitating between HVs and Syrian women. The benefits and challenges of professionals working with interpreters has been documented (Jackson 2007; Quickfall 2014; Burchill and Pevalin 2014); and Maršanic et al. (2017) acknowledge the role of interpreters in explaining cultural practices. However, service users have encountered particular challenges when being dependent on interpreters for translation, in many circumstances (Martzoukou and Burnett 2018). For instance, being confident to access an interpreter and use their expertise effectively is important, but interpreters often are volunteers and may not be available when needed. Without interpreters, some areas have tried to compensate as outlined by Martzoukou and Burnett (2018) by using flash translation cards at medical consultations, but these were not always useful, as some people were not literate.

Known issues include maintaining confidentiality when working with professionals, applying acceptable behaviours throughout the session and working to established high standards (Williams 2005).

Complications can arise, for example, when family members or friends are used to translate (Williams 2005). Sometimes parents' own children will be used, and this poses heightened challenges, both in the appropriateness of using a young person and with raising health issues when sensitive and private matters may need to be discussed. Furthermore, when people from the community are used to interpret, they may not apply the same confidential

standards as those hired from an agency. Nevertheless, is should not be assumed that those from an agency will always apply higher standards (Williams 2005).

Interpreters themselves have reported concerns when enacting their role (Piacentini et al. 2018). Sometimes they can feel ignored and disempowered in a clinical situation, feeling as though they are in the way. Or they may be expected to do more than interpret, such as explain health advice, which may be outwith their capacity (Piacentini et al. 2018).

There exists a national register of interpreters, the National Register of Public Service Interpreters (NRPSI), which sets and monitors standards of practice. A code of conduct is required to be followed by those listed on the register. Interpreters need to be trained to promote high standards, so that the user knows what to expect and how to manage any concerns. When standards fall below expectations, the implications can be serious, such as breaching confidentiality or negatively influencing legal decisions. Professionals who use interpreting services also require to be trained to maximise the benefits and to anticipate and minimise any problems. Not everyone appreciates the need for professionals to be trained in advance of using interpreting services, and, consequently, practitioners can struggle and get into compromising situations. Williams (2005) suggests that the service user also needs to be trained in using interpreters to enable them to gain maximum benefit. This means that each person in the interpreting relationship is trained to understand and benefit from the interpreting function.

Using interpreters in research is an important area for consideration in this study. Wallin and Ahlström (2006) completed a systematic review and reported on the dearth of evidence in this area, illustrating that many studies that relied on the services of interpreters did not discuss the role. From the 13 studies reviewed, they articulated the ways in which professionals aimed to guarantee trustworthiness, through careful selection of the interpreter, working with the same interpreter for the duration of the project, and triangulation of the findings. Tsai et al. (2018) concur, and suggest that building quality assurance processes into the research design helps to mitigate any risks, especially with cross-checking data. Being aware of these points in advance of this study was helpful in its planning.

It was therefore useful to have considered this role in relation to the Syrian women and the HV to facilitate communication between them, as well as for me, in being the principal researcher, in applying strategies to work effectively with interpreters when collecting data for the study.

1.9   Summary

Syrian people arriving in Scotland are likely to have a range of health issues which will need attention. Having ease of access to health care would help them receive the appropriate and timely treatments they require. A large number of refugees are women and children, each of whom have particular health needs and are entitled to receive a health visiting service. It was useful, therefore, to have considered their health concerns and inquired whether HVs could assist with better access to care and improve their health outcomes. However, HVs may not have a sufficient understanding of the health issues and cultural contexts of these families, or have the necessary skills in order to meet their needs appropriately.

1.10   Thesis overview

Chapter One provided the background to the study and outlined the Syrian refugee situation and their health issues. It continued with a concise explanation of the role of the HV especially their unique contribution to family wellbeing through forming close relationships. It then considered key definitions and concepts and highlighted cultural issues for practice. In particular, it identified potential gaps in HVs' understanding of the health and cultural contexts required to meet the needs of these women and children appropriately.

Chapter Two sets out the policy context, following which the review of the literature in Chapter Three provides evidence which informed the research questions. The methodology and methods are presented and justified in Chapter Four, and this chapter includes the quality assurance considerations made and the steps taken to facilitate these. Next, the ethical decisions related to the research are considered in Chapter Five. The findings from Cycle 1 are then presented in Chapter Six, with the findings from Cycle 2 detailed in Chapter Seven. The meanings attributed to these findings are discussed in Chapter Eight, which concludes by making recommendations, written as Provocative Propositions, in line with AI. The thesis concludes in Chapter Nine with a reflexive account, which provides an explanation of the study strengths and limitations along with implications for practice. The appendices include an article draft for publication.

Chapter Two: Scottish Policy Context

This chapter considers the relevant policies for HV practice in supporting refugees in accordance with the research study presented in this thesis. The four selected from the many policies in place were identified as being universal and to which the Syrian families were entitled. Each of these policies are relevant to HVs in delivering care to Syrian families and are important for meeting the Syrian families' health care needs. These policies include the GIRFEC framework in Scotland (Scottish Government 2020a), the person-centred care approach to quality approved healthcare delivery (The Healthcare Quality Strategy for Scotland, Scottish Government 2010a) and the Universal HVP (Scottish Government 2015). Furthermore, Scotland has in place a multi-agency strategy to support refugee families to integrate with Scottish communities: the New Scots Refugee Integration Strategy 2018–2022 (Scottish Government 2018).

2.1 'Getting it right for every child' – GIRFEC

GIRFEC (Scottish Government 2020a) has transformed children's services in Scotland over the last decade, combining many strands of children's services under one umbrella. Most practitioners and families anywhere in Scotland now recognise the language used in the policy and its ethos of promoting the wellbeing of children. The National Practice Model (NPM) is the set of combined tools representing GIRFEC; the terms GIRFEC and NPM are regularly used interchangeably. The development and implementation of GIRFEC has been challenging at times, particularly where legislation was intended to legalise roles and responsibilities, and this instead resulted in parts being revoked. Legislation was deemed necessary to speed up the implementation of the policy and its consistency across Scotland. However, public challenges, made through the legal system, resulted in a Supreme Court judgement, and parts of GIRFEC policy to be legislated were found to be in breach of a family's right to privacy, with the potential for inappropriate information sharing (The Supreme Court 2016; Black 2020). Nevertheless, the practitioners' roles remain in national policy and a major cultural shift in practice has taken place. This facilitated collaborative working through a recognition of agency responsibility for leadership to respond to need and to co-ordinate the various networks of support. In turn, solutions to childhood difficulties have been tackled at an earlier stage, avoiding many delays, and prevented crises (Stradling et al. 2009). However, as Coles et al. (2016) recognise, challenges to full implementation remain, particularly for aligning practice with child protection procedures.

GIRFEC approaches have moved parents and carers from a central role alongside the child in a family model to surround them in supporting roles, with the child at the centre of their

world. This model emanated from Bronfenbrenner's (1979) ecological theory, which proposed how, in a family system, the interacting components of a child within their specific family and community context determines their success in life. He showed how families' ability to cope with the stresses and pressures they encounter influences their ability to parent and hence can influence children's health. This is recognised in the three key components forming the GIRFEC NPM: the 'wellbeing indicators'; the 'my world triangle'; and the 'resilience matrix'. Each of these elements form the assessment building blocks for analysis. Assessment and analysis, from applying these tools, inform a child's plan, where interventions can be agreed and monitored. While there has been considerable debate over a definition on wellbeing, which can be interpreted in different ways (Coles et al. 2016), these wellbeing indicators are now enshrined in law, and represent a wellbeing definition for Scotland (Children and Young People (Scotland) Act 2014). The indicators and their associated instruments have largely been accepted and supported by practitioners, institutions and families. The clear advantage is that families benefit from a consistent approach across agencies who are working together to support them (Scottish Government 2010b). Nonetheless, in practice, elements of the model can be cumbersome and time-consuming to complete, for which practitioners are encouraged to seek guidance and training from GIRFEC champions or leaders to help them better understand this important way of working (Scottish Government 2010b). To support practitioners, managers are expected to have change leadership and training available to develop systems and to educate the workforce of the changes in culture and in practice required; in turn, it is assumed that these will help reduce concerns (Scottish Government 2010b). Nonetheless, there is little empirical evidence from the workforce of their experiences of implementing and working within GIRFEC procedures. Most evidence is government-led, and this is recognised as being consistent with other integrated models in the UK and wider afield (Smith 2018). Practising HVs and trainee HVs on the programme have reported on the burden of additional paperwork, and The Royal College of Nursing (RCN) recognises these concerns (RCN 2017). Furthermore, information is not always presented in an accessible format for service users which may exclude the very people to engage who need support (Smith 2018).

2.1.1   The National Practice Model (NPM)

The United Nations Convention on the Rights of the Child (1989) provided the platform for construction of the NPM model. This international treaty outlines the entitlements of children aged under eighteen years, in addition to those of adults, in fifty-four articles. Part 18 of the Children and Young People (Scotland) Act 2014 sets out each stage of the GIRFEC model.

Stage 1 – The Wellbeing Indicators (SHANARRI): safe, healthy, achieving, nurtured, active, respected, responsible and included. These indicators provide a vehicle by which practitioners can consider each area of a child's needs and identify any deficits that may need further assessment. Prevention, minimisation and mitigation of any risk to the child is essential.

Stage 2 – The 'My world triangle': places the child at the centre of assessment within their surrounding ecology – their family and community and wider society – enabling practitioners to assess the range of factors that contribute to and influence their individual situation.

Stage 3 – The 'resilience matrix': helps to balance the factors in a child's world that cause adversity and vulnerability within their resilience and protective elements, facilitating a comprehensive analysis for decision-making, which helps to inform and construct the child's plan.

These three stages are underpinned by the key principles from the GIRFEC approach.

2.1.2   The GIRFEC principles

These principles form the key concepts for utility within these stages of the model and explain its essential elements. These are:

- *Child at the centre:* this principle originates from the earlier Children (Scotland) Act 1995, which clearly emphasised that the child's needs were paramount.
- *Wellbeing*: this concept recognises that the child's health, with age and stage of development, as well as their circumstances, are dynamic, and that these benefit from a holistic approach to their needs. Coles et al. (2016) argued that the concept of wellbeing is not well understood and is difficult to define, but these wellbeing indicators are now set within the Children and Young People (Scotland) Act 2014.
- *Collaborative working:* recognises that sharing information for children in need supports safeguarding.
- *Early identification of need and early intervention:* recognises that intervening earlier in a child's life, and at the earliest opportunity to mitigate risk, results in the best outcome.

The model is intended be used proportionately and in a timely manner, to meet the child's needs. However, professionals may not always understand this, and often overly complicated children's plans are developed. For instance, some blank child's plan templates are over ten pages long before any content is added, and then can reach twenty pages or

more when complete. Similarly, in a review of integrated family assessments, Smith (2018) noted how families can struggle to read and understand them. Some areas have developed easily-read and children's versions, which may be helpful, but GIRFEC was intended to reduce bureaucracy and paperwork. Furthermore, a national child's plan is not available, so, when children move areas, the existing plan is not always compliant with the new Local Authority area.

2.1.3   GIRFEC roles

Two specific roles were introduced to enact parts of GIRFEC policy. One attracted controversy when it was set out for legislation, that of the role of the Named Person (Scottish Government 2020b). The other role, the Lead Professional, was not included for legislation, so attracted less attention. One of the main critical points is the overlapping features between both roles, causing blurred boundaries (Stradling et al. 2009). Another, regarding information sharing, is discussed later.

The Named Person role was introduced for children, from birth to age eighteen, to provide them with a single point of contact – a professional person to oversee their wellbeing (Scottish Government 2020b). Local Authorities and Health Boards provide the Named Person service. For children under school age, this is a role that the HV (or a Family Nurse) fulfils. For school-age children, this is a head teacher or depute head teacher's function. This Named Person is a unique concept for HVs in the UK, as such provision only occurs in Scotland. Stradling et al. (2009), in the early days of the policy implementation, recognised professionals' struggle with adopting the role, who were having difficulty grasping how the role was to be fulfilled. Supporting evidence was noted, however, in that, with Named Person interventions, there was earlier identification of need and engagement with additional services (Scottish Government 2010b).

The introduction of new children's legislation in the Children and Young People (Scotland) Act 2014 embraced the entirety of the GIRFEC principles and set out to legislate with the intention of ensuring that all children in Scotland would be supported with a consistent approach, wherever they lived. This included having the Named Person made available to them. What had not been worked out though, was that information sharing, to meet the lower threshold of wellbeing as opposed to children at risk of harm, would be necessary. Consequently, the breach of data protection and human rights legislation was possible (Black 2020), as was a potential breach of *The Code* (NMC 2018). Following court challenges, two parts of the legislation were revoked, one part being the Named Person role (pt. 4). Coles et al. (2016) pointed out that, had this been passed, families could feel

unnecessarily under scrutiny, and this could impede already established relationships. This view was supported by the RCN (2017).

The Named Person service, however, remains in policy (Scottish Government 2019). This means that Local Authority areas can decide whether to adopt the role. It is not now imposed on them. Nevertheless, some HVs may feel uncomfortable fulfilling a role that the families may not support, and so lose the trust of those families because of a fear that HVs may pass on information about them to others (RCN 2017). Furthermore, the search for a consistent approach has been weakened as a result.

Other HVs are fearful of errors in judgement when carrying out the requirements of the role, particularly in this ambiguous area of information sharing, which could place them at risk professionally (RCN 2017).

The key requirements of the Named Person are to co-ordinate care, and to identify and manage risk of harm to children (Scottish Government 2020b). Consistent with how HVs currently practise, the Named Person provides information, advice and guidance, helps families access health services, or refers them to other agencies as necessary, and, crucially, acts as a single point of contact (Doi et al. 2017; Isdscotland 2021). This aspect was requested by parents who were tired of repeating their stories to different professionals, and children needed to know to whom they could turn to for help when needed (Scottish Government 2001). However, another issue arises with concerns for the number of Named Persons with whom a family may need to communicate, as one is available to each child under eighteen years of age. This is not an area yet reported on, but, when there are several children in a family, this can be a different person for pre-school, primary and secondary ages, and can vary between children in the same family who attend different schools or those with additional support needs. This could be an added complication for Syrian families to comprehend, as Scottish families struggle with this concept when the Named Person is intended as a single point of contact. Nonetheless, Syrian families need to know about and understand this role, along with its associated responsibilities, to ensure that they have access to this service in the same way that other Scottish parents do.

The Lead Professional role, on the other hand, is activated when a multi-agency plan is needed for high level or complex issues, where they co-ordinate and review the plan, such as a child protection plan.

This study considered how the Named Person role was enacted by HVs and received by the Syrian women. However, as discussed next in the person-centred care section, there is

conflict when adopting the child-centred model, particularly when parents have their own health needs.

2.2   The healthcare quality strategy for Scotland 2010: person-centred care

The three aspirations for healthcare quality, as defined by the Healthcare Quality Commission, are to deliver safe, effective and person-centred care. Each of these elements are important, but, for this study, it was the delivery by HVs of person-centred care for Syrian women that was explored, and, consequently, that is the focus of the discussion. Person-centred care is one of the twelve priority areas identified in the Healthcare Quality Strategy, and defined as:

> *Person-centred: providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions.* (Scottish Government 2010a, p. 22)

Person-centred care changed health care delivery from one that followed a biomedical model in the doctor-patient relationship, to one that recognises the individual behind the 'patient' label (Godfrey et al. 2018). The balance of power shifted to considering the individual as a partner, whose views are equal or more important than those of the professional, thereby supporting their human rights. Previously, individuals may have relied on others to make decisions about them without their input. Now, it is widely accepted that the professional needs to actively seek views and encourage contribution from people at all stages of the decision-making process. Forming a partnership relationship to empower people to make decisions for themselves requires a supportive model to achieve these wishes, one 'that takes into account the whole person – not a narrow focus on their condition or symptoms but also their preferences, wellbeing and wider social and cultural background' (The Health Foundation 2016, p. 6). Furthermore, recognition is assigned to delivering a service where individual needs are respected in overall strategies. Quality improvement in service delivery is apparent, and cost benefits can be measured (The Health Foundation 2016). The value of this approach is also evident in workers' job satisfaction. This is shown to be nowhere more important than when caring for those who are affected by dementia (Godfrey et al. 2018), for example, where the challenges faced in implementing person-centred care in a hospital environment for vulnerable people cannot be overestimated. Godfrey et al.'s (2018) study showed how professionals struggled when there was insufficient staff on duty to fulfil the requirements for providing person-centred care and became disillusioned. Over time, they were less likely to maintain this care approach, which took more effort and was more time-consuming. Bender et al. (2017) concur, promoting

transformative leadership to champion person-centred care. The issues for providing person-centred care in a community context, particularly in HV practice, are less likely to meet these same obstacles. Nonetheless, I would argue that it is especially important to commit and deliver person-centred care for Syrian women, who may have a range of health and social care needs, and where language is an immediate barrier. McCormack et al. (2015) emphasise the efforts needed to provide person-centred care as being essential for promoting human dignity. The World Health Organization (WHO) (2007, cited in McCormack et al. 2015, p. 3) promote this holistic approach, while being cognisant of meeting cultural and ethical wishes. To this end, cultural shifts in practice may be required to encompass this philosophy of empowering people to direct their own needs in order for professionals to respond in a respectful, meaningful and humanistic way. The One Person-centred nursing framework (McCormack and McCance 2010, cited in McCormack et al. 2015, p. 4) situates the individual as being central to the care model, similar to that in the GIRFEC approach for children, with the added positionality of professional and organisational contributions to effect person-centred care. The person is central to support mechanisms for themselves. Syrian women are included in decision making while placing their child at the centre in GIRFEC policy, the model applied by HVs, but the women may have their own personal care needs and are entitled to these being person-centred approaches for themselves, as provided by HVs in the Scottish National Health Service (NHS).

> *NHS Scotland is committed to understanding the needs of different communities, eliminating discrimination, reducing inequality, protecting human rights and building good relations by breaking down barriers that may be preventing people from accessing the care and services that they need, as well as meeting the legal duties in relation to age, race, disability and gender. It aims to address inequalities by recognising and valuing diversity, promoting a person-centred approach and involving people in the design and delivery of healthcare.* (Scottish Government 2010a, p. 24)

This policy supports their own entitlements, and this commitment to equality is congruent with the topic of this study.

Cowley et al. (2013) promote the salutogenic approach, valuing people within their ecology, as being paramount to contemporary HV practice. HVs have delivered a family-centred approach to practice for decades (Cowley et al. 2007), but GIRFEC policy has shifted their attention to placing the child at the centre of their world with the 'my world triangle' (Scottish Government 2016) (Appendix 1). As such, it may not effectively represent a mother with her

own health needs. Yet, she is entitled to person-centred care from the HV for herself, for example, in relation to such issues as post-natal depression (PND) and breastfeeding.

Placing this focus on the child in GIRFEC is necessary to promote the best outcomes for children and to ensure that each member of their network of support is working to the same goals. However, the care provision for mothers is not clear, and, for Syrian women, could indicate that the GIRFEC model does not include care for them. The model illustrates pictorially (Appendix 1) how the parent is not situated in the centre with the child. So, the model does not represent a parent with their own needs, and may be confusing when the parent may also need care. Consequently, a layer of complexity emerges that the HV needs to navigate to provide for a mother, as well as the child. Many midwives follow an ante natal GIRFEC pathway for pregnant women, but their care plan does not routinely pass to the HV at handover (Evans et al. 2021). Also, this plan has been critiqued for creating stigma when only applied to women with additional support needs (Cross et al. 2012). The GIRFEC model allows for consideration of the impact of a mother's illness on the child, but does not highlight her needs, her support network, or care plan. The HV could be at risk of caring for the child while losing sight of the mother's health needs. However, this focus on the child could also represent how the HV is responding to the mother's needs (Coles et al. 2016). I would argue that this not necessarily an automatic development and so could easily be overlooked. Since GIRFEC implementation, HVs regularly emphasise their role in caring for children of under-school age, in contrast to previous practice, of being a 'family' oriented practitioner (Chalmers and Whittaker 2017; Malone et al. 2016). HVs do provide support to mothers, but it is currently unclear how person-centred care has been applied to specifically meet a mother's needs, especially for her cultural requirements, and these may be different to the needs of the child.

Such concerns, in not being adequately addressed for the mother, may be a weakness of the GIRFEC policy. To explore these concerns, this study considered how person-centred care was applied in HV practice for Syrian women.

2.3   The Universal Health Visiting Pathway

HVs work within the Universal Health Visiting Pathway (HVP) in Scotland (Scottish Government 2015), an evidence-based framework produced following a review of HV services. The review sought to maximise the expertise of the HV workforce to deliver the national agenda to reduce health inequalities for future generations, and to support GIRFEC implementation. The concepts of prevention, early identification of need and early intervention are supported in the HVP (Scottish Government 2015), as is the distinctive role

for HVs as a Named Person. A set number of home visits and contacts are set out in recognition of the need to build supporting relationships with families, but also to ensure families receive a consistent service and know what to expect. To this minimum set of core visits, the Scottish Government (2015, p. 4) adds certain responsibilities:

> *HVs exercising the function of a Named Person on behalf of their Health Board will be required to be available and responsive to parents to promote support and safeguard the wellbeing of children by providing information, advice, support and help to access other services.*

To gauge the needs of Syrian families, as assessed by the HV, the review asked about the allocation of the Health Plan Indicator (HPI) to understand the HV service level applied to Syrian families. The Health Plan Indicator is a national tool applied by HVs in Scotland to all families on their caseload, which denotes the service provision following assessment. Following assessment, which is dynamic and continuously reviewed, the HV is able to allocate families to a service delivery pathway based on need, through the allocation of the HPI. Resources can then be allotted, and, in cases where vulnerability is identified, a tailored approach, with additional home visits, can be taken.

2.4   The New Scots Refugee Integration Strategy 2018–2022

Scotland has developed a multi-agency strategy, to support refugees and asylum seekers to integrate into Scottish communities (Scottish Government 2018). This policy is central to the research undertaken here in this thesis. It suggests collaboration across agencies, promoting a sharing of expertise and resources, and adopts a rights-based approach for users; one which is inclusive, person-centred and non-judgemental. This is clearly demonstrated with input to the strategy from over 700 refugees. Contributing their lived experiences to the development of the policy adds authenticity, which helped shape its content towards actual needs. The Syrian people who arrived after 2015 were involved in shaping the strategy from 2017 (Richards and Gundel 2017). It confirms refugees' entitlement for free person-centred NHS care and treatment, in the same way that all Scottish citizens are. GIRFEC also applies, for their children's benefit. 'Integration' in the strategy is defined as:

> *The process of people settling and being welcomed into a community, being able to access the services they need and to participate in society.* (Scottish Government 2018, p. 12)

To realise this aim, integration is supported by multiple agencies from the moment of arrival. Positive relationships are encouraged, within welcoming, open and supportive communities, each acting to empower and support refugees and maintain their human rights. Unlike the English policy, where refugees are expected to adapt to our ways, the Scottish policy recognises the added value that each refugee contributes, in enriching our multicultural society (Hepburn 2020). This evidenced-based strategy acknowledges the enhanced benefits to individuals and wider society of the approach.

Syrian families arriving on the resettlement scheme are assisted to register with a General Practitioner (GP). It is unclear whether they have any choice as to who or where they can register. Neither is it clear whether they receive assistance to comprehend the roles of other members of the primary care team, or who, how, when and where to access health services and meet urgent care needs. Key issues to improve their health and wellbeing are understanding of entitlements, and health services, with access to interpreters and the education of staff with appropriate skills and knowledge. These themes were consistent with the intended study aims, supporting action point 3 in the government action plan:

> *Refugees and asylum seekers are able to access well-coordinated services, which recognise and meet their rights and needs.* (Scottish Government 2018, p. 61)

Refugees need to be able to improve their own health and, for this to be realised, they require access to the most appropriate service when needed. Health inequalities add further to the burden of Syrian refugee families (Scottish Government 2018). Consequently, strategies to improve refugee health and wellbeing through exploration of the HV role for them is an aim worth pursuing to benefit them, their children and, ultimately, for future generations to come. Research with refugees to augment and increase knowledge and understanding is also promoted, and the knowledge gained from this study can add to this.

The health needs of refugees are a devolved responsibility from the UK Government. The health strand of the Scottish strategy is of interest to this study in terms of how it serves Syrian women and children's access to health care. The respective role of the HV in providing culturally appropriate health care and support to improve health outcomes for Syrian refugee women and children was important information gathered for this study.

2.5   Summary

The numbers of Syrian refugees continue to rise in Scotland. It was important to understand the lived experiences of Syrian women and children as well as gain insight into HVs'

perceived competence in providing health care for them. The range of policies discussed in this chapter support the aims of this study, and there are a number of unclear issues. It was useful, therefore, to explore how each policy is enacted in practice.

Chapter Three moves on to review the literature.

Chapter Three: Review of the Literature

3.1   Conducting the review

The aim of the literature review was to identify and evaluate studies related to Syrian refugee women's healthcare. The review was designed to consider the methodologies, key concepts, theories and findings of these studies, as well as to highlight areas where further inquiry could be useful, in order to inform the development of this study.

Hart (2006, p. 13) defines a review of the literature as:

> *The selection of available documents (both published and unpublished) on the topic, which contain information, ideas, data and evidence written from a particular standpoint to fulfil certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed.*

However, confusion exists in defining a literature review, as a range of approaches can be applied and these are not always fully explained (Grant and Booth 2009; Arksey and O'Malley 2005). For example, in some reviews there can exist minor differentiating features between professions when taking the same approach, resulting in different explanatory definitions. These differences can be very minor, and it is not always clear why (Grant and Booth 2009). In addition, the scoping review has been criticised for being less rigorous than others, as it does not require full synthesis of the findings. It can, however, be undertaken to support the justification for completing a full systematic review (Arksey and O'Malley 2005). Sometimes a scoping review can be conducted as a rapid review, which can be misunderstood in being too quick and therefore may imply less rigour (Arksey and O'Malley 2005). However, Arksey and O'Malley (2005) do refute this assumption and go on to suggest there are no reduced cost benefits which can often be presumed. As with other methods, Arksey and O'Malley (2005) claim rigour and transparency are absolutely necessary components in all scoping reviews to ensure quality.

Systematic reviews are the gold standard for reviews of literature and are necessary, particularly for evidencing medical advancement where a high bar for attainment of standards is demanded (Bryman 2008). To this end, there is a need to meet audit requirements and to minimise bias in making clinical decisions (Bryman 2008). It may seem that taking this approach to attain these highest standards would be the best review approach to select for any study. However, this dedication and attention to seek out all studies in support of the review question would require additional time and resources to

accomplish. This extra time and effort for systematic reviews is essentially a study in itself, particularly when a meta-analysis of quantitative data is undertaken, and this would not be essential to inform this study.

Accordingly, a scoping review method was selected for this study as it sets out to 'identify the nature and extent of research evidence' (Grant and Booth 2009, p. 101). This would help to reveal what was already completed in the field, with whom, where, when and how the studies were undertaken. The analysis from this approach aims to reveal the quantity of studies as well as appraise the study design and literature methods; and identify gaps for further exploration. This review method is consistent with many approaches tried and tested therefore would be a validated approach to help inform this study (Grant and Booth 2009).

Other reviews, such as the systematic review, would be more concentrated on a complete synthesis of the findings, guided by a specific question, to address research methods, whereas my review was intended to explore a range of research methods to inform this study. Also, a meta-analysis would focus on quantitative studies for statistical analysis, and a narrative review does not appear to contain each of the elements included in a scoping review method, which together provided the background and context for my study.

The appropriate type of scoping review to complete is further determined by the outcome required, as four techniques have been identified, each tailored for a specific purpose (Arksey and O'Malley 2005). As previously mentioned, these include: rapid reviews; or reviews to inform the requirements for a systematic review; reviews to summarise studies in a form accessible to policy decision-makers; or, as in the review conducted in this study, those designed to highlight areas for further research. For the latter method, there is no requirement to weigh up the evidence or comment on its value.

The approach taken to the review applied in this thesis comprised the five stages suggested by Arksey and O'Malley (2005). These are: Stage1 – identifying the research question; Stage 2 – identifying relevant studies; Stage 3 – study selection; Stage 4 – charting the data; and Stage 5 – collating, summarising and reporting the results.

This review of the literature was conducted to identify the potential health and wellbeing requirements of Syrian families arriving in Scotland, to grasp the range of health issues that the HV may encounter, and to find out what distinctive cultural needs should be respected and supported. As the Syrian refugees in the study entered the UK via the resettlement scheme, it could not be assumed that they each have the same health needs or that they have the same difficulties in accessing health care as other refugees and asylum seekers.

Further, the review aimed to establish what HVs already know about the health and cultural needs of Syrian families, whether their understandings are accurate and relevant, and whether they feel sufficiently equipped to meet their obligations. It was important to uncover the lived experiences of HVs in responding to the health care needs of Syrian refugee women and children in particular, and to check whether they perceived that their educational qualifications had met the cultural knowledge and skills required to provide safe and effective practice to this particular group. In addition, a key element of this review was to identify an area for research where a contribution to existing knowledge can be added.

Stage 1: The research question:

> *How can health outcomes be improved for Syrian refugee women and children?*

Four key questions were developed to explore:

1. What are the potential health issues of Syrian refugee families arriving in Scotland?
2. What are the specific perceived or expressed cultural needs of Syrian refugee women and children?
3. What are health visitors' experiences of supporting Syrian refugee families and how competent do they feel?
4. How educationally prepared do health visitors feel in providing culturally sensitive health care to Syrian refugee families?

3.2   The search strategy

The search strategy incorporates Stages 2 to 5.

Stage 2: Identifying relevant studies

Parameters and search terms with inclusion and exclusion criteria were developed in order to extensively search for pertinent literature. Two searches were undertaken, one at the outset of the study, which was then updated in 2020. The search engines utilised in the review were CINAHL, Health Source, InterNurse, socIndex, and MEDLINE with EBSCOhost. All texts, written in the English language, and no time parameters were included in the first search as the volume of hits could not be anticipated. For the second search, time parameters of 2015–2020 were applied, to supplement the previous search with more recent findings. Key words and search terms, including multiple combinations of these, consisted of: 'refugee', 'migrant', 'asylum seeker', 'Syrian', 'UK', 'nurse', 'health visitor', 'public health

nurse', 'health professional', 'health issue', 'cultural sensitivity', and 'education'. Boolean 'and/or' searches were included. For the literature search flow diagram, see Appendix 2.

Stage 3: The study selection

In this stage, the inclusion and exclusion criteria were set (Table 1). One article, Martzoukou and Burnett (2018), acquired from an open access university repository, may not have been peer reviewed, but was included in the review as it was deemed relevant to national data.

Table 1: Literature inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Empirical studies	Non-specific discussion papers and brief editorials
Peer reviewed, with one exception	Broad-based populations without specific reference to Syrian, refugee or asylum-seeking people
English language only	Non-English language
Full text only	Abstracts only
Health issues specific to or including Syrian or refugee people	Non-human-related studies
Cultural issues specific to or including Syrian people	Specific only to citizenship
1st search No date parameters	
2nd search 2015 to 2020	Before 2015
	Full text articles with reasons

Stage 4: Charting the data

During this stage, the author(s), date, journal, article title/subject and aim, methods, size, findings, summary, conclusions, recommendations, limitations, comments, and key messages were noted.

The studies were dated from 1997 to 2019 with the majority published during the last decade due to a notable increase in research conducted following the Arab spring uprising of March 2011, which led to the civil war in Syria. Qualitative studies featured more prominently,

However, surveys or questionnaires are less likely to capture the lived experiences of participants. Global studies are also represented.

These subjects highlight the health challenges which might have been faced by the Syrian refugee families before arriving in Scotland and may still be problematic for them. This information will be useful for HVs to know about, to recognise and identify any issues and provide culturally sensitive person-centred care. This information will also, be useful for educators in preparing HVs for this role. The review identifies what is already known from HV practice in supporting refugee families and shows areas where less evidence is available.

Stage 5: Collating, summarising and reporting the results

The framework for reporting was drawn from nine themes, identified as being important to inform HV education and practice for their salutogenic role with Syrian families: data context; health needs and access to health care; children's health; women's health; cultural considerations; female abuse; mental health; HV practice and cultural education; and practice models.

3.3   Data context

Firstly, it is important to set out the challenges faced when gathering data, during and post-war, to recognise and take account of their unique issues (UNHCR 2016). Gathering health data during war is fraught with inconsistencies, as medical records cannot be depended on. They are not always available or accurate, and people are not always truthful, which makes drawing conclusions more uncertain (Garfield 2008). For instance, although it is against WHO recommendations, countries can refuse to allow entry to refugees on the basis of chronic health conditions. This is due to ongoing medical costs, for which they do not wish to be burdened. Australia, for example, refuses people diagnosed with physical and mental disabilities, cancers, renal impairment and HIV (Abubakar et al. 2018). As such, people affected by these illnesses hide them and avoid seeking medical help. Furthermore, it complicates accurate data collection in host countries if people with certain conditions are barred from entry. For this study, one group of participants are from Syria, a country at war, so, many of the studies identified in this review emanate from war areas and displacement countries.

3.4   Health needs and access to healthcare

War negatively influences the ability of people of all ages to keep well, particularly those diagnosed with chronic conditions (Sevinç and Kiliç 2016), and care is interrupted by

continuous moves, which disrupts ongoing treatment (Al-Fahoum et al. 2015). Barriers to healthcare is a recurring problem for Syrian people, as discussed in many studies (Al-Krenawi and Jackson 2014; Meiqari et al. 2018) – for those who remain in Syria, those who have been displaced outwith Syria, and those being resettled. Solutions to mitigate the challenges faced by these people are few.

Syria has had a third of its hospitals destroyed in the conflict, and there are serious shortages of medicines and supplies (Jabbour et al. 2018). People may not have received effective health care for some time and worry about underlying conditions (Al-Fahoum et al. 2015). For those in need of medications, many take huge risks, making dangerous journeys to adjoining countries in anticipation of treatment. Women and children are disproportionately affected; often women are in urgent need of obstetric care (Orcutt et al. 2019).

For people displaced from Syria, navigating new healthcare facilities in the host country and refugee camps is frightening (Al-Fahoum et al. 2015). Jordan, Turkey and Lebanon are countries adjoining Syria to where refugees regularly escape. It is known that Syrian people present at a much younger age for health treatment, and women attend more frequently than men. This is connected to female-only issues of fertility and childbearing, but can also be due to having to cope alone while men are away fighting (Sevinç and Kiliç 2016).

However, in a cross-sectional analysis in Jordan, in a questionnaire, women reported poor health in 24.3% of cases, while 59% men reported having very poor health (Al-Fahoum et al. 2015). In the camps it was recognised that those who were worried gave a negative view of the health care provision. Yet, most had access to the same high standard of health services as did the Jordanians. This may be explained by the psychological response to war, where people become highly anxious, are in fear of their safety and are in more need of immediate support (Al-Fahoum et al. 2015). This may be an important factor of which to be mindful in the delivery of health care for refugees in Scotland.

Sevinç and Kiliç's (2016) retrospective records analysis lacked depth in not talking with the participants and was further limited by the significant difference in the population sizes studied and the age differences between the control and study groups. These are reflected in the chronic disease patterns presented; with digestive, circulatory and liver diseases prevalent in the older Turkish group, and with renal and genito-urinary diseases in the Syrian study group.

Accessing health care in a resettlement country was studied in two connected studies in the UK (O'Donnell et al. 2007). One study incorporated language-appropriate asylum seekers as facilitators for six focus groups with 36 participants. The other study engaged 16 participants in researcher-led interviews with an interpreter. The participants came from African countries, Iran and Syria. A number of concerns were raised, such as registering with a GP of choice, time to wait for appointments, and access to interpreters. The participants were not made aware of the range of health services or how to utilise them, and so at times resorted unnecessarily to emergency services. One area employed an asylum support nurse, who facilitated primary health care access and was most beneficial. Nonetheless, the nurse was employed in only one area, and the duties were limited to registration and health checks. Positive relationships were formed with health professionals. Highlighted was the HVs, who fostered within them a sense of worth, having visited their homes, which is a useful factor of note for this study.

A further study inquired how best to address refugee information needs from arrival in Scotland (Martzoukou and Burnett 2018). Interviews with three integration leaders and six focus groups, with 39 new refugee settlers from Syria, were conducted. An art exercise captured ideas and was useful where literacy ability was unknown. The refugees had received a welcome pack, but the health services information within it was not well absorbed, as other issues at arrival took priority. The transition from camp to host country was reported as being particularly disorientating, so written materials were found not to be the most useful resource at that time. The participants used digital instruments for all sources of information. Understanding what is useful in terms of communicating with new Syrian arrivals is therefore helpful information for HVs to know.

In addition, a range of factors, such as age, gender, ability to cope, transport, mobility, communication, and distance to services with childcare needs, stacked up to impede access to health care. Children's health and wellbeing featured prominently.

3.5   Children's health

Children are particularly vulnerable to war conditions, and their physical, mental and emotional health suffers. However, with early intervention in the host country they can recover and progress well in both their education and in achieving their ambitions (Lorek et al. 2009).

Meiqari et al. (2018) reported from a Médecins Sans Frontières study, which interrogated qualitative and quantitative data from reports and data sets in Northern Syria. The analysis indicated that malnutrition, infectious diseases, and respiratory and gastric conditions are the

key contributing factors to child deaths. Over 50% of children had not received any vaccines as immunisation programmes were extremely challenging to deliver.

One study, a section of a longitudinal study with children aged 5 to 17, took place two-to-three years after migration to understand how well they had developed from arrival in Australia (Lau et al. 2018). Of the children, 76–94% were reported to have developed within normal ranges, and better progress in school correlated with better health and wellbeing. The age group 14 to 17 showed that the refugee boys had performed much better than the Australian boys had, but the girls did not show the same correlation. This could be a result of gender issues, such as sexual abuse and emotional pressures, or that these issues are not experienced, or are lesser experienced or not reported by boys. It appears that, with good community inclusion, education and support, most of the young people went on to have productive lives. Similar to Syrian refugees in the UK, they had entered Australia via a humanitarian scheme, which may have shielded them from some negative experiences. Protective elements used to reduce risks and adversities in planning for the young people may be important features for their success (Lau et al. 2018). This study highlighted the benefits to them, their families and communities, and to wider society from this early investment, and may be important factors for HVs in Scotland to know of, as early intervention is a key strategy, and its application is aligned with the GIRFEC model.

3.6   Women's health

Understanding women's health beliefs can help professionals to find acceptable ways of inclusion and encourage engagement with health-promoting behaviours. Gholizadeh et al. (2011) undertook an explorative study with women living in Australia from the Middle East to understand the benefits of preventative health care from cardiovascular disease (CVD). This qualitative study formed part of a larger mixed-method study, with 66 participants in focus groups. The age range was 21–63, which may be important when interpreting the findings, as perhaps the younger women would not recognise their risk of CVD at this age. The women were not well informed, especially the older women, who had more entrenched beliefs around traditional lifestyles. However, they associated stress, particularly that linked with acculturation, as an aggravating factor for CVD.

Stress was also connected with challenges in navigating new systems and fitting into places where lifestyles may be in stark contrast to their own (Al-Krenawi and Jackson 2014). In one region in Australia, a study with 35 migrant mothers, including those from Syria, reported experiencing stress related to social isolation, conflict and coping with the new culture and

language, while aiming to hold on to traditional ways (Renzaho and Oldroyd 2014). Stress also had an impact on their health and influenced their uptake of preventative measures.

Refugee women face multiple ongoing stressful issues, especially with communicating, which contributes to low self-esteem and depression. Al-Fahoum et al. (2015) showed that 68% of refugees started smoking in the camps, with 78% of them being women. This is a serious issue, creating potential health problems should they continue to smoke, and may exacerbate chronic conditions (Abubakar et al. 2018). Worrying about those at war, others left behind, and taking care of ill family members with little support added further pressures (Gholizadeh et al. 2011; Al-Krenawi and Jackson 2014).

It is known that there is a reduction in births as a consequence of the separation of men and women during war. But there is a very worrying rise of cervical cancers and HIV due to changes in sexual behaviour, including rape, leading to high papilloma virus infection rates (Inhorn and Kobeissi 2006). Cervical screening is critical to save lives, as it is holds the highest death rate for women in times of war (Inhorn and Kobeissi 2006), and this needs to be better understood by women.

Researchers in the USA undertook an exploratory study on female health screening (Salman 2012). Multiple variables were tested and showed 86.4% of those over forty years of age had received a breast examination, with 25% too embarrassed to have one; and where 50% had received a cervical screening. Although a quarter were embarrassed, a high number did receive a breast examination, which was encouraging, and this may be due to 72% of the participants understanding that their faith allowed them to receive medical checks. Nonetheless, only 50% had attended for a cervical smear, leaving the other half vulnerable to a progressive life-threatening condition. Barriers to low attendance were no health insurance, with childcare and transport issues. The longer their residency in the USA, the more likely it was that they had received screening, and this correlated with their language acquisition. With acculturation, and adaption to USA ways, the less embarrassed they became. Syrian women arriving in Scotland may behave in a similar manner, which is important for HVs to recognise.

A limitation of this study (Salman 2012) was whether the questionnaire had been validated. All participants did not answer some questions, which could reflect the questionnaires being circulated only in English, which was not the first language of the majority of participants. It is known that acquisition of the host language can take up to ten years and is a key factor for accessing health care (Al-Krenawi and Jackson 2014). Education attainment did not appear to be a barrier to uptake of screening. Nonetheless, McLean et al. (2012) suggest that

education attainment may be an influential factor, as other commitments with work and appointment times also posed a barrier. HVs would be in a position to influence women's uptake of screening through education interventions and explanation of services.

3.7   Cultural considerations

However, cervical cancer screening and subsequent analysis are not straightforward. For Syrian women, this test is associated with being married, as unmarried women are expected to be virgins (Inhorn and Kobeissi 2006). Furthermore, women reported their embarrassment in attending appointments with the cervical test and having to wear a hospital gown. They preferred, instead, to wear something reflecting their traditional clothes. Cultural considerations enable positive engagement with services (Inhorn and Kobeissi 2006; Gholizadeh et al. 2011), and, in this case, the provision of culturally appropriate gowns could have improved attendance. Nonetheless, how and which cultural issues to consider is open to interpretation. For instance, religious beliefs and practices can vary widely, even within the same religious group. Both studies (Inhorn and Kobeissi 2006; Salman 2012) confirmed increasing uptake of screening was possible, particularly where religious beliefs had had an impact on behaviour. Women were not frightened of a cancer diagnosis, for example, for those who believed that God decides who lives and who dies. Faith, therefore, is an important cultural factor to consider (Gholizadeh et al. 2011).

Within an Arab-Muslim study group, Gholizadeh et al. (2011) recognised the subtleties between ethnic groups, where religious practices, traditions, and political perspectives can influence behaviour. However, the authors' chosen method used influences the quality of the data. Here, focus groups as opposed to questionnaires may have promoted discussions where women from the same ethnicity could then hear others' views and help with understanding the benefits of screening, while supporting integration. In contrast, McLean et al. (2012) presented questions to participants by a researcher, facilitated by describing case scenarios to explain and improve understanding. Of the Muslim women participants, 96.8% preferred a female doctor for obstetrics and gynaecology procedures, and 94.5% for abdominal examinations. Age and marital status did not indicate preferences, but those women with low literacy and who were less educated were more restrictive with their choices. The women generally desired a female doctor, whatever variables were tested (McLean et al. 2012). These preferences stem from modesty restrictions associated with religion and traditions.

Al-Krenawi and Jackson (2014) explored marriage and family life and acknowledged that Arab people predominantly follow Christian and Muslim faiths, with noticeable common traits

in religion and traditional practices. Honour is important, so many strive for a good education and income. This USA study considered the perspective of being an Arab ten years after 9/11 and two years after the Arab Spring. The issues considered cultural misunderstandings being treated as facts, leaving people confused and suspicious of each other. Identity issues, with changes of roles, were highlighted as factors that make adjustments difficult. For women, the wearing of the hijab led to discrimination and harassment, yet not wearing it could result in reprisals from husbands. The ability of women to express their health needs requires further exploration, particularly about how language, culture, and lifestyle factors interrelate and influence behaviour where tensions exist (Inhorn and Kobeissi 2006). HVs may need to navigate some of these issues and know about different practices.

In traditional Arabic-Muslim and Arabic-Christian households, marriage continues to precede having children, and male partners do not tend to be birth partners. This is in contrast to the UK, where over half, 51.5%, of children are being born to non-married couples (Registrar General 2017). The father's role during this critical time is not clear, however, and assumptions should not be made that men may not engage with women's health care. One study made it clear that the father's role was to ensure that women arrived safely at the hospital and that the children were taken care of. Also, it was also found that men would remain within the delivery suite to the point of delivery, when they would leave and then re-enter once the baby arrived (Abushaikha and Massah 2012). Emotional support and praying for women in labour was felt to be extremely important in taking care of their wives, and was highly appreciated by the women.

This small study conducted 17 in-depth interviews and five focus groups with 23 mothers and 14 fathers (Abushaikha and Massah 2012). Not all of the fathers attended hospital at the time of childbirth, due to childcare or work commitments, and so were excluded, resulting in vital details being omitted. It may have been of benefit to have arranged a meeting with these fathers at a later date to ascertain their reasoning and views.

Both researchers from this study, as with Salman (2012), were Arab-Muslim, having the advantage of understanding and supporting the cultural practices. Nevertheless, this could have had a negative impact on the objectivity of the study. Having included at least one researcher from a different ethnic background could have offered an additional perspective. Furthermore, no professionals took part, and the participants' level of education was not considered. The generalisability of the findings is therefore restricted.

Understanding traditional and cultural community context is important for HVs practising in a culturally sensitive way. Arab culture, defined by Al-Krenawi and Jackson (2014) as 'High

Context', refers to the collective body of community being more important than the individual and influences how people live their lives. Human rights are understood in a collective way, where more traditional authoritarian structures exist. Marriage will normally be arranged, and people marry into the family, not just the partner. This then influences the new couple, as they are told where to live and how to behave. Sensitive matters are dealt with privately within this wider family. Sharia Law is an example of structure and controls some practice. It is important for the professional to know to provide culturally sensitive guidance. Also, when single, there may be questions about how much freedom a woman has, whether she is allowed to work and keep her pay, and what she is permitted to wear. Sexual health matters add complexity, so it is important for the meaning of marriage and family structures to be clear and understood by health professionals.

Sexual health has been the focus of previous studies with Syrian women (Ussher et al. 2012; Al-Krenawi and Jackson 2014). Ussher et al. (2012) conducted five focus groups with 42 women, married and unmarried, encapsulating a wide age span to establish women's experiences and beliefs with regard to sexual and reproductive health. The participants were recent refugees to Australia. While these women's religious beliefs and practices stemmed from Christian and Buddhist faiths, their beliefs and behaviours were similar to those of the Muslim faith. No sex outside of marriage, with mandatory sex and becoming pregnant within marriage, were noted as rules they should follow. The study exposed the plight of young refugee women who can be vulnerable to sexual exploitation and become alienated from their communities when they become pregnant. Difficulties also arose in trying to access sexual health information, contraception and abortion. Many women revealed being a virgin on their wedding day and being ignorant of sexual practice. Same-sex relationships were discussed in the focus groups but were dismissed as not being relevant within their community.

This study was limited to women from two refugee groups and acknowledged that some women may not have revealed truthfully their experiences and views in a focus group. Individual interviews may have captured views anonymously and gleaned additional data. Further, seeking out same-sex couples discreetly and anonymously could have provided additional insights, and paved the way for others to speak out. However, it is likely that there were fears of revealing their true sexuality, as it may be illegal to form same-sex relationships. Hence, their views were omitted.

3.8 Female abuse

Refugee women are at heightened risk of domestic abuse from the tensions and pressures placed on relationships that arise out of war and displacement. Kaur and Atkin (2018) conducted a review at the intersections of policy, practice and research in Australia, where domestic abuse is a huge problem, with one woman per week murdered by her partner or former partner. Research on refugee women's experience of domestic abuse remains in its early stages, partly as a result of the many issues impacting on their lives, which can be difficult to disentangle. Gender and social class, together with race, ethnicity and settlement status, add to the language barrier that many face. This isolates women, leaving them vulnerable to abuse from the impact of the intersection of multiple issues, and lack of awareness of support (Yasmine and Moughalian 2016). The repercussions on family life can be devastating, particularly on children, where emotional abuse and separation can result. Yet, women feel powerless and fear seeking support or may not be aware of what they are entitled to (Al-Shdayfat and Hatamleh 2017; Kaur and Atkin 2018). Furthermore, it may be regarded as a matter to be managed internally within families. Others fear reprisals if their husbands were to find out that they had reported them or sought support, and the abuse could escalate (Yasmine and Moughalian 2016). Some women believed they should not confide in healthcare providers as they could not be trusted (Al-Shdayfat and Hatamleh 2017). Also, a lack of private areas in which to discuss concerns in confidence was a factor that prevented women from reporting abuse and support from being obtained.

In addition, the consequences of reporting abuse prevent many from seeking help. In Jordan, 182 women completed a self-administered questionnaire on their experiences of domestic abuse (Al-Shdayfat and Hatamleh 2017). A thematic analysis revealed that 122 married women reported one or more types of domestic abuse. Of the married women, 44 did not report it, being worried about the implications of being financially dependent on their husband, having police involvement, losing their home, or the reporting leading to divorce and losing their children.

A Palestinian study in Jordan provided some insight into the nature of domestic abuse within refugee camp communities. Al-Modallal et al. (2015) concentrated on women who had experienced two or more concurring violent incidents from their partner, of a sexual, physical, emotional, or partner-controlling personality nature, and economic restrictions. A questionnaire was completed at clinics by 300 literate married or engaged women. This, however, excluded already marginalised or illiterate women. Of these, 24.3% experienced two types of abuse, and 22.7% experienced three types. The most common abuse experienced was that related to partner-controlling personality, and these women were then

more likely to suffer other forms of abuse. Yasmine and Moughalian (2016) highlight the gender inequalities faced by Syrian women, where they endure insults from multiple sources. In Lebanon, they can face poverty, where husbands cannot work and are unable to pay rent or buy food, leaving them at risk of exploitation. The women needing to work can lead to a blurring of gender roles and contribute to violent attacks. Compounding this, there is little support from the authorities, who the women fear may also violate them. The women can be raped within and outwith marriage, they can be refused contraception and termination, and can have little access to health care, which is also expensive. Furthermore, reporting rape or not paying health care costs can risk them being arrested or deported. Single women may be targeted for abuse, and, for protection, some can take extreme measures and enter into polygamous marriage, which may also be violent. Further, younger women can be married off to older men to 'protect' them (Yasmine and Moughalian 2016).

Attitudes appear to play an important role, in that violence seems to be 'accepted' to a degree by both parties, as Al-Modallal et al. (2015) claim. The idea that a victim would accept violence needs to be questioned, as they are more likely to keep quiet to avoid shame and embarrassment, but also to avoid further abuse (Al-Krenawi and Jackson 2014). Furthermore, understanding male disempowerment needs to be addressed to avoid making things worse. For instance, it is revealed that men will often report the attack, being justified in claiming that their wife has disrespected or disobeyed him or his family (Al-Modallal et al. 2015).

What is useful knowledge within the studies from the refugee camps is that, in the camps, domestic abuse can be amplified as a manifestation of their situation. Many families go on to be rehomed, so the studies provide a window to the abuse some may have already suffered. It is possible that moving to a new country could reduce family pressures and provide opportunities to build new futures. HVs are therefore pivotal in supporting families in any of these instances.

Another feature of female abuse needs to be considered – that of FGM/C, or female genital mutilation/cutting (Love and Norton 2015). FGM/C is illegal in Scotland and is a child protection concern that HVs need to be aware of. The suffering from FGM/C is increasingly well documented, but remains a serious painful and enduring matter for those affected (Lundberg and Gerezgiher 2008; Love and Norton 2015). In a review of the literature, Love and Norton (2015) reported that many women claim to accept FGM/C and ensure that their daughters receive it to avoid any shame to the family; it can be intergenerational. However, when some women realise that it is not a religious rule, they can go on to change their views (Love and Norton 2015). This is further supported in a study with 15 Eritrean women living in

Sweden (Lundberg and Gerezgiher 2008). Semi-structured interviews revealed that the women believed FGM/C was instruction from religious teachings to protect them and keep them clean for marriage. Many had little education or were illiterate, and unable to check and challenge these regulations. Consequently, women experienced gynaecological problems and suffered ongoing pain and fear, which was exacerbated at time of childbirth when further cutting was likely. Love and Norton (2015) concur – the women worried about having examinations and the associated explanations they needed to give. A major change in attitudes can be noticed with those who move to a new country of residency, where different practices in the protection of children occur, and where views can change (Love and Norton 2015). Although Syria is not listed as one of the countries where FGM/C is most prevalent, a small number of females from Syria can be subjected to FGM/C. HVs need to be aware that this might happen to a minority of women and that children may be at risk, but also need to be very careful of making any assumptions.

3.9   Mental health

One of the main health issues identified in the literature for refugees, affecting all ages, both men and women, is mental illness from trauma.

Post-traumatic stress disorder (PTSD) is a condition where severe distress occurs following a life-threatening event to self, or with exposure to, hearing of, or witnessing others facing life-threatening violent incidents, which can lead to serious harm or death (Abu-Ras and Abu-Bader 2009). It is commonly diagnosed in refugees arriving from war zones (Killian and Agathangelou 2018). In a comparative analysis of three groups of Cypriots who suffered a range of losses, it was revealed that many refugees do not show any symptoms of PTSD. For those who do, this can negatively affect everyone in the household. Up to one-fifth of refugees can go on to experience PTSD, and violent images of war can feature as recurring flashbacks, 50 years later. People's suffering is intensified with loss of close family and friends and where sexual violence has been experienced. These findings are congruent with a large cross-sectional survey of the mental health of 1,200 Arab and Muslim communities in the USA (Abu-Ras and Abu-Bader 2009). Depression rates were high following 9/11, although some women had reported having had depression prior to 9/11, which may have influenced the findings.

Others dismiss PTSD, claiming that it is a Western construct, developed to explain a collection of distressing symptoms, and not always acknowledged by other cultures (Summerfield 2001). However, different cultures may use different ways and language to express their feelings, mood and anguish. PTSD is a recognised illness in the UK, according

to the Diagnostic and Statistical Manual of Mental Disorders (DSM), though the term can also be misused in the UK.

Exposure to violence and death, separation from loved ones, relatives not being accounted for, torture, sexual abuse and rape of themselves or their kin, all feature as risk factors for PTSD (Killian and Agathangelou 2018). Furthermore, displacement, in having to flee home and country, has a profoundly negative effect on health, where people become traumatised from the decimation of their families and communities (Almqvist and Brandell-Forsberg 1997).

It appears that, while many show remarkable resilience, mental ill health symptoms often are consistent with the magnitude of the trauma experienced. Each exposure adds an additional layer of stress, with increasing depths of mental illness (Montgomery 1998). Mental distress and suicide rates are high (Inhorn and Kobeissi 2006). The psychological symptoms include: reliving danger with flashbacks, regression and anger; sleep disturbance with intrusive thoughts, often leading to severe anxiety and depression; and, for some, anger can become difficult to manage. These symptoms can often take months or more to manifest (Almqvist and Brandell-Forsberg 1997). Notably, 55% of males expressed severe worry about their safety alongside sleep disturbance and depression. Their symptoms reduced, however, once they started to feel settled and safe in their host country (AL-Fahoum et al. 2015).

Many prefer to ignore or hide their symptoms and often do not attend appointments, fearing stigmatisation; and language barriers add complexity (Al-Fahoum et al. 2015). A number of positive influences on mental wellbeing include social supports from extended family (Abu-Ras and Abu-Bader 2009), however, for some this is unobtainable (Killian and Agathangelou 2018). Limitations arise within the Abu-Ras and Abu-Bader (2009) study. For instance, Arab people would have experienced a much higher level of abuse and racism post-9/11 and may have experienced altered mood as a result. It is not clear whether a mental health assessment had been undertaken with the participants before they took part in the study. In addition, self-reporting questionnaires may not have been the optimum method for a study such as this, where the sensitivity and empathy promoted in a one-to-one interview could have elicited a deeper discussion and may have facilitated explanations for the questions raised.

Those who viewed solutions being within their power fared better (Killian and Agathangelou 2018). Medication and talking therapies are common treatments, but they may not be a solution or viewed as being as essential, as rebuilding homes and employment are often prioritised. Also, attending therapy in some communities can be viewed as a sign of mental

illness and is not of prime concern (Killian and Agathangelou 2018). Furthermore, interpreters can sometimes filter questions, making it uncomfortable to raise, discuss and follow accurately. Added to that, women may be too ashamed to talk to husbands, fearing reprisals from having suffered sexual violence (Killian and Agathangelou 2018).

Refugee women are particularly vulnerable to PND following the birth of a child, which can significantly affect their ability to function and cope (Urquria et al. 2012). In an examination of the healthy migrant hypothesis, a theory which recognises unexpected high health status of migrants, Urquria et al. (2012) highlight the complexity of this phenomenon. In particular, increasing health deterioration, arising from an increase in smoking and obesity, can have an impact on mental and obstetric wellbeing. Statistics from developed countries show that 10 to 20% of women experience PND, and this proportion is much higher in developing countries (Shafiei et al. 2015) but is higher again for refugee women (Urquria et al. 2012). These high rates exist because of displacement and inadequate maternity services. Health inequalities and worries about paying for treatment make women hesitant to ask for help (Firth and Haith-Cooper 2018). Sexual violence, FGM/C, and rape are highlighted as known causes of PND (Firth and Haith-Cooper 2018).

Shafiei et al. (2015) conducted the first study with migrant women settled in Australia from Afghanistan where 41% of the participants reported feeling down four months after giving birth. In in-depth interviews a year later, women reported feeling disconnected and isolated far from home. They delayed seeking help as they did not expect to receive any assistance. Others reported that the health professional was seen as being too busy and only concerned about the baby's needs.

Integration added further pressures, particularly if women wished their husbands to be more hands-on like those in the host country. Shafiei et al. (2015) noted that many cases of PND go undiagnosed, as some do not recognise or understand the symptoms or look for support. Firth and Haith-Cooper (2018) point out that women's expression of PND symptoms needs to be recognised by health professionals where, culturally, these may differ, such as how they describe symptoms of physical ill health attributed to depression. As they are key professionals in caring for women in the post-natal period, the women will benefit from the HVs' better understanding of their situation.

Since the second world war there has been a growing body of literature on the impact of war on children's mental health, including that relating to PTSD (Montgomery 1998; Abu-Ras and Abu-Bader 2009; Maršanic et al. 2017). Educated parents appear to mitigate PTSD symptoms, and support resilience in their children (Reavell and Fazil 2017; Killian and

Agathangelou 2018). Sometimes, however, parents may not recognise symptoms in their own children. Almqvist and Brandell-Forsberg (1997) undertook a two-part study using the same assessment and questions repeated over two years later. In the first part, the parents believed their children to be misbehaving, but recognised these behaviours to be mental ill health symptoms in part two, as a result of the children getting older.

The magnitude of the violence witnessed was important, particularly if involving a family member and, the younger the child, coupled with the length of time exposed to war and violence, the more serious the symptoms were that they displayed (Montgomery 1998). Anxiety symptoms were exacerbated when the parent also suffered mental ill health (Maršanic et al. 2017). Children suffering abuses such as sexual exploitation, trafficking, and servitude, compounded their mental health (Maršanic et al. 2017).

In children under age six, their behaviour regresses, and they seek nurturing and close proximity to an attachment figure. Loss of a secure base, having no close adult for comfort, can lead to hyper vigilance (Almqvist and Brandell-Forsberg 1997). Sleep disturbance, over dependence, bed wetting, headaches, anorexia and developmental delay, are predominant features (Maršanic et al. 2017).

Young people may go on to develop addictions, depression and personality disorders years later (Hebebrand et al. 2016). Those who have been sexually violated may need specialised treatment. Having a significant other provided the main antidote to severe mental distress in children (Maršanic et al. 2017). But further, a key mitigating factor for children's mental health is the ability for them to play, especially outside, but this too is often denied in times of war (Montgomery 1998).

HVs are well placed to observe for signs of such symptoms. They can help and support parents to understand concerns with any of their children, and to refer on to appropriate services when required.

Having considered the health issues of Syrian women and children, this review now proceeds to discuss the respective role and education of the HV in meeting their health and cultural needs.

3.10   HV practice and cultural education

To answer the questions for this part of the review, it may be useful to clarify that the search terms for the HV's role were incorporated from the outset, and that the same databases

were searched as those indicated in Section 3.2 (Stage 2) with the same inclusion and exclusion criteria as indicated in Stage 3 (Table 1).

Little evidence was available on the HV role, including research relating to the Named Person working with Syrian women and children or their perceived health and cultural education needs. This highlights the need for empirical evidence (Lawrence 2014). Consequently, the broader literature, including community nursing and primary care teams working with refugees more generally, has also been included.

The benefits of the HV role in supporting refugee families and the challenges that HVs have encountered has been studied (Drennan and Joseph 2005; Lawrence 2014). Most studies focused on cultural competence and reported on the associated instruments for determining the level of cultural competence that an individual has achieved to show where learning is required. Lawrence (2014), Burchill and Pevalin (2014), Quickfall (2014) and Gunn (2016) have each reported how HVs lacked confidence and education in this area of practice.

HVs aim to form trusting relationships with parents, but relationships take time to establish. This is made more difficult when refugee families are suspicious of HVs' motives. Parents may associate HVs with authority aligned to their legal residency status (Lawrence 2014). Other influencing factors include the frequent house moves which interrupt relationship-building (Drennan and Joseph 2005). Language barriers in particular impede the forming of positive relationships. Nonetheless, HVs often felt personally responsible for assisting refugee families, as little support appeared to be available from elsewhere. These extra burdens could ultimately affect the HVs' own health, especially as lone workers (Drennan and Joseph 2005; Lawrence 2014). Despite this, many HVs made significant efforts to help families, even when their needs were outwith their area of expertise, such as helping with welfare benefits and housing issues (Burchill and Pevalin 2012).

From an exploratory study in inner London, semi-structured interviews were conducted with 13 HVs who worked with refugees (Drennan and Joseph 2005). The HVs recognised that they lacked appropriate education, and so turned to Maslow's Theory of Hierarchy of Needs (Maslow 1943) to ensure that the needs of children were addressed – first for their safety and wellbeing. What was not clear was why this approach appeared to work in that situation. It may be due to the absence of other models on which to draw. The HVs expressed high levels of stress and helplessness when families spoke of harrowing war experiences. A limitation of the study was that the study only looked at women in the first three months after giving birth and focused specifically on PND.

Another key HV function is the provision of parenting support. Globally, parenting styles tend to follow traditional family and cultural ways. In an exploratory discussion paper, Gunn (2016) drew attention to individualistic parenting styles recognised in the West, comparing these with collective parenting, where the wider family members have significant input in a more traditional style, as many do from the Middle East. HVs were uncertain with how to handle the parenting situations they encountered as a result of cultural differences. There were misunderstandings, and HVs found that challenging parents on some of their parenting approaches was very difficult, for example, with children being left at home without supervision. Quickfall (2014) recognises the necessity for HVs to be aware of this and to fulfil their safeguarding responsibility.

This highlighted another important element of HV practice; to identify and support the protection of children. Also identified was how to comprehend and manage cases where there was a lack of understanding of child rearing practices from the refugees' country of origin. HVs struggled to distinguish between cultural or traditional approaches and any that might be considered abusive (Quickfall 2014). Practitioners should be alert to cultural differences that may potentially mask child protection concerns (Lawrence 2014). HVs could help explain relevant family legal matters to parents who could become vulnerable to legal action by the authorities if they are unaware of national policy and legislation. For example, parents may be unaware of the legal position for girls who are at risk of FGM/C (Lawrence 2014).

HVs recognised their inability to respond appropriately to mental health issues, particularly from the reported stories heard, and distressing PTSD symptoms presented with exposure to war and the loss of loved ones (Drennan and Joseph 2005). HVs were familiar with some symptoms, such as anxiety, depression, and substance misuse, and also with PND, where HVs are confident in regularly supporting women. They also recognised that refugee women may be predisposed to low mood from social isolation (Lawrence 2014). HVs felt out of their depth at times, where several of these symptoms existed, along with other complex health and family dynamic problems (Gunn 2016). HVs need to have the ability to recognise these symptoms and provide immediate support, but they are not mental health specialists, so need services available to refer on to. It may be that HVs felt unsupported when these services were in short supply.

A further challenging area for HVs was domestic abuse, where they were concerned about asking probing questions (Lawrence 2014). HVs are alert to some women being at heightened risk of domestic abuse when they are socially isolated and do not speak the host

country language. However, they were not aware of the range or magnitude of abuse some may have experienced (Drennan and Joseph 2005).

To address cultural education requirements, practice models have been developed. Some of these have been tested, and are considered in the next section, as the cultural education of HVs is a key area of interest to this study.

3.11   Practice models

Cultural Competency emerged as a concept to address the health care needs of people from different cultural backgrounds (Leininger 2002; Clarke et al. 2009). This concept set an agenda for professionals to learn more about different cultures, and to develop skills to provide services to meet the needs of all people, whatever their culture, and was of interest to this study to address HVs' learning needs. Addressing issues such as unfounded assumptions about what might be required to meet people from different ethnic backgrounds, as well as challenging personal beliefs and biases about what their needs might be, contribute towards cultural competence. Other strands that contribute to cultural competence have arisen, such as cultural sensitivity and cultural safety. However, no globally accepted definitions exist. As such, there is some overlap in explaining how each is defined.

Practice models have been developed to address shortfalls in cultural knowledge in practice, and some of these are targeted to individual practitioners (Leininger 2002; Jackson 2007; Papadopoulos et al. 2016; Banfield and Lackie 2009), while less include organisational responsibilities, which are recognised as being important factors in creating a positive cultural ethos in the workplace and for resource provision (Quickfall 2014).

Nevertheless, the debate on whether this route leads to more appropriate care for the individual is yet to be established. Truong et al. (2014) noted benefits to patients with culturally appropriate care, for example, in managing chronic health conditions with culturally specific approaches. However, Gustafson (2005) challenged the underlying framework on which the ideas of cultural competence were based, concluding that there were weaknesses in its founding theories. It has been suggested that nothing can be proven, or indeed disproven, about the benefits of applying cultural competency strategies, due to its active properties; measuring concrete facts is not possible (Gustafson 2005). Other concerns have been raised around the possibility of introducing practitioner bias in applying cultural competency models, as well as deeper concerns in not addressing major issues of racism and prejudice in health care (Narayanasamy and White 2005). Gustafson (2005) goes further in claiming that cultural competency approaches were more likely to reaffirm racism

rather than eradicate it from practice. This in itself could suggest that some models might be explained from a cultural perspective from their own cultural origins. The Sunrise Model (Leininger 2002, p. 79), for example, emanated from the USA, where political and historical influences may be noted when reflected on, and has been challenged for not adequately addressing racist issues (Gustafson 2005). Nonetheless, the Sunrise Model was developed from an inclusive and non-discriminatory perspective involving many ethnic groups as contributors. Had Leininger (2002) not embarked on this journey, nursing theory and the delivery of holistic cultural care may not have advanced to this stage, and these subject matters may not be currently debated.

The Sunrise Model (Leininger 2002) encompasses a range of interacting elements, drawn from a world perspective on the individual's health, illness, cultural beliefs and values. Practitioners also reflect on their own values, which helps to develop their understanding (Clarke et al. 2009).

Jackson (2007) blended two models to create the Culturally Competent Practitioner Development Model, which consists of five components: cultural awareness, cultural practice, cultural sensitivity, and cultural knowledge. Together, these four form the fifth component, culturally competent practitioner. This model specifically addresses racism and oppression. The HVs in the study had omitted to include racism as a challenge to be addressed in practice, clearly highlighting an area for education. Quickfall (2014) considers racism in the negative component of her model as a deficit, but fails to include mitigation in the positive aspect, thereby being unclear about how this can be achieved.

In Jackson's (2007) study, 78 HVs completed a questionnaire. Over half of the respondents were Caribbean, themselves representative of an ethnic minority. These HVs had high levels of experience and expertise, yet, they too reported inadequate cultural education preparation, and poor skills for working with interpreters. Half of the HVs had attended training, implying that the training may not have met their learning needs or the needs of the populations they served. This finding is consistent with those of Morton-Miller (2013), who reported that educators themselves had limited knowledge and understanding of cultural issues on which to base their teaching.

The Transcultural Skills Development Model, developed by Papadopoulos et al. (2016), consists of four components: cultural awareness, cultural sensitivity, cultural knowledge, and cultural competence, and seeks to address anti-oppressive issues in practice. Quickfall (2014) developed this model further to become the Five Steps Model. This works through a progressive stepladder, where a further component 'Institutional Regard' was added as a

first step. Placing this step first was designed to acknowledge the essential role of the organisation in the support of culturally appropriate practice. Each step represents a level of attainment towards cultural competency. Positive and negative markers at each of the steps enable gaps in knowledge and services to be identified. This model was tested by Quickfall (2014) and Burchill and Pevalin (2014), and, in a further study, Gunn (2016) considered its application to HV practice.

Quickfall (2014) explored her model with 21 practitioners, including some HVs, for their understanding of cultural competence through observing their behaviour with 39 refugee and asylum-seeking clients. This ethnographic study included a follow-up interview. It was, however, limited to Glasgow, where most migrants were hosted and a specialist HV service was available, limiting wider transferability. Burchill and Pevalin (2012) tested this Five Steps Model with a small group of 14 HVs in London, conducting in-depth interviews.

The findings of Quickfall (2014) and Burchill and Pevalin (2014) were similar, and suggested that cultural competence was limited in HV practice because of poor support from local and national policy. HVs reported that their core work was impacted by extra responsibilities entailed with migration problems, such as legal issues, which were new to them. The scale of problems presented by some of the women was immense, and the HVs felt inadequate in supporting them. Providing practical help and communicating through an interpreter added further pressures.

Gunn (2016) concurred that there was limited HV understanding about what constituted culturally sensitive practice, and evidence was weak for how this could be developed and delivered. Little education had been received and gaps in knowledge were evident. Performance criteria was suggested as a way in which quality assurance could be augmented, and it was suggested that experiential assessments could enhance learning. Furthermore, the importance of diversity in the workforce being representative of the community they served was promoted as being an important factor for HV training and recruitment (Gunn 2016). However, Jackson (2007) considers that this may not be sufficient to raise the standards. To support this hypothesis, I initially aimed to gain data relating to the diversity of the Scottish HV workforce, which appears to be predominately white and female, but these data were not collected. HV data to this regard is incorporated with other disciplines. However, this information could be useful to add depth to future research studies.

The final model discussed consists of a toolkit called a Competency Document (Banfield and Lackie 2009). Three domains for the toolkit were established: interprofessional facilitation,

collaborative patient-centred practice, and cultural sensitivity and safety. Facilitators act as role models for learning, and provide a vehicle where practitioners can observe, question and learn to develop partnerships, to reduce professional power and enhance cultural understanding. The strength of the model lies in its explicit competency outcomes, which are useful for practitioner and tutor assessment.

With this model, there is potential for the facilitator role to be assigned to the practice assessor and supervisors for HV programmes, and this is worthy of further exploration. This toolkit can be used for professional development, performance assessment, curriculum design, and faculty guidance overall (Banfield and Lackie 2009). It was developed by a cancer care team, so it is illness focussed. With some modifications, it could have a wellness emphasis that is more orientated to HV practice.

Comparative studies have been difficult to execute on models without agreed definitions, and on those that contain similar components or that have the ability to measure learning outcomes. These were further challenged where a wide range of instruments and variables were used for testing (Truong et al. 2014). Furthermore, many self-assessments introduced subjectivity and therefore could not be relied on.

It has been suggested that HVs should be more creative in their work with refugee families and that they should share this learning (Burchill and Pevalin 2014). However, this may be aspirational as difficult to execute in reality. Situating the responsibility for making progress with culturally appropriate practice with the HV, who may have little time, and who may face challenges in communicating and experience poor management support, does not appear to be fair. The multifaceted needs of refugee people posed significant challenges for the HVs, and, when resources were not available, they felt let down (Burchill and Pevalin 2012). Cultural practice needs investment, which should be commensurate with that invested in clinical skills (Quickfall 2014). A crucial component in HVs' ability to deliver a culturally sensitive service is dependent on employers supporting their work and providing resources (Banfield and Lackie 2009; Burchill and Pevalin 2012; Quickfall 2014; Gunn 2016).

Cultural competency education might be better replaced with components relating to 'race and ethnic differences', which would illuminate the real issues, bringing transparency to the fore (Gustafson 2005). This may highlight the power of individuals and institutions in shaping the acceptance of discrimination concepts in everyday language and work, without people realising this (Gustafson 2005). On its own, cultural competency education cannot address systemic racism in institutions and may contribute to reinforcing stereotypes. However, Gustafson (2005), in articulating a highly critical position on cultural competence

approaches, fails to offer concrete solutions to deliver good evidenced-based health care. Practitioners need to know more about people's culture to deliver safe and effective care, and there are limited alternative means by which to address their learning needs. Instead, it is suggested that cultural competence may provide a vehicle for awareness which could encourage change (Gustafson 2005).

Racism is one area that cultural competency education is intended to address, and these models may not be the answer. The issues of racism go much wider and deeper than any model can eliminate. However, what they can do is raise awareness, and this in itself may be sufficient and may add value to person-centred care in addressing the needs of individuals. For HVs, what is important is to be aware of the different approaches that may be needed for all women. To avoid stereotyping, reflexive anti-racism training may instead gain more promising outcomes (Truong et al. 2014). However, no training should exclude the health inequalities that people face, so, addressing these issues needs to be integral to any HV education programme.

3.12   Summary

Syrian women and children arriving in the UK may have been exposed to serious additional health and wellbeing issues as a result of war and displacement. The challenges they face are comprehensive and demand that they have high levels of coping strategies to keep well. For women in particular, there are concerns about sexual health and cervical screening, smoking, social isolation, low self-esteem, stress and mental health, as well as concerns for some who are exposed to domestic abuse. There are also concerns for the general health and development of children. Their immunisation status, as well as exposure and response to trauma with few symptoms for many years, were worrying features. Children's trauma symptoms may not be recognised by parents, which heightens the need for HVs to be alert to them. This could be significant for facilitating children's ability to recover and lead successful lives. There is a recurring theme throughout this literature review: access to appropriate and timely health care has been a major problem for these people since leaving Syria and remains an unresolved barrier yet to overcome.

No specific literature was identified related to HVs' work with Syrian refugee families or their Named Person function. The literature reports that HVs feel underprepared for the task of providing health care to refugee families, compromising their promotion of health-enhancing behaviours. An intersectionality framework to practice could help HVs recognise the holistic approach from which to provide person-centred care to Syrian women, inclusive of cultural and social needs (Bastia 2014). HVs have the opportunity to assess the home situation while

taking account of home and family circumstances. This is where HVs already have expertise.

HVs' understanding could be improved with augmented education. The brief consideration of models for cultural practice was useful to understand how the advancement of knowledge and confidence in practice can be achieved and measured, and many similarities are evident in the models discussed. Nonetheless, critique of these models is limited, without sufficient studies to form robust and balanced views, particularly for HV practice. There remains a number of questions to be answered where HVs could feel more competent to identify and discuss health concerns, particularly issues arising from exposure to war, and deliver person-centred care to meet the health and cultural requirements of Syrian women and children. To include the views of Syrian women would provide the information necessary to deliver this service more effectively.

The qualitative studies reflected the deeper meaning intended to be gathered from data in the study planned, particularly those where interviews and focus groups took place, and one where vignettes were applied. The strengths and limitations of the studies were considered. Because I planned to work with two different participant groups, the approaches to each were considered separately. No studies were identified that used Appreciative Inquiry. However, the information on conducting research with refugee women who may be vulnerable was of real value, particularly for considering inclusivity, the role of the interpreter and facilitating giving the participants a voice. These factors helped direct me to seek out approaches where consideration of the researcher's position was important and where inclusive and ethical issues would be appropriately addressed.

It was anticipated that this study would contribute to the limited evidence base for HVs who work with Syrian women and children, and potentially with other refugee and asylum-seeking families. Augmenting HV education has the potential to improve health outcomes for Syrian women and children. Knowledge gaps were identified, which helped to inform the research questions and highlighted where this study could make a contribution to existing knowledge.

The study aims and research questions, followed by the methodology and study design, are presented next, in Chapter Four.

Chapter Four: Methodology and Research Methods

This chapter outlines the methodology and methods followed, and also provides justification for the chosen approach and research design. Explanations for the way in which recruitment, sampling, data collection and analysis were conducted are given. An outline of the quality assurance methods applied is followed by a short summary which concludes this chapter. The ethical considerations and a statement on data management follow, in Chapter Five.

4.1   Introduction

The literature review clearly identified the complex health needs of Syrian refugees, particularly those of women and children. It highlighted the struggles that many face in the accessing and uptake of health care. It was felt to be important, therefore, to use a study approach that recognises the strength and resilience that could empower this participant group. Similarly, I was firstly keen to understand the HV role from an assets-based position, without highlighting possible deficits in their practice, to recognise what they do well and to build on that. To demonstrate a high level of ethical considerations, these principles informed the methods selected for the study design.

4.2   Study aim:

To explore the health visitor role in improving health outcomes for Syrian refugee women and children.

Research questions:

1. What are Syrian refugee women's experience of gaining access to health care in Scotland for meeting their own and their children's health care needs?
2. How do Syrian women perceive the HV role, including that as Named Person, with facilitating their access to health care?
3. What are the views of HVs on their education and preparation for working with Syrian women and children?
4. What educational intervention, if any, do HVs feel would enhance their understanding, knowledge and skills for working with Syrian women and children, and other diverse communities?

4.3   Methodology

Research studies are intended to advance knowledge and develop theory (Bryman 2008). For this to be accomplished, Bryman (2008) suggests that clear, robust and transparent measures must be incorporated into the design to demonstrate rigour. Two clear paradigms,

positivist and interpretivist, for undertaking research are typical, referred to commonly as quantitative and qualitative approaches (Bryman 2008; Harvey and Land 2017). Other approaches exist, and some follow more contemporary paths, such as post-positivist and critical realist. Each approach determines a study route specified by the research question; but the value attached to each can differ (Bryman 2008).

Quantitative research is recognised as the scientific route, where the researcher is positioned external to the study and tends to follow a realist ontology and etic epistemology (Bryman 2008). Sample sizes are usually large, and numerical data are collected for analysis to determine measures to solve problems, and to search for truth (Bryman 2008, Creswell 2009). Randomised controlled trials (RCT), where experimental groups are compared to control groups, are acknowledged as being intended to produce robust replicable methods and data of the highest standards (Bryman 2008; Robson 2011). This is essential, for example, in medicine, where accurate data and interpretation can have life-changing implications. Nonetheless, Bryman (2008) warns that participants can interpret questions differently, and thus the results can also be open to dispute, as not everything can be controlled. On the other hand, with qualitative studies, drawing meaning from data is of more importance and there is an acceptance that data can be interpreted in different ways (Miles and Huberman 1994). Although the results obtained in qualitative research may be replicable, this is extremely difficult to achieve (Miles and Huberman 1994). Furthermore, this is not essential, as the study context, including the contribution of the researcher, is recognised as being imperative to interpretation and understanding (Bryman 2008). For this study, my own position, as the researcher, was closely related to the study methodology, in following a relativist ontology and emic epistemology (Bryman 2008; Robson 2011). I became immersed in the study and worked with smaller sample sizes. This facilitated an understanding of a deeper nature and helped give meaning to the data (Bryman 2008). However, context-specific data limits generalisability (Bryman 2008). Nonetheless, this position supports many perspectives, recognising reality as being a fluid and changing construct, where participants and researchers add depth and value. Some dismiss this route as being less scientific (Robson 2011). Yet, such data can produce information of real value in knowledge generation for practice (Miles and Huberman 1994, Bryman 2008).

4.4   Rationale for adopting a qualitative approach

Quantitative data could be of benefit in estimating the size of the problem or suggesting where resources need to be focused (Bryman 2008). However, this would not be useful for answering the research questions and understanding meaning. The views of Syrian women were important for advancing knowledge in an under-researched area. Thus, an essential

starting place was to consult the women. The same principle also applied to the HVs in order to find out how they currently practise and to seek their views on their education. This therefore entailed designing a study where individual participants could freely express their views without judgement, and in an environment that was made as confidential and safe as possible.

There was a need to extract in-depth knowledge from individuals, so participant numbers needed to be limited to allow deeper exploration (Miles and Huberman 1994), to manage the data, and to be facilitated by one researcher. Furthermore, the study was not intended to produce broad generalisations, but rather to highlight an area of practice where improvements could be made, which may then contribute to better health outcomes for Syrian women and children. Harvey and Land (2017, p. 61) state that 'qualitative research enables us to gain an understanding of the behaviours, interactions, attitudes, beliefs, experiences and opinions of individuals or groups of people and in so doing we obtain a window into their world', a view which supports the approach to this study. These data could then be captured in narrative form to contribute recommendations to future healthcare provision, and to HV practice.

4.5   Methods selection

One approach considered was phenomenology, originating from Husserl (1859–1938, cited in Bryman 2008). This requires the researcher to consider the world from the participant's perspective (Bryman 2008). This is important in clinical situations to understand the patient's lived experience to give meaning, and to provide high quality care. This helps to understand the interrelationships between the person in their context and their reality. Also, reflection on transcripts allows for another perspective to be incorporated (Al-Amer et al. 2018). Further layers of interpretation are also possible, including reinterpreting other views of the phenomenon under study. Ideas, theory, literature and practice situations can also form interpretive lenses (Miles and Huberman 1994; Bryman 2008). While it may have been advantageous to understand the participants' world from their viewpoint, I would only have been able to partially achieve this. Working with an interpreter with Syrian women in this context, as a novice researcher, could have been challenging for deeper probing and extracting the accurate meanings required with phenomenology, and I wished to avoid distressing the women in any way.

On the other hand, a cultural lens is frequently used in ethnography, allowing participant observations, field notes and document reviews for analysis (Harvey and Land 2017). This is best undertaken by a person from within the culture being studied, or the researcher

becoming submerged in the culture under scrutiny from inside, which can elicit details not easily discovered with other methods (Bryman 2008; Harvey and Land 2017). However, this approach was not possible, considering that I come from a different culture and speak a different language to the participants included in Cycle 1. An Arabic-speaking interpreter would have been a suitable co-researcher, but this was beyond the capacity of this study.

Another method considered was action research, a process which connects research to practice development, where its value can be illuminated through a service, practitioner or team improvement (Robson 2011; McNiff 2017). Cycles of research are conducted, and several can be conducted in a project. Action research studies are increasingly common in social research and nursing, where taking evidence into practice for improvement is a desired outcome (Harvey and Land 2017). In keeping with the intention to improve health outcomes for Syrian women and children, action research was an attractive option. At the same time, the benefits to health visiting practice could be accomplished and future education could be informed. One example, Olsson and Lau (2015), showed improvement in the uptake of cervical smears in an ethnic minority community through a collaborative action research project.

Furthermore, action research can contribute to the overall quality assurance strategy within organisations through continuing action progress loops, which can demonstrate continuous progress in working with people to bring about change (Robson 2011; McNiff 2017). Action research therefore was a serious contender.

4.6   Benefits of action research approaches

As stated, action research involves working with people through steps in cycles to bring about change (Robson 2011). It means including participants in the research process, often referred to as participatory action research, where their involvement in each step of data collection influences the study outcomes (Robson 2011; McNiff 2017). The participants are included within the study as opposed to a study being conducted on them, which was an important feature for this study as I worked with Syrian women participants. This etic approach in action research attempts to view the reality from within the area of examination, allowing a participant perspective to feature as an important lens for examination of findings (McNiff 2017). Change is possible from the study outset, and participants are witness to and involved with the progression through change because of being involved in the study (Robson 2011). The value of contributing to the study is visible and felt by the participants as it is being witnessed by them first-hand. Moreover, the participants can feel that being involved has been worthwhile through having their voice heard (Robson 2011).

Furthermore, a continuous improvement methodology, which can be applied with action research approaches, is a desirable concept for learning communities (Robson 2011). This is particularly important in health care, where it can feed into the overall quality assurance processes, and action research can fulfil this requirement (McNiff 2017).

4.7   Action research critique

Arguments against action research often state that the study findings and recommendations are not generalisable to other areas and, as such, this limits the value of the evidence, and further claims suggest that rigorous processes are not always applied (Chen et al. 2017). However, this is not entirely true, as, while the results are unique to the circumstances under which the research was conducted, often there is transferability of elements to other studies as well as advancement of theory and knowledge (Robson 2017). In addition, small-scale projects can have significant benefits for the area in which the research is conducted and can have wider benefits for other areas that are addressing similar issues (McNiff 2017). It can avoid reinventing the wheel, and instead advance knowledge to direct practice. It is also important, however, to be transparent with action research, and to avoid critique such as being labelled as exploitative when working in sensitive areas. This is where researcher integrity can be challenged for gaining access to sensitive data through participatory routes (Hammad et al. 2018). Proving the validity or truthfulness of the data gathered is an additional comment on the action research approach (McNiff 2017), and, to minimise this transparency, robust measures must be applied alongside. Nevertheless, it is not always clear, Chen et al. (2017) noted in a systematic review of action research projects, that for those starting out, to find a pathway to follow in action research that has been tried and tested and able to be replicated. One way to do this is with academic involvement from a critical friend to provide another layer of scrutiny to help bolster the quality of the study (McNiff 2017). This academic support can be particularly useful for novice researchers and can help to ensure that research processes are rigorous (McNiff 2017). In this study, this support was provided by the academic supervisors.

It could be argued that action research is more accessible and applicable to practice than many other methods (McNiff 2017). Implementing findings for practice development is an enviable outcome of any research and can prove to be cost-effective. Many studies may start with the intention of informing practice but never reach those who could best implement the findings (Robson 2011). In action research, practitioners often state that they have grown in confidence and that their practice has been enhanced by their role within the study (McNiff 2017; Harvey and Land 2017). It can open channels of communication *with* others involved,

as is inclusive of them being participants or co-researchers, which is in contrast with other studies performed *on* them. This can have a positive impact on the depth of data gathered.

Action research incorporates a cycle of reflection, to review what has been achieved and how it came about, which develops the individual or team professionally (McNiff 2017). There is then the opportunity to change course, should that be needed. Further, the enhanced development of reflexivity for the individual to become self-aware could be advantageous. This suggests there would be potential to gain a deeper understanding of Syrian culture, and is an attribute worthy of learning (Papadopoulos et al. 1998; Burchill and Pevalin 2014).

4.8   Appreciative Inquiry

The method selected, Appreciative Inquiry (AI), can be considered as a form of action research (Grant and Humphries 2006). However, Cooperrider and Whitney (1999) suggest that action research, with its focus on problems, is less likely to engage people in visualising and working towards a successful outcome and future. McNiff (2017) gives recognition to overlapping approaches, such as the cycles of research which each adopt. AI is a relatively new research method, developed in the 1980s, as an innovative way for making change in a large organisation that demonstrated the benefits of taking a strengths-based approach, as opposed to a problem-specific approach (Cooperrider and Whitney 1999). Cooperrider and Whitney (1999) showed that, with AI, best practice could be built on to generate change from what already works. In essence, it could be argued that the action research approach was further developed through being reframed and theorised to emerge as AI, a distinct and transformational method of research (Reed 2007). AI has the potential to effect positive change from the outset when conducting research with others for positive change (Cooperrider and Whitney 1999). Organisations the world over have successfully applied this model (Hammond and Royal 1998; Jacobsgaard 2003; Coghlan et al. 2003; Cooperrider and Whitney 2005; Reed 2007), to make changes in culture, promote healthy communities, and develop leadership in challenging areas.

AI facilitates change that is centred on and through enhancing individual and/or organisational attributes. This approach recognises the significance of relationships in the dynamic of change; how change happens, and the way in which interactions influence progression (Hammond and Royal 1998). This supports people to make positive changes through recognising individuals as being expert in their own world (Olsson and Lau 2015).

A key distinguishing feature of AI from action research is at its foundation, in that, when change is needed, AI asserts that it is best to start from the position of what is already

working well and to build change from there (Cooperrider and Whitney 1999). Participants are asked to provide their views on what is working and what accomplishments have already been achieved, and these are considered in decisions about how to make positive change. This includes promoting the capacity-building of individuals and collectively as an organisation (Reed 2007). This promotes a strengths-based way of working, which is increasingly common in the social sciences, including health visiting practice (Sigerson and Gruer 2011; Luker et al. 2017), but the application of strengths-based methods in research is an emerging field. This approach is in contrast to most projects, where views persist that problems need to be identified and strategies to solve those problems need to be created and implemented.

Problem-solving approaches and models for solutions are numerous (Robson 2011; Harvey and Land 2017). Nonetheless, the literature is recognising AI as an alternative approach for research, where the inquiry is noted for facilitating change from the outset (Kelm 1998; McKeown et al. 2016; Watkins and Mohr 2001). From this, an identifiable vocabulary has developed to explain its properties. For instance, a feature with some studies is the asking of a miracle or wish question (Reed 2007). This is to encourage participants to think beyond that which is possible, encouraging creativity (Trajkovski et al. 2013). However, AI is not without its critics, as Van Der Haar and Hosking (2004), Grant and Humphries (2006), and Bushe (2012) have reported.

Grant and Humphries (2006) have examined AI as a research method through a critical appreciative lens. They counter the same arguments against AI as others (Van Der Haar and Hosking 2004; Bushe 2012). These include arguments that the positive bias it may encourage could potentially raise expectations beyond that which is possible, and potentially undermine validity (Bushe 2012).

I was mindful of this positive bias in forming questions, as it would have been unethical to have raised unrealistic expectations. Further caution is expressed with the overuse of appreciative approaches where workers tire of the positive language and steer (Bushe 2012). Furthermore, the wording in questions, it is argued, has the potential for suggesting boundaries within answers, and needs careful thought to avoid researcher dominance (Grant and Humphries 2006). Tensions can exist regarding the positive and negative continuum and can deter less familiar researchers from problem-solving, as they may be fearful of not applying AI in its pure form. Therefore, I discussed any problems raised as they evolved, as it would have been disrespectful to have ignored or dismissed them. Furthermore, I took account of events within the study and applied a reflexive perspective. Similar to action research, reflexivity is an important feature in AI contributing to evaluation (Bushe 2012; Van

Der Haar and Hoskings 2004), as with reflexivity comes new insights, which develop the method further.

Another critique relates to fluidity. Rather than applying tight regulations, AI facilitates the people, place and circumstances to plan for what would work in their situation. Clearly articulated by Trajkovski et al. (2013, p. 1232), "every application of AI is unique … not undertaken in rigid steps … each phase built on the previous phase … used as an ongoing process" and should be embraced as a strength rather than a weakness.

It can also be argued that, with participant contribution in AI, the likelihood of the research impacting practice is higher, and therefore of more value. This method was appropriate for the participants in this study for ethical reasons because it provided the possibility of enhancing their self-esteem and aligned with the study aim and objectives to explore the HV role in improving health outcomes for Syrian refugee women and children.

Just as with action research, AI is best viewed as a methodology for inquiry and change, with the researcher working in partnership with others involved, operating in continuous cycles, each cycle influencing the next, and there should be no end. The desire for continuous improvement keeps the momentum flowing. It is an iterative process, and key to learning and progression is reflection, an important component which functions in parallel with each phase in AI, feeding into each step and influencing the next phase.

4.8.1   AI models

A range of AI models have been developed over time, each with similar components and properties, comprising from four to fourteen steps (Mishra and Bhatnagar 2012). These include the 4D model: Discovery, Dream, Design and Destiny (Cooperrider and Whitney 1999) and the Delivery in place of Destination (Attiah 2015) model. Also developed is the 5D model, with Definition added as a first step, a stage where decisions are taken on the topic of study (proposed by Attiah (2015) as an addition to the original 4D model). Another example is the 4-I model, consisting of Initiate, Inquire, Imagine and Innovate (Watkins and Mohr 2001), where some of the stages of the 4D model are fused and incorporated under different headings. The eight-step model (McLean and Sullivan 1989, cited in Mishra and Bhatnagar, 2012) includes numerous other headings to explain different steps and sub-steps. Some models are more explanatory on specific stages from the planning to implementation and evaluation (Mishra and Bhatnagar 2012).

Stemming from action research, the first model developed by Cooperrider and Whitney (1999) was the 4D cycle of AI, which is the model chosen for this study and is next explained

in the study design. The 4D model was selected as, being the original model, evaluation data is available on which it can be validated which is not yet widely available on more recent interpretations (Van Der Haar and Hosking 2004; Grant and Humphries 2006; Bushe 2012). From reading the literature, it appeared to me that the ideas from the 4D model were being explained in slightly different ways in the other models. The original authenticity is apparent in the 4D model. Furthermore, the 4D model felt like a good place to start as a novice researcher, taking into account the original ideas in its development. AI is formed using a number of key principles: constructionist, simultaneity, poetic, anticipatory, and positive, and their associated assumptions (Table 2). These principles have been incorporated in my research and will be explained with illustrations in Cycle 1. The assumptions further emphasise the positive focus of AI, with the way in which each individual's contribution is valued and interpreted for inclusion.

Table 2: Appreciative Inquiry principles

Principles
Five principles were articulated from the outset of Appreciative Inquiry.
The **Constructionist** principle
This principle emanates from constructionist theory in recognition that our views of the world are formed by how we interpret meanings and supports the notion that we are all unique and form our own views of the world from our unique experience of it. What is important with AI is this uniqueness in each of us individuals in how we tell our story, what we believe and how our lives are influenced by our own experiences.
The Principle of **Simultaneity**
This principle gives recognition to how asking questions brings about change, from the asking of the first question and raising an idea, change occurs. The simultaneity is with inquiry and change operating together, not being viewed as separate steps. The inquiry step, from asking the first question, is regarded as an intervention which facilitates change in our reality by provoking thought.
The **Poetic** Principle
This is probably the most fascinating element in the Appreciative Inquiry understandings, in my view, in that, as people give their account of events, and what they do not say is as important as what they do say, with how they say it. It gives credence to how individuals select the elements of their stories they wish to share, and this can give deeper meaning to the narrative.
The **Anticipatory** Principle
Here the notion of what the individual believes is possible forms a key construct in their future. In other words, the direction of travel is influenced by their beliefs, whether they are positive and energetic, or whether they can be bothered, as they see the effort as a waste of their time. In AI, the intention is starting from what is working well and to steer participants in the search for positive possibilities for the future.
The **Positive** Principle
This principle suggests that how we ask questions is important for engaging and encouraging people towards positive pursuits. Hence, when asking questions there is the opportunity to feed their mind with a positive question as opposed to making them feel bad by reminding them of difficulties with negative questioning. The theory is that they are therefore more likely to engage with that which will make them feel better.

Adapted from Reed 2007 p. 26–27

4.9   The study design

The study was designed to operate in a succession of cycles, where each cycle would inform the next. A two-cycle AI study was therefore undertaken to facilitate inquiry into the lived experiences of two distinct participant groups. The first cycle was designed to generate data from co-participation with Syrian women to be used to inform the data collection in Cycle 2. In this way, the voice of the Syrian women could be represented in both cycles. Furthermore, I planned to amalgamate the analysis from each cycle for further interpretation, as it is important to initially consider the data from each cycle in tandem, to then inform the future education of HVs. This study could be continued onto a third cycle, post-Doctorate.

4.9.1   The 4D model

The AI model for the study is best described as an upward spiral capturing the four stages, Discovery, Dream, Design and Destiny, which together comprise one study cycle. The starting point is at the bottom of the spiral with the study idea, leading into Discovery, at Stage One. Each stage of the upward journey has a purpose in progressing the project. When one cycle is complete, it continues on into the next. It is an iterative process, so there can be some overlap between stages and cycles. The study progresses upwards through each step of the four stages, gathering knowledge along the way, and this knowledge informs further progression. On completion of Cycle 1, Cycle 2 begins. The model (Figure 1) shows two cycles of research. The top loop, Destiny Cycle 2, does not necessarily mean the end, here the next cycle can begin. The increase in size of the loops represents the growing knowledge generated with the study's progression.

Figure 1: Appreciative Inquiry 4D model
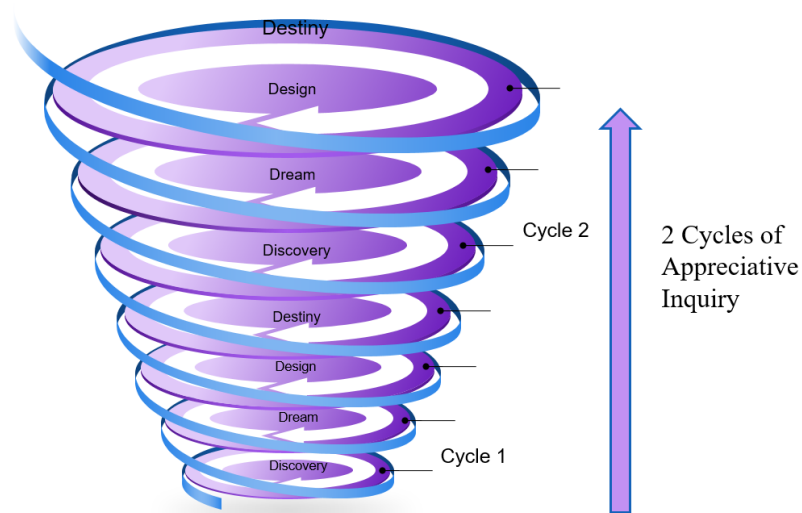
Data collection is next explained following the AI 4D method. Data was collected between September 2018 and April 2019.

4.10   Data collection Cycle 1

The key overarching question for Cycle 1 was:

> *What is the Syrian women's experience of access to health care, including the health visiting service, in Scotland?*

Secondary questions:

1.   What are the positive experiences and challenges encountered by Syrian women when accessing health care in Scotland?
2.   What strategies do Syrian women use to effectively navigate the Scottish health care system?
3.   What is the experience of Syrian women (with children under school age) of having a HV and their role as a Named Person?
4.   How do Syrian women consider their cultural, traditional, religious and personal preferences can be effectively met by and communicated to health professionals?
5.   How do Syrian women propose access to health care could be improved for them?

4.10.1   Cycle 1 methods

Firstly, one-to-one semi-structured interviews were conducted with 12 Syrian women. Following this, eight of the same 12 women participated in four petite co-creation groups, with two-to-three women attending on each occasion. Semi-structured interviews will be discussed in the Discovery stage, and petite co-creation groups will be discussed in the Dream stage.

Discovery: is about asking positive questions to elicit facts about what is working well to generate knowledge, spark interest and engage people. For this, semi-structured interviews were conducted.

Semi-structured interviews

Individual face-to-face interviews were selected to gather data, as it was felt that it was important to work with the women in a reciprocal and dialogic way, to be respectful. It followed the constructionist principle, which stems from constructionist theory, in recognition that our views of the world are formed by how we interpret meaning. It was important to respect the uniqueness of each person to tell their story. This is because what we believe

and how we live our lives is influenced by our own individual experiences. There is a personal element that can be relayed easier in face-to-face interviews than with the telephone interviews conducted in Cycle 2, for example, which would have been difficult through an interpreter. In addition, interviews are a common tool that works well with AI methodology (Trajkovski et al. 2013). The simultaneity principle, applied from the first question, gives recognition to how, from asking this first question and raising an idea, change occurs. The simultaneity occurs with inquiry and change operating together, not being viewed as separate steps. The inquiry step, from the first question, is regarded as an intervention which facilitates change in our reality by provoking thought. Question design can be a challenge, raising ethical dilemmas in striking a balance between asking good questions to facilitate good answers, and asking questions which may be considered intrusive. With AI, however, questions designed in a specific positive style facilitate reciprocal dialogue, avoiding a situation where participants may feel violated. This is based on the positive principle, which suggests that the way in which we ask questions is important for engaging and encouraging people to pursue positive actions. This is opposed to making them feel badly by reminding them of difficulties with a negative style of questioning. The theory is that participants are therefore more likely to engage with what will make them feel better. I was eager to minimise any discomfort, and there was no intention to use deeply probing questions with the women, or to uncover difficult memories. This style was therefore more useful in this context.

Interviews within AI are more relaxed, referred to as 'having AI conversations' (Reed 2007, p. 125) to reflect the reciprocal serve and return aspect in a conversation. As a consequence, these conversations can be unpredictable, allowing freedom of expression, and can reveal some interesting insights. This happened at the outset of one interview, where one woman entered into a dialogue about her housework routine. This can represent the downside, however, in that the discussion can go off track. I kept focus by referring to the topic guide (Appendix 3), which I aimed to do without inhibiting the women, although it was challenging at times (Kvale and Brinkmann 2009). This approach allowed the opportunity to answer the women's questions as they arose, and to offer support should that have been needed. No additional support was required by any of the women. Furthermore, privacy and confidentiality were respected, which may have been compromised in groups or pairs. The semi-structured questions facilitated a more natural progression through the interviews, where closed questions may have limited the answers. This style of interview felt comfortable with the interpreter in attendance, as it allowed time for translating without the interview losing momentum. A translated printed topic guide was also made available to the women at the time of the interview. This was intended to ensure that the questions being

asked and delivered by an interpreter was received by the participant as intended. This provided a degree of assurance, as this is an area identified as having the potential for reinterpretation by the interpreter, which I wished to minimise (Tsai et al. 2018).

These individual face-to-face interviews enabled gestures and body language to be noted as well as context. Al-Amer et al. (2018) advocate the inclusion of these key components for interpretation. The women appeared happy to converse and pleased that their views were requested and important. A couple of questions were omitted when they did not feel appropriate to ask. For example, I did not ask the widowed women about contraception, and only asked questions about the HV service to those with children.

Dream: this stage encourages participants to think of possibilities, not mainstream ideas, more 'blue sky' thinking, where positive ideas can be shared, and possibilities for the future can begin to emerge. Embracing the anticipatory principle, the notion of what the individual believes is possible forms a key construct in their future. In other words, progress is influenced by their beliefs, whether they are positive and energetic, or whether they see the effort as a waste of their time. In AI, the intention of starting from what is working well steers participants towards positive possibilities for the future. Petite co-creation groups provided the medium for this stage.

Petite co-creation groups

The focus group is an instrument widely used in qualitative research as it facilitates discussion in a controlled environment with group members and is the second-most common tool for data collection recognised for working well with AI (Trajkovski et al. 2013). Although questions can be prepared in advance and posed in a systematic order, the answers and discussions that ensue are unpredictable. This is because they are influenced by what the participants bring to the group, their views on the subject, and the conditions applied. The groups I conducted were similar, but rather than asking questions from a pre-prepared topic guide, I completed a task with participants, hence the co-creation of data. The questions raised were aligned to the task and followed the natural progression of the session. This is an alternative method to pre-planned questions or in addition to questions that have been pre-prepared (Finch et al. 2014, pp. 212-242). The Syrian women were asked to contribute to the development of a case scenario vignette to be used as a data collection instrument for Cycle 2, henceforth referred to as a vignette.

A vignette can be a situation or event, and, in this study, depicted a fictitious family developed to provide a vehicle for asking questions which may be sensitive, without aligning them with real people. This was an important feature when being created by women who

have been exposed to war. Vignettes have been used to replicate real situations and can be presented in many forms, such as photographs, video, audio or written text (Finch 1987; Barter and Renold 2000; Bradbury-Jones et al. 2014).

Focus groups work best with around 6–10 people to generate a range of views for discussion (Kvale and Brinkmann 2009), and I intended to work within this range of participants. This was not possible, however, as the woman struggled to attend, even with transport and childcare available. Eight were invited from the first site to the first group, and only three attended. As others wished to contribute, I arranged another group where a further two attended. Four interviewees were invited from the second site, where two attended on the first occasion and two on the second. This second opportunity at each site supported inclusivity. One woman attended twice, and I allowed her to remain, because I considered that I could not ask her to leave. She was, however, only counted once. In total, eight women contributed. The groups were smaller than planned, so were named 'petite' co-creation groups (referred to as groups going forward), forming a workable solution to facilitate the Syrian women's contribution to Cycle 2. Finch et al. (2014) contend that smaller groups may be less effective and may have a negative impact on the quality of data collected. However, as I had four separate sessions, I believe that this added another dimension, as the groups added to previous data from their own perspectives. I had previously observed and joined the women in creative tasks while getting to know them, and, from this, anticipated that they would enjoy being creative. My role was as facilitator. At the first group, we developed the family construct for the vignette and raised some questions. A table-top exercise with flip chart paper, post-it-notes and pens captured the ideas. The second group then added to this first set of data, and the third and fourth groups sequentially added content. This approach was productive in completing the task to a stage I was able to work with. These small groups were advantageous in that they allowed time for translations and explanations, and for each person to contribute. The vignette and questions developed provided useful instruments for Cycle 2. This meant that the women were able to construct the family and pose questions that were important to them, which I was then able to take forward to ask the HVs.

These groups incorporated the poetic principle. As per Table 2, this is probably the most fascinating element in the Appreciative Inquiry understandings, in my view. I observed the women chatting together and giving their account of events, which gave deeper meaning to the narrative in observing how they said it. This gives credence to how individuals select the elements of their stories they wish to share. In being focused on an activity, it was interesting to observe the women's dynamic and observe how they reached decisions.

Limitations with focus groups include participants not being able to say certain things in front of others. They may be uncomfortable with particular subjects and could perhaps feel that others in the group may judge them. This was not an issue, however, as the groups were not focused on any set of questions, so the women were able to contribute as they desired. Following the positive principle helped to encourage participation and enabled the women to talk and make suggestions. As it was an exercise, they approached it with fun and much laughter. In the first group, I asked the women to give the family a name, and, in line with Bradbury-Jones et al. (2014), I requested this was not to be the name of a family member or friend. The intention was not to trigger any sad memories of loss. From this request, they gave names from a TV soap opera in Syria and, following the group, they took delight in telling me about the relationships in the soap opera.

Design: This stage involved my listening to the groups' digital recordings, reading notes, and early interpretation to create the vignette and gain a deeper understanding for the development of the questions for Cycle 2. For this, the vignette subject data (i.e., the family details, medical conditions, and suggested questions) were copied from the overall transcript and notes and prepared for Cycle 2. The completed vignette is presented in the second part of the Cycle 2 topic guide (Appendix 5).

Destiny: In this stage, appraisal and planning to move forward takes place. This is where I undertook the data analysis. The full transcripts and notes were included for thematic analysis in the Destiny stage, the process followed is discussed in Section 4.15, and the findings are presented in Chapter Six.

4.11   Data collection Cycle 2

The key overarching question for Cycle 2 was:

> *How does the health visitor role and their function as a Named Person facilitate access to health care for Syrian women and children?*

Secondary questions:

1.   What are the positive experiences and challenges encountered by health visitors working with Syrian women and children?
2.   What strategies do health visitors use to support the health needs of Syrian women and children?
3.   How does the health visitor and their role as a Named Person support Syrian women and children to access health care?

4. How do health visitors perceive they work within the cultural, traditional, religious and personal preferences of Syrian women?

5. How educationally prepared do health visitors perceive they are for working with Syrian women and children?

6. What education, if any, do health visitors feel would benefit their practice for working with Syrian women and children, and diverse communities more generally?

4.11.1   Cycle 2 methods

Postal questionnaires and two-part sequential telephone interviews were selected for data collection in Cycle 2. Face-to-face interviews were not possible, as I wished to include HVs from rural and island communities and did not have the budget or travel capacity within the study parameters.

Discovery: This stage engaged the HVs using questionnaires. These were selected as an efficient method for collecting contextual data. This reduced interview time and time away from health visiting duties. Questionnaires were sent to 11 HV participants asking about their health visiting background, education and experience of working with Syrian refugee families (Appendix 4). Space was available for free text to add any information they felt would be useful to the study. All questionnaires were completed and returned.

Individual two-part sequential telephone interviews were then conducted with these same HVs, arranged at a time to suit them. Topic questions (Appendix 5) were asked in the first part, forming the Dream phase. The questions raised from the vignette were asked in the second part of the interview, forming the next stage, Design.

Dream: The telephone interviews were selected to facilitate the inclusion of HVs from any area in the study sites where Syrian families were receiving health visiting services. In this way, the voices of HVs practising in rural and island communities were treated equally, not being prevented from participating due to geography, time or travel expense.

Telephone interviews have been critiqued for not establishing the same positive relationship as with face-to-face interviews, with it being more difficult to notice and respond to cues (Drabble et al. 2016). It has been reported, however, that listening is more attentive during telephone interviews and that the anonymity facilitates a discussion where participants feel less self-conscious about contributing (Harvey and Land 2017). The HVs had the opportunity to freely speak without the pressure of having the researcher in the same room or any interruption and comments from peers, which avoided others influencing the direction of their thinking, as would be the case in group interviews (Harvey and Land 2017).

Furthermore, the cost for their participation was minimal, and reduced their time away from practice.

The AI strengths-based question style gave recognition to what the HVs already knew and understood, as opposed to highlighting any knowledge deficit. This did not inhibit the HVs from being open and frank about their experience, and their ideas are included for future learning possibilities. In this stage, participants were encouraged to begin to think of possibilities for the future, captured in a 'miracle question' (Q15 Appendix 5) for this purpose.

Design: this stage followed on with a discussion on the vignette, using questions developed from Cycle1 (Appendix 5). This allowed a deeper discussion with consideration of new ideas and planning for a better future.

The vignette comprised a family genogram and text which was read aloud to participants in Cycle 2. Robson (2011) suggests that vignettes can complement studies through opening up an interesting and focused discussion for exploration and are cost efficient. Questions can be closed or open, which supported the preferred semi-structured approach used (Harvey and Land 2017). This facilitated response to the conversation as it unfolded. This way, participants' views were explored, and specific areas given focus without interruption or direction. Practitioners were less likely to feel their practice was being questioned (Bradbury-Jones et al. 2014), as this method avoided raising anxieties about their role in real cases. Vignettes enable consistency to be applied with data collection (Robson 2011; Arthur et al. 2014) and support anonymity and confidentiality (Bradbury-Jones et al. 2014). This avoided the potential for HVs transferring their discussions to an actual case, which could trigger memories of difficult cases. The ability to question more deeply is a real asset when using vignettes (Arthur et al. 2014). Being permitted to apply deeper probing of the interview questions to this simulated family avoided the need for this level of inquiry on a real family. The HVs' views were ascertained while protecting them from a real situation where they could feel exposed. The insights gained were of real value to the study, and congruent with AI.

There is a real challenge when applying vignettes, cautions Harvey and Land (2017). In the search for truth, it may be difficult to be absolutely honest about what you say you will do. This can be in contrast to what you would do in the real situation. Hughes and Huby (2004) advise the researcher to be clear about the degree of reality the vignette represents, and the claims made in data collection. Yet, Barter and Renold (2000) acknowledge this distinction and the reality of practice. This makes another interesting layer for analysis, however, and

need not be avoided. To maximise the real benefits of vignettes, Steiner et al. (2016) suggest careful consideration of the design components to include validity and reliability measures. The development of the vignette and questions posed therefore needed careful scrutiny, and also for determining reliability, as there can be complications when interpreting the data from different perspectives. With that in mind, two pilot interviews were conducted to test the questions, the vignette and the telephone interview, and to assure this quality.

Destiny is the stage where appraisal of data and planning to move forward takes place. This is where thematic analysis was conducted. The method undertaken is discussed at Section 4.15, with the findings presented in Chapter Seven.

4.12   Study setting

The sites selected provide data from communities across Scotland where Syrian families have been dispersed through the resettlement scheme, other than from the larger cities. These communities had less experience of, and less research undertaken with, Syrian people and were developing services in response to need. The information from this study could be of value to future planning.

Cycle 1 of the study recruited twelve Syrian women attending two support groups from four different council areas. The aim was to recruit ten to twelve participants, which was felt to be an achievable recruitment number from the two groups and a sufficient number from which to gain a range of views. The women who were recruited lived in a city, town or a suburb, and no one lived in a very rural or island community.

The interviews took place at the community centres or rooms near a university art group on the same days they were attending. All rooms used were private, and childcare facilities were provided. Two interviews and the final group meeting took place at a woman's home. This was because one woman was unable to travel and she and a friend both requested for me to go to them. The resettlement officer facilitated my visit to the home. Another interview was conducted online for one woman who had made several attempts to attend, and she requested for me to speak with her online from the community centre. She also contributed to the group activity in this way. My aim of the study was to be inclusive and enable the women to have a voice, and so, I facilitated these requests.

In Cycle 2, eleven HVs participated from three Health Board areas covering six Local Authority areas. These were in smaller cities, urban, rural and island communities. The aim was to recruit ten HV participants to allow representation from each of the geographic areas.

4.13 Sampling

Sampling in research is a process designed to extract a select number of people or objects from larger populations of interest, to generate and work with datasets of a manageable size (Harvey and Land 2017). This project required a sampling approach to identify and obtain subsets from two distinct groups of participants. Convenience sampling was selected for Cycle 1, and purposeful sampling for Cycle 2.

Convenience sampling involves selecting participants from easily available sources (Bryman 2008). In Cycle 1, this took place through women's support groups via the Local Authority resettlement officer, who facilitated access to the group leaders.

Purposeful sampling, a method used for directing recruitment to attract those who meet the criteria needed (Bryman 2008), was selected for Cycle 2. This was to target HVs working with, or who had previously worked with, Syrian families from the resettlement scheme, as it was their experience which was vital to inform the study.

Neither of the selected sampling methods are generalisable, which is not the aim of qualitative research, but each can be of value to their respective wider populations. The Syrian women could possibly be a small representative sample of similar towns, where small clusters of Syrian families live. Their ages ranged from 26 to 59, most were married, and ten were mothers. The HVs represented HVs more generally across Scotland, with the exception of large inner cities, but including very rural and island communities.

4.14 Recruitment

The recruitment criteria for choosing participants to include in the study are presented below in Table 3.

Table 3: Recruitment criteria

Syrian women	Health visitors
Women from Syria	Registered health visitors
Entered the UK via the SVPRS	Currently or previously worked with
Attend a women's support group	Syrian women who entered the UK via the SVPRS
Able to attend 1 IV and 1 group activity	Willing to complete a questionnaire and participate in a 2-part telephone IV.

For Cycle 1 (Table 3) recruitment was facilitated via the resettlement managers where I was introduced to the women at two support groups. These groups aim to support women's integration and are provided at community centres and church halls. I presented and explained the study to the women at each site, and I provided a participant information sheet (Appendix 6) which had been translated. The women were invited to join the study.

Permissions and dates were agreed with the group leaders for the research to be undertaken with minimal disruption. Recruitment via these groups provided a safe environment for the women in making the decision whether to participate or not. They were able to discuss this with each other before making a final decision. The women were familiar with attending these groups, where they met with friends and support staff, and refreshments were available. A key ethical consideration was to minimise disruption to family life, and these venues provided for that, because they were already attending the locations. The interpreter was also known to them. A crèche was provided on site, and the groups functioned within school hours. These all proved to be very important factors, as without these, the women would have struggled to engage, and their voices would have been silenced.

In Cycle 2 (Table 3) HVs were recruited via the Board Nurse Director or the Lead Nurse for HVs in the Health Board area. They were requested to identify and send an email to HVs who were working with, or had worked with, Syrian families from the resettlement scheme. Information on the study was provided in a PIS, and a contact telephone number was provided to contact me, should they be interested in participating (Appendix 7). A telephone conversation took place with those who made contact, where I explained the study and answered their questions. I then sent them a PIS, a consent form, the questionnaire, and 2 stamped addressed envelopes for their return in the post. They returned the consent form and the questionnaire in two separate envelopes to allow for the questionnaire to be returned anonymously.

Data processing

Digital recordings: For Cycle 1, digital recordings were made of eight interviews and two groups who consented. For those who declined, notes were taken using the topic guide and supplemented with more detail afterwards. In Cycle 2, all participants agreed to digital recordings. These recordings were erased once the transcriptions were completed.

Intelligent verbatim transcriptions were undertaken by a university-approved company who were legally contracted within the European Directive General Data Protection Regulations (GDPR) (2018) legislation.

4.15   Thematic analysis

Thematic analysis was conducted to undertake a systematic appraisal of the data, endorsed as an essential foundation to interpreting and extracting important messages in a study (Bryman 2008; Trajkovski et al. 2013; Braun and Clarke 2013). Some regard thematic analysis as a forerunner to other data analytical methods or as forming one aspect to a more complex analytical process (Bryman 2008). Braun and Clarke (2013) report that there can be confusion on how the term is applied, which makes it difficult to immediately identify, evaluate and replicate. Thematic analysis is recognised as an instrument with which to dissect and study qualitative data, seeking patterns and meanings from which to make sense and understanding, where themes are generated. In turn, this provides a vehicle for answering the research questions, while at the same time learning the skills to undertake robust studies, providing a launchpad for novice researchers learning the craft (Braun and Clarke 2006). Rather than claim that themes emerge from the data or are revealed in the data, thematic analysis should lead to development of themes (Braun and Clarke 2013). The assumptions and theoretical framework, and in this case, the AI assumptions and principles, followed an inductive approach and these guide the reader with the world view being represented. Thematic analysis was appealing for learning, as well as in applying AI principles consistent with the study. Furthermore, it was highlighted to be most suitable for studies where social justice was of interest and is not affiliated to any specific philosophy, which widens the applicability to most qualitative studies (Braun and Clarke 2013). Additionally, in a systematic review, Trajkovski et al. (2013) established that thematic analysis was the most consistently applied data analysis method used with AI.

Qualitative studies can present substantial volumes of written data. QSR NVivo 12 (QSR International Pty Ltd, 2018) was selected as a workable tool to manage this and is an important step to avoid being overwhelmed. The significant features within the data were coded, categorised and themed within NVivo, with annotations and memos added. These represented interpreted meanings and noted patterns. A further stage of hand processing, as suggested by Braun and Clarke (2013), for novice researchers, was conducted and added robustness to ensure that there were no omissions of pertinent data for inclusion and interpretation.

AI supports rigorously and intuitively working through each step, with each element informing the next iterative stage, extracting meaning from the data and the context, and taking account of the researcher's positionality. Disconfirming data, and negative expressions with any outliers, were identified and explained. Any nuances noted and metaphors expressed

added richness. This facilitated ongoing thinking and reflection, which influenced the decisions taken and continued for the duration of the study.

4.15.1   Thematic analysis phases

Table 4 presents the explanation of how I conducted the thematic analysis.

Table 4: Phases of thematic analysis

Phase	
1.	*Familiarising yourself with your data:* Often referred to as immersing or submerging yourself in the data. This was where I formed a positive relationship with the data, I listened to the digital recordings twice to get a grasp of the content. First reading of the transcripts: taking initial notes and checking accuracy of the transcriptions from recordings. Second reading of the transcriptions: edit, corrections made, identifying features removed. These then were uploaded to NVivo. Recordings then deleted.
2.	*Generating initial codes:* Coding was conducted separately for each cycle. Initial codes were systematically applied to each cycle and a coding frame was established. This was refined and changed over time from further analysis and interpretation. An ongoing process of annotations and memos were added.
3.	*Creation of themes:* I undertook a third reading of transcripts in hard copies which provided the opportunity to delve deeper into the data. Themes were created and these changed over time as interpretations developed.
4.	*Reviewing themes:* The themes further developed as more data were analysed, interpreted, and reinterpreted in relation to the codes which also were revised.
5.	*Defining and naming themes:* The final themes were defined when the story to be told from the research became clear. This point was the final naming of the themes. Writing the thesis confirmed the key messages from the study.
6.	*Producing the report:* The final thesis involved ensuring direct quotations from the participants reflected accurately their contributions, answered the research questions and located the findings in the literature.

Adapted from Braun and Clarke (2006)

4.16   Quality assurance

Assuring quality is essential to the credibility and integrity of any research, therefore, it is important to show how this has been addressed. Demonstrating validity through evidencing that the study has met its objectives, and reliability, where the methods can be replicated by others, are common approaches (Braun and Clarke 2013). These measures are more applicable to quantitative studies, where replicability is crucial and there is a requirement to generalise the findings. This approach is less likely in qualitative studies, where

trustworthiness is increasingly the preferred option taken to evidence that rigorous processes have been followed (Braun and Clarke 2013).

Four aspects to demonstrate are: credibility, transferability, dependability, and confirmability (Korstjens and Moser 2018). Credibility is the degree of truthfulness. One robust approach is triangulation, where more than one method of data collection is generated to confirm answers to research questions (Braun and Clarke 2013). Data were collected from a range of sources and support credibility. It could be argued, therefore, that these methods support triangulation. Nonetheless, triangulation was not the goal, as these different perspectives were intended to involve the participants as fully as possible. Transferability was where I set out the contexts for each cycle, and this could show how these methods could be applied in other contexts. Dependability is where management of the data is transparent. Reflexivity, where notes throughout the research project are taken and reflected on, are a common feature which I used to meet dependability (Korstjens and Moser 2018). I ensured that I was transparent, where robust notes and reflective accounts were checked against transcripts.

Confirmability, where it is made clear the findings are real and have emerged from the data, was attained through systematic coding with NVivo, which also supported equity. The data were also hand checked (Korstjens and Moser 2018).

Other measures taken were, in Cycle 1, an interpreter attended where agreed for eight interviews and two groups, and translated materials were provided. Two random digital recordings were cross-checked against the transcriptions by an Arabic-speaking researcher and minor errors were noted. Tsai et al. (2018) suggest that this is very important with translations and communicating between differing cultures. In Cycle 2, two pilot tests of the HV questionnaires and interviews were undertaken and minor adjustments made.

Furthermore, I followed the 15-point checklist (Braun and Clarke 2013, p. 287) as a guide to reassure myself that robust research standards had been applied.

This chapter has detailed the methodology, research design and quality assurance processes followed in this research study. Chapter Five develops the study further by setting out the ethical considerations, including confidentiality and consent, with consideration of the researcher's position. A statement on the management of the data is provided.

Chapter Five: Ethical Integrity

5.1   Ethical integrity

The purpose of ethical considerations in research with human participants is firstly to protect and do them no harm, but also to ensure that the research has been conducted with integrity. With some participants being Syrian women, this was essential. Israel and Hay (2010) acknowledge the harm to communities where researchers have been less than sensitive to culturally diverse and Indigenous people. The evidence that this rigour was accomplished includes demonstrating how ethical considerations have been accounted for and how permissions were granted. These are discussed next.

5.2   Respect for persons

5.2.1   Consent

Informed consent, where the potential participants make a decision about whether to join the study based on the information given to them, is important for every participant, but was particularly important as English was not the first language of some participants. For the Syrian women, the participant information leaflet (Appendix 6) and consent form (Appendix 8) were translated, and an interpreter was present at the information session, interviews and groups where required. Consent was assimilated within the study as a continuous process, an important feature in AI, to demonstrate that consent has been robustly managed throughout (Reed 2007). This included the women being asked regularly for confirmation of their continued permission. All participants were permitted to withdraw from the study and leave the interview or group at any time should they choose to do so, and this was made clear to them in the information leaflet and information session. Following this initial meeting, a 48-hour timeframe was assigned to allow them to consider their involvement without any pressure, before written consent was requested. Other forms included the PIS (Appendix 7) and the consent form for HV participants (Appendix 9).

5.2.2   Confidentiality

Every endeavour was taken to maximise confidentiality and anonymity. Minimal personally identifiable information was collected. The interpreter and support personnel completed a confidentiality statement (Appendix 10), and confidentiality was agreed by all in attendance at each data collection contact.

There was an ethical risk of identification of individuals due to small sample sizes arising from small communities, so names and places will not be revealed. Reed (2007) promotes the disclosure of the venue to align with AI research, but, for this study, I disagreed. Due to

the small size of the study, where both Syrian women and HV participants lived or worked in small clusters, and with the cultural identity and vulnerability of the Syrian women, I decided that the venues will not be disclosed. All participants were promised confidentiality and anonymity.

5.3   Beneficence

Ethical tensions can arise with regard to including or excluding refugees in research, particularly relating to the exploitation of vulnerable groups (Leaning 2001; Hugman et al. 2011). I considered that the nature of this research would not be detrimental to their health and wellbeing and that it might instead contribute to promoting health and wellbeing. In addition, the women may feel valued and included as a result of being involved in the research. This, in turn, could add to their resilience. The women were not asked questions relating to their personal health care needs, but some raised their own issues, and I was able to discuss these in a sensitive and respectful way as I was prepared (Ellis et al. 2007). The women had immediate support available from their peers, volunteer support workers, group leader and the resettlement officer. Contact details of the resettlement officer were made available should any support be required outwith the research study.

5.3.1   The researcher position

The relationship of the participant with the researcher also poses ethical issues (Webster et al. 2014). It can appear to the participant as a close friendship and they can unintentionally reveal personal stories. This highlights the power imbalance and the need for the researcher to reduce this risk through clear relationship boundaries. The AI approach facilitates a more equal balance between researcher and participants through involving them in the research process (Sharp et al. 2016), and this enabled the experiences of each of the Syrian women to contribute to data collection, demonstrating the value of each person's story equally. In particular, the development of the vignette with the women facilitated their questions to be asked in Cycle 2.

I recognised my position as being more powerful than that of the participants. I was the project lead, while some of the participants were refugee women without the ability to speak English. The women were aware I had been a nurse and health visitor and was now a lecturer. Two women did ask questions about how to become a nurse at the introductory meeting, before agreeing to engage with my research. I obtained information from the local college of a contact for access courses and gave this to their project leader to share. At interviews I found it challenging on a couple of occasions in not being able to provide a supportive clinical role.

From previously holding a strategic post and as a HV lecturer I know many HVs across Scotland. To ensure no coercion took place, the HVs were recruited through their lead nurse. Being explicit about the boundaries in the relationship at first contact reduced any potential power imbalance. This enabled the HVs to contribute as they felt comfortable and to participate without feeling coerced.

5.4   Justice

Justice is concerned with people being treated fairly and equally and having good reasons for the selection of the study participants.

Refugees are regarded as vulnerable people for involvement in research due to their health, housing and legal status needs (Hugman et al. 2011), and, as such, careful consideration of who and how to involve them was given serious attention. For this study it was important to know how accessible the health care system is for refugees, so the best people to ask were refugees themselves. The selection of which refugee population to approach was made through seeking out those who were best supported and less likely to be seeking benefits personally from the research or researcher. This led to recruiting the participants from those who have supported entry to the UK through the Syrian Vulnerable Persons Relocation Scheme (Home Office 2017).

The women who have migrated through this scheme have their status of residency secured. They will not, therefore, request help from the researcher to support their residency status, which is known to be a difficulty and an ethical challenge for researchers working with refugees and for asylum seekers who are seeking this security (Hugman et al. 2011).

To minimise any bias and to apply the empowerment model consistent with the New Scots Refugee Integration Strategy 2018–22, I followed the human rights approach, supporting the Syrian women to realise their rights within the study from the principles of 'decency, humanity and fairness' (Scottish Government 2018, p. 12) by undertaking the following steps:

- ❖ Removed barriers to enable their contribution, such as with language: an interpreter and childcare was available, and I positively responded to requests for where and how three interviews were conducted; the PIS, consent form and interview topic questions were also translated.
- ❖ Additional time was allowed for interpretation and explanations as needed.
- ❖ Respecting cultural and traditional practices through not planning or conducting any data collection at requested prayer times, and a prayer room was made available.

❖ Ager and Strang (2008) reported that for refugees to really feel included they needed to be welcomed by friendly people and to have their needs respected, and I ensured that this happened.

HVs were selected as their views were essential to develop the programme further to meet their education needs. Without them the study would have lacked credibility. The rights of a range of HVs to be included is discussed further in the next section.

5.5 Participants as partners

The relationship with the participant is a critical area for clarity within AI research as a number of positions can be applied, such as co-researchers or researcher/participant, and it is not always explained well what role they are fulfilling (Chen et al. 2017). Three distinctions, on a continuum – collaborative, insider, and participatory – are useful terms in understanding the possibilities (Chen et al. 2017), and each explains the degree of participant involvement in the research alongside the researcher. In planning the study, I considered it imperative that the research was conducted collaboratively with the Syrian women participants, not on them. This was deemed to be important to their dignity and to show respect. Due to language barriers, time constraints and the limitations of this being a doctoral study, and the need to provide training, it was not possible to consider the participants as co-researchers, which is a model successfully applied in other Scottish refugee studies (Abdulkadir et al. 2016). However, the women were 'the experts' in their own families' health care needs. This was important to be understood by everyone. Hugman et al. (2011) promote this methodology in meeting the ethical principle of human agency, where research is conducted with participants. A key objective was inclusivity, giving each of the participants a voice, to capture their lived experience as they understand it. Such an approach facilitated collaboration and enabled the women to make an important contribution to improving access to health care provision for the future.

From the conflict in their Syrian homeland, together with the journey many have encountered to reach their new destination, many refugees were and are vulnerable to serious health issues. Despite this, many show remarkable resilience, and it was also important to give recognition to their abilities. The issue of relationships with participants was considered important to ensure professional relationships were formed to facilitate good working with them and to guide participants without being over-friendly or coercive.

Conversely, HVs, the other group of participants, also needed to be considered. It was important to engage HVs at this stage as partners in the development of their education. The

intention is to continue this relationship into the next research cycle. However, this study could identify individual training needs of HVs, and, as such, the HV may be sensitive to this issue being raised. Also, they may be affected by the experiences of the people with whom they work, or by the stories they hear about Syrian families regarding the suffering and health issues that many endure. It was essential therefore to ensure they were supported. Managerial support and supervision were signposted, as was occupational health in their workplace, should the need for support have been identified. Telephone interviews were conducted with HVs with the intention to minimise disruption to their working commitments, which further supported confidentiality and anonymity. At the same time, the telephone interview approach reduced participant bias through eliminating influence from other participants. Furthermore, it allowed for recruitment and captured the views of a more diverse group of HVs, through enabling those from rural and island communities to participate as easily as those from urban areas. This supported the rights of HVs from island and rural communities to be treated equally and contribute to research should they wish. Webster et al. (2014) argue that human rights is an area that is often confusing for the researcher when trying to ensure that they protect their participants' interests.

5.6   Ethics committees and access permissions

Ethical approval was sought and granted from The University of Stirling ethics committee, NICR (NHS Invasive Clinical Research) in two stages; first for Cycle 1 (Appendix 11) on 27th April 2018; and for Cycle 2 (Appendix 12) on 26th September 2018. Access permissions were granted from the Local Authority and support group leaders, and Research and Development departments at three Health Boards. Because I am a registered nurse, I was also governed by the NMC *Code* (2018).

A final ethical consideration was the importance of research dissemination and the need to distribute the research findings to the community involved (Ellis et al. 2007). To this end, a summary report has been sent to the integration managers for onward distribution and this was also be made available to the HVs via their managers.

5.7   Data security

All data were managed in line with University and European Directive General Data Protection Regulations 2018 (GDPR).

The thesis now continues by presenting the findings and related themes in Chapters Six and Seven.

A diagram (Figure 2) is presented below, showing the six themes in the order of presentation:

Cycle 1: 'rabbits in the headlights', 'loss of home', and 'reclaiming home'.
Cycle 2: 'thrown in at the deep end', 'above and beyond', and 'you don't know what you don't know'.

Figure 2: The six themes

Chapter Six: Cycle 1 Findings – Destiny

6.1   Introduction

This chapter presents the study findings for Cycle 1. Of note, regarding the identification of persons speaking in quotations:

- 'I' represents interviewer, and 'R' is respondent (R1, respondent one and R2, respondent two)

- SWIV – Syrian woman interview

- SWCCG - Syrian woman co-creation group (S1 Syrian woman 1)

The Cycle 1 findings comprise the accounts of Syrian women's experiences of navigating the health care services from arrival in Scotland. Their views about what helped and what hindered are presented with discussions on health conditions. Added to this are their views of how services could be improved to better meet their needs. The relationships between Syrian women and HVs, for those who have children under school age, was of interest in relation to their use and comprehension of the service.

The discussion is situated in the thematic framework developed from Cycle 1: 'rabbits in the headlights', 'loss of home', and 'reclaiming home', each with an explanatory definition and each incorporating several subthemes. The demographic data are presented first.

6.2   Context

6.2.1   Demographic data

The youngest woman participant was 26 years of age, and the eldest, 59. The mean age was just under 34 years of age. The average time living in Scotland was two years, three-and-a-half months, ranging from six months to three years. All except one was of childbearing age, and two had never had any children. Two of the women were widowed. One was single. The remaining nine were married. Between them, the women had thirty-two children in total. Of these, 17 were boys, and 15 were girls. In one family where there were six children, all were grown up, with only one living in Scotland. The other families' children all lived in Scotland and were aged from one to fourteen years. One woman lived alone, the others lived with their children and husbands, and one lived with her parents. No grandparents had travelled to Scotland, as of yet. Two sisters travelled together, one with her husband and children, the other a widow with her children, but they each had their own separate homes. No women had any extended family with them, although some family

members had made the journey from Syria but were living elsewhere, in England, Europe or dispersal countries in close proximity to Syria.

6.2.2   Family relationships

The women explained that they had no choice as to which country they were to be sent to through the resettlement scheme, hence many extended families were separated having migrated to other countries. Family relationships are a significant component of Syrian family life and the agony of being separated from loved ones, particularly during these troubling times, was clear in every woman with whom I met. I observed how they were continuously in contact with family and friends wherever they were in the world, via social media. During the first co-creation group, where a fictional family was created for the vignette, I asked the women to give the family a name, a fictional name. Immediately 'Grandpa House' was suggested to name this household, illustrating the significance of the grandfather role as head of the family:

> I.   *So, who would like to give the family a name? […] So, have you got a family name?*
> R2.   *Grandpa House.*
> R1.   *It's Grandpa House […]*
> R1.   *Yes, Grandpa, or Grandad or Grandpa House.* (SWCCG1)

It was evident that the grandparents and other close family members who had not travelled with them were at the forefront of their thoughts every day; they worried about their safety and missed them dreadfully. Conversations about relatives occurred in social groups where support was present. I did not specifically raise sensitive questions during the one-to-one interview so as not to trigger painful emotions. Where it was felt safe to do so, women did speak of their own painful situations naturally within the interview. An example of this is when one woman discussed how long she had been widowed:

> *About four or five years […] when the problems start in the country […] when there was bombings, he lost his life.* (SWIV11)

6.3   Rabbits in the headlights

'Rabbits in the headlights' is defined as 'to be so frightened or surprised that you cannot move or think'. This expression was utilised by a HV during her interview to describe her experience observing Syrian families' struggles on arrival in Scotland. This expression fitted with what I was hearing from those I interviewed, including the women, others I had

conversations with, and in reading the emerging data. It was evident that it was extremely challenging on arrival in Scotland, in not speaking or understanding the language, not knowing anyone or your way about, to find, contact and attend the health service needed. This expression naturally developed into the first theme.

6.3.1 Accessing health care

Enablers and barriers to accessing healthcare were both considered. On first arrival in the UK, most migrant people are given a welcome information booklet or pack from the Local Authority area where they have been housed. This booklet contains information about the local area and cultural practices, with helpful tips and ideas intended to assist integration. There is a section dedicated to healthcare information. I created an initial question on the healthcare section to explore whether the participant recipient had found it useful. This health information section will vary in each Local Authority area, but I was more interested in whether the participant remembered receiving the booklet and recalled anything that they found to be of benefit for their access to health care. As each had been resident in Scotland for different lengths of time (up to three years), some may not have recalled the booklet or pack. I showed an exemplar of this booklet to the women at the time to trigger their memory. This proved to be a necessary prompt. There were a few positive comments made about hospital, telephone numbers, and transport information. Some local cultural information was also found to be of benefit, as well as for making appointments:

> *It was the first step that we knew how to deal with services, the health services and how to book appointments.* (SWIV4)

Most either did not recall the information booklet or remember much of the content. Instead, they relied on someone verbally informing them. It may be the case that on arrival they could have been bombarded with a lot of information and the booklet may have been shelved. This timing of its delivery may not ensure its optimal use. Further, there may be a need for someone to go through the information in more detail at regular intervals with them to point out information that may be of value, becoming more relevant as time went on.

6.3.2 Views on useful information on arrival

For the Syrian women to be well informed and able to function on arrival, the findings suggest that they need specific information early, to have timely appointments, reduced waiting times for procedures, good transport and also a good doctor.

This illustration captures these feelings:

> *It's difficult because we can't see the doctor as fast as we need; and I think*
> *just faster […] I've got to find a faster doctor … so maybe the locals get used*
> *to this kind of service, but for us […] it just maybe takes a while to get used*
> *to.* (SWIV1)

Additionally, from this illustration: 'so maybe the locals … but for us', she separates Syrian people by their specific needs from those in the community where they are now living; they are used to their needs being met more efficiently. Although the door is left open for integrating, later they do not yet seem as though they feel quite ready. A plea for the HV to visit more frequently is also made, for reassurance that children are doing well, but also to have home visits. The women had few visitors and were keen for people to visit their home. Furthermore, there is a need to be listened to, to be understood, and the women sometimes felt ignored. Being provided with relevant information before arrival and early after arrival appears to be important for the women's self-esteem and for them to feel less dependent on others:

> *If I had known what I know now it will make a big difference because I will*
> *know how to deal with things and how to treat myself, where to go. So, I*
> *learnt everything after I came here.* (SWIV10)

The women were told to expect good and free healthcare before travelling, but little about the hospital provision. Officials being truthful about what to expect before making the journey to the UK could help enormously and avoid the women having high expectations, which may be unattainable.

The question about the booklet helped lead into a question on how the women accessed healthcare and who helped. I was keen to know who provided this initial support, and whether a HV would be named. The HV is an important health practitioner for those with babies and young children and provides a front-line face to health services. Each participant clearly explained receiving help from a support person, a resettlement officer or volunteer who assisted their registration with a GP and dentist, and optician if needed. One participant did mention receiving help from her HV but only after her resettlement officer and the GP were mentioned first.

6.3.3   Enablers

There was a consensus on the help received from an integration person, described in a number of ways as the integration worker, integration manager, resettlement officer, support worker, and volunteer. It appears that there are different names in individual Local Authority

areas for these roles, and these terms were used interchangeably. For consistency, in this thesis I will refer to the role as a resettlement officer. There also seemed to be misunderstandings by the women about people's roles and what each could do to help them. Nonetheless, a resettlement officer was pivotal in facilitating access to all essential services, as illustrated:

> R.   *She helps me to get to my appointments with a specialist after my operation.*
> I.   *[…] Does she travel with you?*
> R.   *Yes. […]*
> I.   *Is it the same person since you've been here?*
> R.   *Yes, integration worker. Yes, integration worker and support worker.*
> I.   *So, was that two people?*
> R.   *Two people.* (SWIV4)

In addition, I was informed by the resettlement officer that some women would approach anyone they thought would help them. Sometimes they got this very wrong, and it was inappropriate, but they were unaware. In one case, a woman asked at the English for Speakers of Other Languages (ESOL) classes for contraception advice. The woman may not be receiving the correct information from a person who knows and can explain, at the right time. Also of note, people who helped the women and their families did so beyond their role boundaries. For instance, transporting them where needed and babysitting.

6.3.4   Barriers

Media images support assumptions that Syrian people are being rescued from a war zone, where they will very likely have been exposed to illness, injury and trauma. Mulvey (2013), however, caution against overplaying the notion of consequential vulnerability. Nevertheless, the literature suggests that many refugees have underlying chronic health conditions, in particular where mental and maternal health support is needed. It could be assumed that they would be in need of health care. I felt however, that it would be useful to hear directly from the women of their own experiences rather than making assumptions. I was particularly interested in their ability to overcome any barriers. The women did reveal their health needs and spoke predominantly of difficulties in obtaining care and how their needs were not understood. Not having important information about roles and responsibilities made clear to them at the outset was problematic, and transport was difficult, but communication was the main issue.

6.3.5 Communication

The language barrier was a major communication obstacle. There was heavy reliance on the resettlement officer and interpreter. Some women have high expectations of themselves. In this illustration, the woman is harsh about her own competence, and is very judgemental of herself and her ability to speak English:

> *If I were ever to speak English of course, it would help me, and another how to make an appointment in health care. Because I am a graduate, is it English literature for my home country, but I don't know what happened in Syria I lost it.* (SWIV11)

Being a graduate, speaking English is important to her. Perhaps she is feeling inadequate, that she is being treated differently, like someone with little or no education. Her statement 'in Syria I lost it' also emphasises the point of loss, of leaving a familiar language behind. I recognised how much her English was improving over the course of my meetings and fed this back to her. However, simple measures can make a positive difference, such as sending text messages with appointments was found to be helpful, received by some women from their GP practices.

6.3.6 Transport

Transport can be a key problem for those attending appointments. Issues include distance and access to transport where there is some delay or avoiding making appointments because of the difficulties. Also, the expense of travel is an issue, with bus passes being distributed in some areas but not in others. There is a dependency on others for lifts, but this also raises questions over entitlements. Living within walking distance to an appointment is viewed as being of great benefit, as navigating bus routes and buses is particularly daunting:

> *Just saying we wait for a while in the bus stop and just say for the hospital we need to change two buses, so sometimes it's quite tiring.* (SWIV7)

This may indicate a need for help to plan journeys, such as route maps. The women are proficient with smart phones, so an app could be of value. Having the ability to understand money and to explain to a driver where you are going in English is extremely challenging. An additional layer of complexity arises when childcare is required for those attending appointments:

> *I had been unwell, very dizzy, and had to travel nearly twenty miles, too far. This is very difficult for husband and children.* (SWIV1)

6.3.7   Appointment issues

It may be the case that the women have a different perception of healthcare provision here than is provided, such as immediate access to health care when needed. Those expectations will be based on their experience of health care in Syria and that received on their journey to Scotland, possibly from having spent time in an adjoining dispersal county after leaving Syria. But also, these may be based on what they will have been told before coming here by officials, information from friends and family, and with what is shared on social media. First it may be useful to understand the women's perception of health care in Syria:

> R.   *Yes, every time that you need a doctor. It's a private one. So, you just go to the doctor, you wait for your appointment, you get the help and even if you want to make an x-ray, you get that. You go to the centre, you book an appointment and wait until you make the x-ray and go back. So, if you feel worse or unwell you can get the treatment the same day and everything the same day.*
>
> I.   *You said its private, the doctor. Is it expensive?*
>
> R.   *Yes, it's expensive. Let me just explain. So, we have the same condition. It's affordable. Before the war it was affordable and available for everyone and also in Syria, we have free hospitals and free healthcare. We have. But the ones that need to go to private, it's not expensive. This is before the war. After the war, yes, it's expensive.* (SWIV10)

A distinction is made between pre- and post-war provision, what has likely changed and would cost more now. The time delay waiting for appointments is a major frustration for the women, and whether to see the GP or for a procedure. It was not the case that the Syrian women found the Scottish healthcare system to be superior to their Syrian experience. As illustrated (by SWIV10) above, it was explained that the appointments in Syria can be made and attended on the same day, as opposed to here, where often they need to wait weeks to be seen, with implications for their health and wellbeing:

> *Now, I feel that I'm, I don't feel well, if I phone the GP for an appointment, he will give me one week or two weeks appointments. So, this is very, very bad for me. I feel that I need the GP now or to see my doctor now. So, that long-term appointment is very bad, this is the first thing.* (SWIV4)

Emergency care delay, particularly for children, was very worrying. Repeatedly stating 'very' emphasises her plea for help 'now'. In an emergency situation, the wait can be seen to be unbearable:

> *Sometimes my son, he is very tired; just he is very tired and I need … give me an appointment just next week. It's very bad for my children. I need … now he's tired, I need a doctor now. This is a big problem here. In my country I go, I can go to a doctor any time. Any time I can get a doctor; not the same here. And when we go into hospital, it's two … twice I take my son. Emergency. He's very tired, but I wait in hospital three or four hours before I see a doctor. It was about five hours you need to wait before you see the doctor.* (SWIV1)

The urgency and desperation in this woman's voice is compelling. Of note, the term 'tired' is utilised regularly by Syrian women to explain someone being generally unwell and feeling poorly. Trying to work out solutions to the dilemma of waiting, one woman inquired about private health care, even though it would be charged for. The woman is exasperated having to access secondary healthcare via the GP who is the gatekeeper, which delays her being seen. She does not understand why this is necessary, as Syrian healthcare allows people to go directly to the service and consultant they need without delay. It can also be unclear when to expect follow-up. Additionally, there is a lack of awareness of heath choices, particularly in relation to women's health. One woman explained how she was waiting for surgery for six months for a prolapsed uterus which was causing discomfort:

> *I have a problem with my womb it has fallen six months ago […] and my operation was cancelled. […] Yes very uncomfortable I have to wait six months to have it done now. It is too long.* (SWIV6)

It is clear that accessing health care for Syrian women is very challenging. The top priority for them is to be seen quickly by a doctor, and a number of factors that they outlined prevent this from happening effectively. Being used to same-day diagnosis in Syria, and what they view as a convoluted route to diagnosis in the UK, a number find this perplexing. This is exacerbated when they feel that what they are describing to the doctor is not heeded. The women believe their condition needs urgent attention, and by the GP making a routine referral they are locked into a system which leads to lengthy delays while their condition worsens.

This woman, on the other hand, initially states her satisfaction with the care provided for her husband, but goes on to explain that she does not have confidence in the diagnosis:

> *I believe it's a bit different, the care is great here and the way the people talk to you […] with the GP, sometimes they don't do enough tests, you know, just to support their diagnosis. For example, my husband for a while had a rash and they just expect, okay, maybe because of the insect bite. Because I do believe it's not allergy and not the insect bite, not … but I do believe because they changed his medicine, it's kind of it's an allergy to the second medicine but they are saying because of the plant and the stuff but they never did enough tests to support their diagnosis.* (SWIV7)

She feels that the GP has made a hasty diagnosis without proper investigative tests or consideration of all the facts.

6.3.9   Health beliefs and needs

A range of health beliefs are expressed by the women. The importance of the sun for health and wellbeing is emphasised, but also how the women may really feel, such as feeling disconnected, distant from home and lost in this strange place. In this section, the sun appears to represent home in Syria, what and who has been left behind. The sun is a permanent reminder of home. The illustration shows the woman's feelings of missing home and finding it a struggle to feel at home in her new country as everything is different:

> *So, there's something that is very important. The first time I just thought of this. We Syrian women, have lived and grown up in the Arab world. That means in the Middle East we had sun, we had many treatments that we don't need here. Let's say we need vitamins, we need vitamin D, we need the sun. Another thing that I thought about. Here, they don't prescribe antibiotics a lot. So, we've grown up and our bodies are used to antibiotics and they don't heal until we get antibiotics because in our country, when we have infections, they give antibiotics. So, we're used to using the antibiotics. Here, they don't give antibiotics. So, we don't heal quickly because our bodies are used to these antibiotics, but they don't understand that we need it really to get healthy. Our kids can learn this, and their bodies can get used to not having antibiotics but for us we need this. They don't understand. They don't give antibiotics until we need it very, very much and our condition will get very*

worse. […] The sun. All year we have the sun. […] Yes, the biggest doctor is
the sun. (SWIV10)

From this, it appears that current concerns about antibiotic prescribing, that when they are over-prescribed it may lead to resistance and to difficulties with managing infection in the future, may not have been made clear. It is possible, with conditions in Syria, that the risk of bacterial infections could be higher. However, antibiotics are not appropriate for treating viruses and this needs to be fully explained by the doctor, as often patients will not be aware of the difference between bacterial and viral infections. Failure to make this clear means that people will keep coming back time and time again looking for antibiotic treatment and will feel their concerns are not being properly addressed. The desire to be prescribed antibiotics for themselves but not for their children is also noteworthy for implying that their heath is dependent on them, but not the children's health, who can adapt and respond to new medicines. Although it is acknowledged that people are helpful, they feel that their needs are not really understood. This lack of sun, leading to health problems, is a recurring worry expressed by the women and an explanation for needing additional health supplements. This lack of sun is also blamed for weight issues, and poor bone health.

This woman, when asked about a smear or a breast examination, believes that she has no need for screening as she keeps herself healthy:

No, no, no. Not friends with the doctor and hospital, […] because I am clear
in myself, clear in myself […] I have a system in morning, garlic and water
hot every morning, early, I wake up early and eating garlic and cup of water
hot. (SWIV7)

Repeatedly she sates 'no' and 'not friends with the doctor', meaning she is not a frequent visitor to the doctor as she has no health needs, and does not require screening as her ritual of garlic and hot water every morning keeps her healthy.

6.4   Loss of home

The loss of home theme emerged from an interview which took place in a Syrian woman's home. This was a very warm and welcoming home, but one where the loss of the Syrian home was palpable, and I was struck by the feelings I experienced from being in this home which I still feel as I recall that visit. The woman told me how she takes care of her home, the pride in undertaking her housework and taking care of her family and any visitors.

6.4.1   Health and wellbeing

To gauge the experiences and views for how Syrian women manage general health conditions and to explore their expectations of health services, a number of questions about routine health matters were asked to remove the focus from directly asking women of their own needs to that of their views more generally. This approach was intended to enable them to discuss what they felt comfortable with, without feeling pressured, or needing to reveal any personal information. Despite asking broad questions for general responses, most personalised the answers to their own selves and their family's needs. Health anxieties were evident. Some of these anxieties, it could be argued, can be witnessed in the wider UK population at any time (Axelsson and Hedman-Lagerlöf 2019), but here the focus was on their health concerns in relation to their understanding and prioritisation from past experience in Syria.

I asked the women whether they have ever attended for a smear or breast examination. Some women received these checks in the UK and some in a dispersal country before coming to the UK, such as in Turkey, while others have not been screened. Some have had worrying results:

> *I had a smear test […] It was positive, and they told me that I had many*
> *infections. So, they gave me a treatment and they made a small operation*
> *for me. I got well after that. […] Sometimes during the period I feel that I have*
> *pain and I don't feel well all the time.* (SWIV10)

The heightened risk of cervical conditions for Syrian women may need to be highlighted to them and to professionals.

Expressions of concern about entitlement to health care were raised, even though these women arrived via the resettlement scheme where health service entitlements are much clearer than for other refugees and asylum seekers:

> *They haven't told me if I am entitled for these checks.* (SWIV11)

I inquired about contraception and planning for children to only the married women of childbearing years, as it felt inappropriate to ask the others. This raised a variety of responses, from attending the practice nurse for contraceptive coil checks to advice from a GP, which was perceived as unhelpful:

> *Just we use, I didn't ask anyone for help, but I just used the condom. […]*
> *When I've needed that advice, I went to the GP and the GP gave me four*

things to follow, four steps to follow. So, I just said that all these things I don't want these things, choose to use that condom. But just recently I feel that I have like infections or things like I'm not comfortable with this, so I need really to ask for this. […] They advised for implant. But didn't want that because they said that it is, I will have a constant period, a heavy period. And the tablet is not good because they are not good because they, if you forget once then you will have children. (SWIV4)

One woman was very keen to have another baby but felt she was not getting the medical intervention required. However, this advice could be in line with the criteria for all citizens:

We ask the GP and they refer us to a department, just to help. Just because we had one son, they stopped the treatment, so we are not entitled. (SWIV3)

Headaches are a common condition that most people encounter where self-care with paracetamol would be common. This was consistent with the Syrian women, although, for some, they needed to go through the resettlement officer for assistance. One participant explained having a persistent headache linked to high blood pressure and another had eye problems. Attending a GP does not get the response desired. This example reveals feelings of concerns being dismissed when advised to take paracetamol, which is regarded as ineffective. This may be due to fears of underlying health conditions not been investigated:

Just I have, I take appointment to GP, to see a doctor and explain for him my problem. But not give me medication, not for this, just for me and for my children; just paracetamol for everything. Paracetamol is important here. […] For everything. (SWIV1)

Children's speech development or delay could highlight English not being their first language, but also, delay could be attributed to trauma, possibly originating from a war zone. Maršanic et al. (2017) discussed speech impairment as one symptom of the traumatisation of children dispersed from war countries. Biavati-Smith (2017) suggests that being from a bilingual family should not cause any serious delay with speech development. Those children exposed to two languages from birth should show no delay, but those acquiring an additional language can take longer to process this learning. This can appear to be a delay, but the children catch up as their confidence grows.

Speech delay did not seem to be a priority for the Syrian women, with few having concerns about their children's speech. The women perhaps did not recognise the symptoms or had too much else to deal with, so speech development was not a prime concern. The women

referred to children speaking in both Arabic and English and having speech therapy for them when needed. This was regarded as being positive when improvements were recognised. One participant mentioned that her child was mainly using sign language but was not deaf:

> *He doesn't speak a lot. Sometimes he just speaks to me by signing something. So, I don't know if he improves a lot, but they are slowly improving.* (SWIV10)

This child could have a hearing impairment, but equally could be showing signs of trauma. When I inquire whether she has any concerns about hearing, she assures me that she has no concerns. Another woman treated speech delay like a behavioural issue where corrective action was taken to remedy the difficulties:

> *I don't go to anyone, just explain to them that this is wrong, and I explain why it is wrong and they, my kids, they just hear the word, and they understand that. I just remind them and explain why it is wrong and why they shouldn't do this.* (SWIV4)

She is keen to show she takes action and can deal with most issues she faces. Inquiries about hearing raised responses such as having had surgery for a perforated ear drum and treatment for infections, including the use of home remedies to resolve minor ailments.

When asked what they might do for a family member diagnosed with diabetes or when they suspect anyone may have diabetes, the responses suggest that diabetes is a condition they are familiar with in adults. Concerns arise in that it may now be becoming prevalent in children as a result of the war:

> *Now we have here after the war, a lot of diabetic kids.* (SWCCG4)

It is not clear why this is or whether 'here' means Syria or that Scotland is being blamed. Additional serious health concerns could be missed with conditions rarely encountered locally and symptoms not being recognised. Thalassaemia is one condition where it appears that the symptoms were not acted on by the health professionals, which could be due to them not being familiar with this condition. This is a hereditary condition of the blood, originally prevalent in the Middle East, Asia, India, and Africa, and now found further afield as a result of people migrating (Peters et al. 2012). One woman raised concerns regarding her daughter which resulted in a delay with diagnosis and treatment:

> *My child was not eating, the doctor says she is fine, but she is tired and losing weight. I was very worried she had poor colour. The health visitor came, and*

> *I asked for blood to be checked she said no. I needed blood check now. Now two years later she is diagnosed with thalassaemia.* (SWIV8)

This appears to have been a serious omission. Dental treatment was also a cause of anxiety, and the service provision was not clear. In particular, access to emergency treatment was not recognised. Concerns were raised about getting a dentist, time delays and the condition deteriorating while waiting:

> *The dentist, the one before, I had a pain between two teeth, and they took the teeth, so I wasn't very happy. And even though I told the second dentist, she told me not possible. So, for the last three months, I was looking for a good dentist but thank God, I finally found one. When I made the appointment, the earliest one was in a month's time again. Up to now, I have got pain and for one month, I am thinking ... now the other side is starting.* (SWIV11)

The quality of the treatment with the materials used for fillings is questioned:

> *Okay, the dental stuff, the dentist is the biggest problem because sometimes the teeth is quite inflamed, by the time they see the doctor, sometimes there's like an abscess and it's gone worse. […] And the other thing, you know for the dentist, just was surprised here they use what's called the filling is not the white one, the other one […] as far as I know when I was in Syria, they kind of banned this one because it's got some. I'm not sure, some toxic stuff, so at the beginning just the white, just it's more healthy rather than silver one.* (SWIV7)

Fears exist about the quality of treatment, in particular, serious worries about the substance used for fillings. This may not have been adequately explained in that other treatments are available when paid for. This may indicate that the women felt unable to ask questions. Nevertheless, this demonstrates their expectations and knowledge of treatments, as well as being used to a better standard of care than that received in the UK. However, this is an important health issue, as, for many, dental care has been severely neglected for some time due to the unavailability of services and the prioritisation of feeding families over paying for treatment in host countries (Saltaji 2015).

6.4.2 Home remedies

The findings from questions related to burns and vomiting are presented next, where the women discuss their home remedies, only accessing the doctor if these do not work, if, for

example, there is a fever. A range of remedies are explained to manage routine conditions. First explained is toothpaste and flour used to treat burns:

> *Using flour, and sometimes if it is a small burn, I can use toothpaste, just to make the area very cool. In Syria, so many people use toothpaste.* (SWIV11)

It is explained that the mint in the toothpaste helps to cool the burn. As well as having a lie down, sipping peppermint tea, ginger and honey or milk are used to treat vomiting:

> *First time I try to do some home treatment. And something that I use to get well when they take it is ginger and honey, I just put them together.* (SWIV4)

The women were proud to share their remedies for ailments and felt able to manage without the need for professional intervention. In this next illustration, the woman begins by stating 'he's vomiting', and 'it didn't happen to me', declaring that she is never ill, before she confidently describes how she manages for a family member.

> *Okay I mean if he's vomiting, you know, I mean it didn't happen to me again, but obviously the self-care is a good diet, obviously liked boiled potato, hot pack, you know, I just put the warm pack on my tummy. And vegetables, soups.* (SWIV7)

She names putting onions, carrots and cabbage in a broth to settle the stomach and when these would be given:

> *In morning only liquid soup, after coming, come back school, eating soup, not eating all the sweets, biscuits, no, 24 hours, yes, stop, and after, yes eating all.* (SWIV7)

These remedies are part of the Syrian women's toolkit for home treatments, which they were keen and proud to share. However, the safety and benefits claimed from some of these measures need further exploration.

6.4.3   Mental health and wellbeing

I was keen to know whether growing up in a war zone and displacement was affecting mental health and wellbeing. For children, this could potentially manifest in disturbed sleep, highlighting mood disorders such as depression. In addition, I wished to know how any children's sleep problems were managed. This section revealed some underlying worries when the women used the opportunity to raise concerns about their own disturbed sleep pattern and losses. This could be symptomatic of their displacement and the magnitude of

the losses ensued and represent a deeper depression. Some women were very keen to let me know that their children did not have sleeping problems. Watching TV and storytelling were used to manage any sleep problems with children, however, one woman specifically stated she would not know how to deal with children not sleeping:

I've got no clue because it didn't happen to me. (SWIV6)

The women disclosed their own sleeping issues when the question was directed to the children's needs:

*No worries my children sleep good. **I don't sleep well** I go to GP […] I am only sleeping 3-4 hours […] I have tablets.* (SWIV2)

R.   *I **didn't**, they sleep […] that's why. Half past nine they go to sleep.*
I.   *Do they sleep all night?*
R.   *Yes […] **I can't sleep, I can't sleep**.* (SWIV4)

One woman explained that pain prevents her from sleeping well. This next illustration is where concerns are expressed about being prescribed sleeping pills when, as a lone parent, she will not take them because of her childcare responsibilities:

*The GP just advised me to take sleeping tablets, but I don't take them because I'm alone with my kids. If I sleep and something happens to my kids this is a very big problem. So, I don't end up taking them […] **I don't sleep.** I go with the kids too because they sleep with me in the same room. So, when I go out of the room they wake up. So, all the time, I stay with them in the room, but **I stay not sleeping. Just awake all the time**. I explain my problem many times to the GP, but the GP just advised me of the tablet that I can't take.* (SWIV10)

Some of the women sleep in the same room as their children, even though most have their own room. This may be common within their families, but could also be from having lived in a war zone they need to be close. On a further question about how they would respond to someone with low mood, feeling sad, maybe becoming depressed, a variety of responses were made. One woman's father had recently died, and her husband and friend were supporting her. There was uncertainty for how to manage low mood, but participating in positive activities, such as swimming, having fun activities or engaging with their faith or just staying home was suggested:

> R.   So if it's me I'm not going to see anybody, I just stay home. […]
>   Sometimes it happens you are in low mood you don't want to see
>   anybody.
>
> I.   And sometimes that's fine, isn't it, for maybe a day or two; but if it didn't
>   improve?
>
> R.   I don't know. […] I don't know. (SWIV5)

Reading the Qur'an and taking exercise is viewed as positive, and another intervention was vitamin C. Most would not access professional help unless really concerned and would not be sure how to go about that. Of importance is the woman who seeks comfort in her son, who is six and a half years old:

> Yes. Most of the time when I feel tired or depressed, I have one of my kids,
> a boy, he becomes like his dad to me. He's only six years and a half but all
> the time he just comes to comfort me and speaks to me. So, I feel very happy
> when I speak to him. (SWIV10)

This child reminds her of her late husband. She further demonstrates how resilient she is:

> At the beginning I started to cry a lot. Cry a lot. Then later on, because of my
> kids, I need to just stay away and get stronger in front of my kids. So, I just
> stay and feel like I want to give everything. I don't think of these things that
> make me depressed. And feel like I'm stronger in front of my kids. (SWIV10)

It is evident that the women are suffering multiple loss. The words used in the next illustration are particularly moving expressions of one woman's grief:

> We cry. We cry. […] If you can cry, if you can. […] When I feel like I miss my
> mum, I miss my sister, my family, so I just put on a video and watch them
> and start to cry. (SWIV4)

'We cry we cry', she says it twice, signifying the sadness she feels without her mother and sister in particular, but she is greatly missing her whole family and watches them on video and looks at photographs for consolation.

The women were experiencing loss and depression and appeared to be receiving little support. This could have an impact on the wellbeing of their children, particularly the child who was a reminder of his father. The women were stoical, but their sadness was deeply palpable.

6.4.4   Home and cultural ways

I wanted to understand what cultures and traditional practices the Syrian women would like to be observed by health professionals, and to what extent, if at all, this aligned with the ideas and beliefs of current staff, and with current research and practice. Piacentini et al. (2018) acknowledged that intercultural practice in the home was significantly different to that delivered in a clinical setting, due to the shift of power created by the clinician being a guest the client's home, and that research in this area was lacking. I also wished to know how the women communicated their requirements, especially in relation to home visiting, a key function of health visiting practice. Some women did not request anyone or anything different to the healthcare services already offered here. They just wanted a good doctor. Others requested a female doctor or interpreter, and doctors' receptionists were often asked to arrange for this. In some areas, arranging an interpreter takes time to get right, resulting in appointments being cancelled with delays. It can take some time for some GP practices to request a female interpreter. Particularly problematic was a male attending when a female was needed. Sometimes women can feel obliged to accept a male interpreter, but this can be very upsetting for them. In this illustration, one woman explains how she felt with a male attending, in her being a wearer of the Hijab, when she inadvertently showed her hair. The Syrian women were not always sure how to make their requests for their preferences:

> *It would be nice for the respect because I have got the Hijab; obviously, I need a female doctor and female interpreter. Just for the last, I had a problem with my hair and I wasn't lucky because the doctor and interpreter were both male and I was embarrassed to cancel it. I had to show my hair but I wasn't very comfortable. So, just a female doctor and interpreter. But, for my son and husband it's fine for them to have male or female. (SWIV3)*

It appears that some families have very few people visiting them in their homes. One woman said she had never received a home visit. Another woman, who did not feel at all well, was very keen to have home support and would make no requests for cultural preferences to secure this:

> *R.   I feel that all the time I need a doctor or a health carer or a carer that would be with me all the time, because I feel tired most of the time. And if I can get this help or anyone that they can just visit me or can get help, this help at my home it would be very good for me because I can't just go out all the time.*

I. If they come to you at home, is there anything that you would expect them to do to observe anything, any of your culture or practices?

R. There is no specific thing. […] It's according to my health condition and how can I feel or deal with this, but there's no specific. (SWIV4)

As illustrated, a range of health issues are of concern for health and wellbeing, with dissatisfaction expressed regarding treatment and what appears to be compromises being made to secure their needs.

In the home from where this theme developed, I was served Arabic coffee from a china tea set. It had been carried from Syria and had belonged to the woman's late father. The tea set had been given to the woman by her mother as she departed from Syria, being fearful she may never return home. The woman spoke of leaving Syria, saying goodbye to her mother. This was a deeply emotional moment. She treasured this tea set and I was very humbled to have been served from it. She had carried that tea set all the way to Scotland.

Some displaced Syrian people arriving here through the resettlement scheme may be fragile and feel broken, perhaps needing care. Many others are resilient, rather like china. This theme represents the fragility of the displaced Syrian people, the continuity of and preciousness of their lives. The theme stretches from them remembering their family and friends left behind, coming to Scotland with few of their personal belongings from home. I experienced how the Syrian people arriving here welcome family and new friends into their new homes, and served from their 'tea sets', or whatever precious dishes they might have. Holding close dear memories and special things from Syria supports continuity and helps build resilience and may be critical to their existence and identity and brings hope for the future.

The next theme, 'reclaiming home', considers the Syrian women settling, their relationship with the HV service, and becoming integrated.

6.5 Reclaiming home

Having originated from the data, 'reclaiming home' developed to become a theme influenced by the progress I observed the women make with English language acquisition, and over time settling into their communities. I recognised the efforts they were making to settle in this new world, but, importantly, the relationships they were forming, the new homes being created, and the aspirations they had for the future. The Syrian women shared their wonderful food with neighbours and new friends, and some small businesses, such as bakeries and cafes, have emerged in the areas studied, run by Syrian families. The sharing

included that with professionals who visited their homes. This socialisation appears to be pivotal to their integration, identity, sense of self and belonging, and, ultimately, how they reclaim home, and is a useful theme to explain the next part of the research story.

This section begins by exploring a subtheme on parenting, an area where HVs can have a key support role. I was eager to hear how the women understood their parenting role, their relationship with HVs, and their understanding of the health visiting service and Named Person function. I was curious to find out whether they found the health visiting service helpful and easy to access, and if so, in what ways.

6.5.1 Parenting

The Syrian women take parenthood responsibilities very seriously. This is illustrated earlier (Section 6.4.3), with the woman who would not take her sleeping pills because she was a lone parent and needed to mind her children. But also, they regularly highlighted that their children were healthy and needed little intervention, implying that they do a good job as mothers. Encouraging their children to behave well, they nurture them, stay close, co-sleeping and entertaining them with storytelling. This woman declares she is in tune with her children's needs:

> *I know all about my kids. I know their problems. I know every problem.*
> (SWIV1)

They try to be good role models and expect high standards of behaviour:

> *I try to be tidy but my kids, all the time, they take things, and they don't put*
> *that away, but I try to teach them to put things ... All the time.* (SWIV10)

There was a keenness to show that they were responsible parents and their children had minimal needs, even when they had an injury or accident. For instance, one appeared to minimise a child's burn:

> *Last year my son burnt his knees, toes, because I was cooking but he*
> *touched the pot, but I took him to the pharmacy, give me just gel but it's not*
> *a big problem, a little burn.* (SWIV1)

It is likely that it was his fingers he burnt, and the mother did act appropriately by seeking professional advice and treatment. Nevertheless, she was embarrassed, and so reports that the burn was really small. A burn was the reason for a three-day hospital admission for another participant's child, who had spilled a hot drink on himself. These accidents can

happen in any home. However, the prevention of accidents is another area where the HV can offer support. HVs receive notifications when children attend hospital following an accident, requesting them to provide follow-up to families.

6.5.2   Understanding the health visiting service

Although one or two women were not clear about the HV role, the majority understood that the HV monitored children's health and development. The most frequent comment was that they would like more visits from their HV. They appreciated being invited by the HV to contact her when they needed:

> *So, what I understand about the health visitor that she just watches a child's improvement in health, in growing, is he growing, his height, his weight, his speech improvement, everything that relates to his sleeping, diet, everything. Everything about the health and she all the time, my daughter she doesn't suffer from anything, she is well, so she just comes to watch her. […] And make sure that she is good and that she needs anything. She even, if she is between the appointments if they get, ask for her number she said if you need my any time just phone, to ask for help. […] If the girl needs any help just don't hesitate to phone.* (SWIV4)

One negative comment was made about the HV not following up on a child health concern raised regarding thalassaemia (Section 6.4.1).

6.5.3   Understanding the Named Person service

The Named Person (Section 2.1.3) is a role within GIRFEC policy from the Named Person service provided by Local Authorities and Health Boards which has key functions for certain professionals working with children, including HVs (Scottish Government 2020b). The HV, being a single point of contact for families with children under school age, is important for helping with more immediate access to health services. I was interested to know whether the Syrian women had been informed about the advantages to them of these HV functions, as well as their understanding of the functions. They had minimal understanding of the Named Person role, and most had not heard of it at all. This role appeared to cause some confusion. Blank expressions were noted. Most referred to the HV generally or thought I was asking the name of their HV, and misunderstood the additional aspect of the role. One person said she understood having a named HV but was vague and did not explain specifically the function:

> *R.   No. As a Named Person you mean?*
> *I.   The health visitor, as a Named Person to the family.*

R.   Just to be clear, you mean like they specify one person for this family always?

I.   Yes, for children under school age.

R.   Yes.

I.   Yes, so you heard a bit about that?

R.   Yes. (SWIV9)

No person mentioned help from HVs as the Named Person to access health services. Overall, it appears that the information the women receive regarding the HV service needs improvement. There is a lack of understanding of the NP role and how women can really be helped and supported by HVs. It may be the case that the HV role is not being well explained, is difficult to understand, or that doctors are valued more than nurses. Other roles, such as the interpreter and resettlement officer, may be more familiar.

6.5.4   Being independent

The independence of the Syrian women has already been illustrated with their ability to manage some health care without professional intervention. The need to be independent was further evident with the women expressing their desire to have control over situations themselves, be less dependent on support workers, learn to drive and have choice over where they lived. This illustration provides a bold statement, demonstrating a growth in confidence:

So, before it was council, now I am in charge I. (SWIV10)

Next, she explains what she does at night when she cannot sleep, by using the time effectively learning from YouTube about driving:

That's why I just take the tablet (iPad) and watch driving lessons in bed … I practice because I want to take my driving theory test. (SWIV10)

Another woman is not satisfied that her house meets the needs of her family and is frustrated. She had the confidence to raise this with the resettlement officer, seeking a change, but did not go directly to the housing department. She is confident, however, of independently contacting the health centre for making appointments:

But no, because my house is very big, three floors. Very bad; there is four stairs in my house, and kitchen down. My living room is first floor … second floor. And bedroom is third floor. It's very difficult for me and my children. (SWIV1)

And also,

> *If I need appointment I call the health centre and I take appointment.* (SWIV1)

6.5.5   Integrating

The women I met had been living in Scotland from between six months and three years and lived in very different areas. Their Syrian identity is hugely important to the women, and the notion of integration was perceived differently by different women. For one, it was important to belong in the community, for another, to be less of a burden. One woman expressed her desire to be able to make her own appointments and decisions. She lacked the confidence to do this, mostly due to the language barrier, which had an impact on her ability to integrate and feel integrated. This first woman expressed her first impressions of Scotland and what it means to feel a sense of belonging:

> *The first visit in Scotland all the street, ground, it's green and the flowers are yellow […] and after the tree very nice, very beautiful. […] And in my street, all my neighbours are friendly. I feel understand? The neighbour just made me feel normal […] yes, I'm one of the citizens, like others. […] They like my food and […] coffee or something, you know.* (SWIV7)

This woman really warmed to Scotland and the Scottish people. She reached out to neighbours, inviting them for coffee and to try her food. What is interesting is that she explains how the relationship with her neighbours makes her feel 'normal', and this is partly due to her warm and welcoming nature. 'I'm one of the citizens, like others' compounds her need to feel that she belongs, and she is proactive in ensuring that she succeeds. Another woman was keen to obtain more information to gain confidence, but she also acknowledges the burden she makes on the resettlement officer, which would reduce when she becomes more independent:

> *They're just saying because we haven't been given so much information, we ask please do that, to integration manager. Just if they give us more information so we can rely on ourselves, so even the integration manager can be free.* (SWCCS1)

An illustration is provided here of her journey and the progress she has made towards managing the health care system herself:

> *In the beginning, Integration worker would just ask if we needed anything, you know, he was making us an appointment, but now we just go to the*

health care and ask for appointment. […] I was very happy as well, because once I was very very tired, I phoned the GP again, and they gave me the emergency appointment, the same day. (SWIV3)

Her needs were recognised, and she was dealt with quickly. Where the families have been housed has an impact on their integration and whether they live near friends, made friends, or have access to preferred facilities, such as the Mosque. This woman was asked whether she felt settled, having lived here for two years:

No, not really, I would like to live in the city not here. […] I have a friend there I like to see, and the Mosque is there also, and the hospital. (SWIV2)

She has little control over where she lives, which is holding her back from feeling that she is settling.

6.6   Summary

In this chapter, the findings from Cycle 1 have been presented and the themes explained. The Syrian women I met with encountered a number of challenges in accessing health care on arrival, and some of these challenges are still evident three years on. Furthermore, it has been demonstrated that these are impacting on their health and wellbeing. Communication was a key feature, holding back their independence and integration. The women's grasp of English language was improving. Confidence in speaking English was growing, they made use of Google Translate, and communicated via face time when they needed help to understand or be understood. The acquisition of English was pivotal in their gaining confidence for community integration. Despite this progress, the dependence on the resettlement officer was still evident after three years. Nonetheless, they were especially proud to be able to do things for themselves and they really enjoyed socialising and making new friends. Most understood that the HV service was for their children, not themselves, and wished more regular visits from the HV. However, the Named Person role was not recognised.

Chapter Seven now explores findings from Cycle 2. This includes the lack of HV education, information and preparation for the arrival of Syrian families onto their caseload. Chapter Eight provides further interpretation and discussion.

Chapter Seven: Cycle 2 Findings – Destiny

7.1   Introduction

This chapter presents the study findings for Cycle 2. Of note, regarding coding:

'HVQ' signifies the HV questionnaire, and 'HVIV' is the HV interview.

The findings presented in Cycle 2 comprise the health care and help that HVs provided to meet the needs of Syrian families, along with the challenges they faced in doing so. This includes their role as the Named Person. Their education needs are also considered.

The discussion is situated in the thematic framework developed from Cycle 2: 'thrown in at the deep end', 'above and beyond', and 'you don't know what you don't know'. Each theme is presented with an explanatory definition, and each incorporates several subthemes.

7.2   Thrown in at the deep end

The theme 'thrown in at the deep end' explains the predominant views expressed by HVs regarding their perceived readiness for working with Syrian refugee families. It denotes their anxiety due to having little or no information about the families before allocation to their caseload or preparation for their arrival. They experienced frustration at not being notified when a family was moving in or not being invited to meetings or having relevant information shared. This compounded their anxieties:

> *I was very unprepared for meeting the Syrian family I had been allocated. The worker involved with their care would not even disclose the names of the family members I was going to visit. I arrived at their home with no knowledge on culture, beliefs, or names of the family. I had no idea what health information had been given or not given to the family. I did not know if they knew what a health visitor was.* (HVQ8)

HVs faced challenges in carrying out assessments without basic data and medical information, in working with interpreters and from a lack of translated materials. Also, they were unsure of the role of the resettlement officer, who was tasked with co-ordinating an integration plan for Syrian family arrivals.

7.2.1   *Expected practice for arrival of a Syrian refugee family*

It is common for HVs to be given information in advance of any new family coming onto their caseload, unless emergency situations arise, such as covering for absent colleagues. This

information mostly comes from health services administration, from midwives, or GPs for new arrivals in the practice. Possible notification of a Syrian refugee family's arrival could also be expected from line managers, social work, housing, or resettlement officers. Transfers into a HV caseload require a child's file to be passed on, but also, in some areas, a family file may be expected. Where there are at-risk and wellbeing concerns, a verbal handover, to ensure continuity of any ongoing issues, is considered best practice. These 'transfer in' files are mainly electronic, but some can be in hard copy form. Information expected to be included in the file would be socio-demographic data, such as the family's names, address and telephone number, plus their immunisation status, child development progress, and any health, development or safeguarding issues. These would include a child's plan, and a chronology of events in a child's life. A child's medical history, additional support needs, and details of any prescriptions would also be welcomed. Key professionals' details would also be recorded and helpful if extra information is needed.

In refugee cases, multiagency planning meetings are held in advance of a family's arrival, for a co-ordinated approach to meeting their needs. They are planned for by the resettlement officer. HVs, as Named Person for children under school age, would expect to be invited to and contribute to these meetings (Smith 2018). This information and attendance at meetings would assist in facilitating an understanding and prioritisation of activity for the HVs. Provision of relevant information is paramount to preparing for and delivering an effective service to families from arrival.

Hearing from HV participants about the information they actually received in advance of a Syrian refugee family arriving onto their caseload, with how they prepared for their arrival and first visit, in turn, helped me to understand their practice context.

7.2.2   Notification information

Very little or no information was received by the HVs before the families arrived. They were not invited to meetings and seeking information from the GP practice was often futile, as they had received little information themselves. Notification came through more unusual routes, such as nursery staff, child protection nurse advisors when no child protection concerns existed, or from schools; one HV discovered movements into her practice area via social media. Furthermore, notifications could be received informally from a staff member, just in passing. There was a sense that most did not know from whom or where to expect notification information. Consequentially, HVs felt very much left out of the loop and ignored in the whole process. Weeks could pass without them being aware, unable to make contact to support the families.

This HV explains a positive process where she receives information as expected, and she expresses this as a 'fail-safe'. Yet, no invitation to the pre-arrival planning meeting or follow-up contact was received. Further, the family had lived for several weeks in their new home before she heard about them:

> *I was told via the GP. So, when they register with the GP, we get a slip to let us know, and that normally happens within a week, so that's quite fail-safe. I also knew that they were coming from the refugee settlement officer. He had sent an email to myself and to my … not to myself, sorry, to my manager, which my manager cascaded down to our team.* (HVIV9)

The planned communication with the resettlement officer never happened:

> *And he, so he was just pre-warning us that they were coming, and he said he would get back in touch before they moved or when he knew for definite. And that was the last I heard from him.* (HVIV9)

Once alerted about a family, HVs may have little information to work on. Particulars may need to be obtained direct from the family, relying on them to share essential data. As English is not their first language, this would be challenging and complicated when working with an interpreter (Drennan and Joseph 2005). Furthermore, some information they bring may not be reliable, having travelled great distances, it may be lost or damaged, having possibly been completed in displacement situations.

Many refugees had little personal information, and some arrived without any records – not even a date of birth. I questioned this, particularly as I would expect parents to know the date of birth of their children, but this was refuted. The rationale given was that survival was more important than remembering dates, and, in some cultures, dates of birth are less important than in others. Travel documents would sometimes record a 1st of January birthdate with an estimated year, which would be updated if records turned up later. For other families, a date of birth was the only information the HV received. These issues not only complicate health care delivery, but they also have implications for personal identity. In one case, following a request by a HV for information from a housing resettlement officer, she was informed that there was a two-year-old arriving. No details of other family members were passed on. Generally, there are concerns about the accuracy of the information:

> *So, they did come with some health information from the UN, but it was very, very minimal information and we couldn't really rely on it in terms of the immunisation. So, it was really kind of starting from scratch, pretty much.*

Yes, and the other kind of thing that really impacted the children's health is there was a whole sort of issue around about the date of births for the children. Well, it was only … it was an issue in terms of working out the health needs for these children because we weren't a hundred per cent sure what actual age they were. (HVIV3)

The Community Health Index Number (CHI) number is the unique NHS identifying number that each citizen receives in the UK, and establishing this can add further complications:

I remember one child had two CHI numbers and that was from a transfer up from England. The child had been sort of lost in transition and the child arrived with two CHI numbers. And that was difficult, because in terms of immunisations and what immunisations the children had had, that was obviously difficult as well, because they didn't necessarily come with medical records and child health tend to look for medical records to interpret what they've had. (HVIV11)

Parents often could not recall what immunisations children had received, particularly from the chaos of living in refugee camps. Each of these situations has the potential for error with health care delivery. Furthermore, HVs came to realise over time that they were not being invited to the pre-planning meetings where cases were discussed, when other agencies had been invited. Having this information is important for effective practice, and some HVs would go to exceptional lengths to obtain it. One travelled over 50 miles in a round trip to attend a public meeting to obtain information.

7.2.3   Initial contact and assessment

An initial assessment of health care needs is a routine task undertaken for new admissions in a GP practice and for new cases on the HV caseload (Cowley 2021). It would usually be an essential requirement to gain an understanding of everyone's needs in a new Syrian refugee family's household. However, there was some confusion around whose responsibility this assessment was. No areas from the study held a specific clinic. Most initial checks were undertaken by the HV or practice nurse, or with the GP if medical checks were also conducted.

A key principle of HV practice is seeking out health care needs (Smith 2017), and I was interested to know whether a HV would include all members of the household for assessment, or not. This could have implications for all family members' access to health care, for building positive relationships with the family, and for workload capacity. However,

the scope of the HV role is determined by their employers, and some HVs have specialist roles, such as working with travelling communities (Baldwin and Johnson 2017). Different views were expressed by the HVs in the study. Some only assessed under-school-age children, prioritising the younger children. Others indicated all children and parents were assessed, and some would include grandparents, so taking a full household approach:

> *And then I would think about the health needs of each person individually.*
> (HVIV9)

HVs aimed to ensure that all grandparents had access to universal services, were registered with doctors and dentists, and practice and district nurses. These were viewed as serious HV responsibilities, and, even when they felt that the grandparents were not actually part of their work remit, some did include them. Nonetheless, the inclusion of grandparents was considered from different perspectives. Some HVs considered the grandparents' health care needs only, but others approached this by considering the capacity of the HV time and workload pressures, or the impact of the health needs of the grandparents on the child's wellbeing:

> *No. I think I would be looking at the grandparents obviously if they're living in the same home and I'd be thinking, you know, are they well enough to be assisting in caring for the children? How would that be impacting on the children? You know, would it be that their house needs modification? Would there be dietary requirements? You know, are there safety risks? You know, if mum and dad were to go out and they were left with grandma, who's got arthritis, is she capable of looking after them? Is there additional support that needs you know, home safety provisions? That would be my kind of thing.*
> (HVIV6)

They aimed to ensure the same health needs were anticipated for parents, and also for things such as contraception and health screening.

7.2.4   Communicating with Syrian families

Communicating with Syrian families to arrange a first contact meeting was a difficult process, and the initial approach was treated with trepidation by those with little experience of multicultural caseloads. Fear of the unknown, with perceived inaccurate expectations, fuelled their apprehension. The most successful way to facilitate this were the messages relayed via the resettlement officer, although some HVs found that cumbersome.

HVs' ability to communicate directly with the women was sometimes hampered because the women might speak a number of different languages. The HVs tested several communication tools and booked interpreters, but they were not always reliable. In addition, the mechanisms to secure the funding to pay for them was not always clear, leaving the HVs wasting time making inquiries. Bookings required at least a day's notice. Consequently, a local person was relied on for immediate needs. This presented additional difficulties with trustworthiness, as discussed later (Section 7.4.5). Other sources of communication valued by HVs encompassed both digital and traditional methods. LanguageLine, the telephone interpretation service, is one service that is able to be booked at short notice for short appointments. This HV discusses a number of communication approaches that she attempted:

> *Well, obviously there's a language barrier so any contact would have to be arranged through an interpreter. Actually, some of the problems I've had is actually contacting Mum to arrange visits because I've tried texting her and usually, I've resorted to getting messages through the nursery to her. And she's starting to Google Translate now. But actually, that was one of the hurdles that I couldn't actually contact her, so she didn't have any English at all.* (HVIV7)

HVs recognised that, for many of the women, gaining confidence to speak English was an issue for them, not their understanding of English:

> *They also, now, are understanding more than they are, you know, able to express. But I also think, from my experience of visiting a few of the families, it's not about being reluctant to speak English, I think it's just, they don't feel very confident about it.* (HVIV2)

A number of factors could affect attendance at ESOL classes, such as inadequate childcare arrangements. Some preferred to learn at home rather than attend classes, choosing to learn from the internet. Nevertheless, there can be serious implications with ineffective communication, especially when it relates to language and medicines:

> *I remember quite a lot of support being required sort of explaining through an interpreter obviously what the prescription was and what to actually do with the prescription. Then the whole thing about the … of course, the prescription being written in English and explaining how the medication was*

to be taken, regardless of whether it was vitamins or whether it was antibiotics or what. (HVIV3)

7.2.5   Working with an interpreter

Interpreters are necessary to translate, but they may be difficult to access, are costly and sometimes can break confidentiality (Drennan and Joseph 2005). Furthermore, they can act as a filter and do not always reliably relay information (Drennan and Joseph 2005). Meeting regularly with the same interpreter when a good relationship had been established was valued. Knowing a particular dialect and where it was appropriate to work with a male interpreter was found to be helpful, particularly when only a male may be available:

> *The first interpreter I think the GP ever organised was a male, a young male and it was totally inappropriate culturally, so we very quickly changed that, and we had some very good interpreters. It was okay for males to come to the meetings we had at nursery, the subsequent meetings we had so that was okay because dad was present, so the communication was okay for that but in terms of health appointments whether it was with myself or the GP, and it was tricky sometimes getting, especially with any short notice, it was very, very difficult.* (HVIV3)

Of note is that a number of families still require the interpreter to translate two and three years on. Consequently, this is a burden for health provision, and, for HV services there is recognition of ongoing additional time required. Enhanced skills are also necessary to work effectively with an interpreter (Wallin and Ahlström 2006), as explained by this participant:

> *So, you do need additional time. You know, sometimes, it's difficult to just be sure that the information you're putting across is actually what they're receiving … you have to, you've got to listen really carefully, and like, you would normally do as well, you know, in any kind of visit, but I think you've just got to be even more, you know, kind of attuned with your, with your listening skills to them, and picking up on non-verbal speech, as well, and checking out that, you know, you've understood them.* (HVIV2)

Confidentiality when working with interpreters was raised as a concern. This is known to sometimes be problematic (Williams 2005). One example given was where the HV, having established a positive relationship with one woman who confided in her, later discovered the interpreter had breached confidentiality:

I'm here to support you as well as the children. You can speak to me about anything. You can share with me what you want. You don't have to if you don't want to share anything that's absolutely fine, but I'm here to help you cope with your new situation and she seemed to, kind of, understand that and take it on and then I get a call from my manager […] to do with the conversation I'd had with this lady in private with the interpreter. The interpreter had gone to the resettlement officer or to someone and shared something. (HVIV4)

There were expressions of incidences where interpreters could be rather forward during contacts to the point of taking over and directly answering questions or anticipating a question and asking the women ahead of the HV request. This is recognised as a problem in the literature (Wallin and Ahlström 2006). Familiarity was a further issue raised, which is also reported in the literature (Williams 2005), when there was an already established relationship between the Syrian women and the interpreter, especially in smaller communities where they could be neighbours. On occasion, when visits took place without interpreters and a resettlement officer, satisfaction is expressed by the HVs:

It was lovely. Really, an interesting visit, you know they spoke a lot. Obviously, it wasn't as fluid as if we spoke to somebody that spoke English, but it was absolutely fine. And they were more than happy for me to rearrange for me to go and see them next month as well. So, all in all it's been very successful, the day I would say. Up until then it just felt a little bit, oh why are we having to go through the housing support officer, why was she getting involved, she was taking over, lovely lady but I felt that she was taking over. And kind of, was a bit bossy with the family to […] I don't know. It just felt very very fraught. (HVIV5)

The skills of the interpreter, as well as the ability of the HV to work with them, was vital to the success of the meeting. When the interpreter was no longer needed, both the families and the HVs found these visits much more productive.

7.2.6   Translated resources

In addition to oral translations, written materials needed to be translated, and obtaining these was additional work to acquire them or have materials translated. HVs were unaware whether their core resource materials, such as information leaflets, were available in Arabic. Google Translate was sometimes used, available via mobile phone app, as it was convenient, and could translate text. The information leaflets needed to be translated and,

together with written letters, were routinely used to notify of a home visit or appointment. However, most letters sent out were in English, some with a footnote about where the letter could be translated. The responsibility for translation passed to the recipient, an additional burden for them. Some parents did prefer letters:

> *He said if you write to me, he said I can Google Translate it if I don't understand and then I'll call you back.* (HVIV9)

Clinical notes were also received by the HVs in Arabic, and having these translated could be virtually impossible. Moreover, when the obtained materials were translated there could still be concerns about their quality:

> *We have used UNICEF, like things for the breastfeeding and bottle feeding […] We went online to try and get that, because you don't know how much they're taking in as well, and again it's the interpretation, if the interpretation of the literature is good or not. Previously as well we have asked one of the interpreters if they would read what we were handing out, if it was useful, and they said it was a lot of gobbledegook.* (HVIV10)

Many contacts with the families were made via the resettlement officer and some of them could understand and speak a little Arabic, which was a massive benefit for everyone.

7.2.7 Resettlement officer

Working with resettlement personnel was reported by the HVs as generally positive, but there were occasions where this was less satisfactory. Awkward situations arose, for example, when resettlement officers attended the home visit with the HV and an interpreter. Having additional people at a visit can make the women feel uncomfortable, as illustrated in this instance, where the resettlement officer is from housing:

> *She's insisted on sitting in on the visits. […] It was very difficult, because the translator is there, so I would ask the question, the translator would then ask the family and then the housing support officer would read throughout whilst we were there, but in her way. So, it just didn't feel right.* (HVIV5)

The additional people made raising more sensitive conversations very difficult, leaving HVs feeling they were giving less than optimal service to families. HVs found the resettlement officer very helpful in answering their queries. However, the resettlement offers organised the planning meetings that the HVs were left out of, and some felt that this was an oversight in that they did not understand the HV role.

7.3 Above and beyond

The 'above and beyond' theme represents the different ways in which HVs helped, and the lengths they were prepared to go to in order to ensure the Syrian families had support and access to as many appropriate services as they needed, and that they could possibly help with. Most wished they could be of more help but felt inadequate. They also tried to ensure that their cultural needs were addressed.

7.3.1 Racism

The HVs recognised that the women could need immediate advice on arrival, particularly to address negative comments from people when out and about, to minimise racism in some communities. For example, the identity of Syrian women in smaller communities being recognised by their clothing can make them stand out, particularly when groups of women who are out and about are all dressed in black. HVs helped to explain this to the women by telling them how people did not mean any harm, and that they were curious but friendly. They were alert to community comments, both positive and negative, and attempted to dispel myths.

7.3.2 Supportive partnerships

Syrian people may unknowingly access the wrong service on occasion, due to the challenges of having to navigate an extremely complex health care system, such as attending emergency services instead of primary care. It was recognised that not only those from different cultures may find it testing to find their way through NHS services (Drennan and Joseph 2005).

For Syrian women to successfully access appropriate health care, HVs recognised that a number of factors need to be addressed, which they could support though forming supportive partnerships (Cowley and Bidmead 2021). HVs gave explanations about relevant health issues and distinctive primary care roles to help understand better who to go to. They were pivotal in explaining how the NHS functions, clarifying the range of services and how to access them, with how the appointments system works, including waiting times. Obtaining and understanding prescriptions were significant problems identified by HVs. One HV wrote letters to help the families. Some HVs supported families beyond their roles. For example, HVs accompanied families and give lifts, helping the families to obtain urgent medical appointments and, in one instance, taking a parent to the pharmacy:

> *I do remember doing a home visit and I did actually walk round with dad to the chemist because I what I was explaining to the dad was too complex*

because it was really about either getting a prescription from the pharmacist or asking for this particular thing. So, I mean, that's the sort of thing I would never normally do with another family. (HVIV3)

HVs worked alongside families, supporting them each step of the way where they could.

7.3.3   Raising awareness of entitlements

A number of entitlements are available to Syrian families, but these are not always clear, even for the professionals, such as paying for interpreters, transport, and child care. The result is that many families do not use the services which could make a positive difference to their health, being fearful of any financial implications. Moreover, opposing views can exist as to how local funding should be allocated:

Then they, kind of, organised for some of the funding to be used for the pre-nursery age children to go to nursery […] it was good for those families, but that's a deprived area where lots of families could do with lots of childcare support. (HVIV4)

This situation could potentially set the Syrian families in opposing positions to other families in need, and they may have no idea that this could be an issue. Consistency across the country is lacking with regard to allocation of and raising awareness about such entitlements, which can have a great impact on the uptake of services. In some areas, bus passes are made available, which reduces the need to ask and pay for the ticket. In other areas, the families need to pay for travel out of their benefits and must be able to communicate their destination to the driver.

Another entitlement which may have a significant impact on health is for healthy start vouchers, which the HVs distribute. These provide free vitamins for children and pregnant women, and can be used to buy fruit, vegetables, infant formula or cows' milk. These are important for all families' health, but, for the Syrian women who worry about bone health, these could provide reassurance that they were providing for their own and their children's needs (Baldwin and Johnson 2017). HVs also supported families by applying for grants to obtain essential furnishings:

They literally had a house, they didn't have any furniture or anything, so I kind of supported them with applying for charity applications and onto the housing about furniture and a cot for the baby. (HVIV6)

HVs spoke of families struggling to manage their finances, unable to afford basic essentials, and where the resettlement officer would help to monitor. They also had a role in helping to obtain clothing, household items and food parcels when needed (Baldwin and Johnson 2017).

7.3.4 Respecting cultural and traditional ways

Sensitivity to Syrian families' cultural and traditional ways was perceived as being less than optimal in their practice by the HVs themselves. Most HVs were tentative, having had no prior education about Syrian refugees. Only a few HVs had some previous experience. Cultural knowledge for the home visiting element of health visiting would be useful to understand, and which is different to those for practitioners in clinical situations, and this may need addressed to ensure HVs are sufficiently educated to the meet needs of Syrian families (Baldwin and Johnson 2017).

A range of cultural issues were encountered and positively responded to by HVs. These included removing shoes at the door, a preference for female practitioners, offering refreshments, child safety, dressing modestly, women's clothing making them noticeable in the community, avoiding visiting at prayer times, etiquette for shaking hands, and being alert to Mosques in the area, which is important for community engagement to help avoid social isolation. There were many unknowns raised about cultural ways, such as whether Syrian women drank alcohol. HVs were unsure about asking and needed answers to these unknowns. The degree of confidence depended on whether they had previous refugee experience or had worked abroad. It also rested on whether the HVs viewed these families as needing care different to other non-English speaking families on their caseloads. For instance, those who worked with Iranian families could draw on their experience of weaning advice.

HVs experienced dilemmas with beverages and food being regularly offered to them, including tea, coffee or food. This is a key feature when visiting Syrian families, and HVs had mixed views about accepting the offers. Particular concerns arose regarding the additional time needed to have tea, but there also were fears that, if tea was accepted, it could be seen as behaving differently with Syrian families to that in visits with other families. Such matters are more complex than they first appear, with the potential for offending if hospitality is refused:

> *So, for example, quite quickly I realised that culturally whenever I went to visit the home, mum was offering me a drink of tea or coffee and I tried to refuse one time but she looked so offended that I changed my mind and said,*

okay, yes, I would, and then she was quite happy. I guess then I would have had maybe a conversation afterwards with the integration officer and he must have reassured me that, oh, yes, that's what you do when you go into somebody's home in a Syrian, Arabic family and it would be considered very rude not to take a drink. So, in spite of the fact that it was very strong coffee or very strong black tea then I took a drink. (HVIV3)

Families may bring the drink without asking, leaving HVs in an awkward position in deciding whether to take it or not. HVs searched for information on how to manage the situation online, but questions arose on the reliability of any guidance found. Some HVs were keen to maintain a professional relationship and did not wish the visit to become more social.

Child safety could also be considered as being culturally specific, for example, on the purchase of stair gates to resolve a housing safety problem. Stair gates are routinely bought by parents of small children in the UK and are provided to others in need when they have indoor stairs, to avoid accidents of children falling down the stairs. Many Syrian families are not familiar with stair gates. They prefer to keep small children close by, usually in the kitchen with them where they like to spend their time. The housing that many receive in the UK does not meet their requirements, as many have kitchens that are too small for their needs. Also, some of the houses had more than two floors, so they were constantly running up and down to watch the children. By not using the stair gates, as promoted in the UK, this could wrongly lead to questions about their general parenting ability with regards to UK standards:

So, the baby when he was starting to crawl and just beginning to sort of pull himself up on furniture etcetera. So, the house that they were in was over three floors, so it was like a split level and the wee one fell down the stairs and had to go to A&E. […] then stairgates were purchased for the family, but they never used them. They were there in place and when I visited or other workers visited, they would make the token gesture of shutting them but culturally that was just an anathema to them. (HVIV3)

These gates proved to be unsuited to this Syrian family and no other options appear to have been discussed.

Consideration of the family's religion was also important to think about before a home visit, with HVs going so far as to monitor what they would wear:

> *So, in terms of my preparation, it was to think about cultural things, such as, obviously not shaking the Dad's hand, although I did stupidly offer my hand out and then he, and he was very polite, and I can't believe I made that faux pas. And just be mindful of how the mum was going to be present, trying to gauge that. It was all quite relaxed by the last visit, in that respect, their relationship. I mean, it never felt that he was being patriarchal, for example. So, just be mindful of cultural things, such as taking my shoes off, thinking about what I was going to be wearing that day. Obviously, I don't walk around with short skirts on.* (HVIV5)

The 'faux pas' situation clearly embarrassed the HV when she attempted to shake the father's hand. Nevertheless, this HV considered a number of measures to honour the family's preferences and would appreciate time in advance to research and prepare. But there also is a need to identify the religion, as non-Muslim men may be fine with shaking hands (Baldwin and Johnson 2017). As well as challenging assumptions, such as the male role, it is recognised that there is a need to be open-minded:

> *It used to be initially the men always hung about, always hung about. They're happy to leave me with their families now, don't hang about at all, they will even just say, hi, hello, cheerio, and they go out the door, they are more than happy now doing that. Just about, again as well, I found that the men do let their wives talk. The men tend to be there if they want a form filled out or they want you to do something for them, you know, right, then they'll stay, and then they'll go away.* (HVIV10)

In contrast to treating Syrian refugee families in a special way, it was felt by a couple of more experienced HVs that they should be treated the same as other similar families coming onto the caseload:

> *Not to generalise but their kind of cultural needs are much the same as, you know, the Iraqi families and the Iranian families, it's quite similar and I didn't really find there was anything that stuck out. There certainly wasn't anything that I couldn't manage.* (HVIV6)

Some adaptation to practice was recognised to be needed to meet cultural needs, and this exemplar raises the potential need for revising assessment techniques, such as the Edinburgh Postnatal Depression Scale (EPDS), which is used for assessing PND:

> *When you do your visit and you do your EPDS, I find that really hard and I've stopped doing it with a lot of my women. Sort of more generally talking. Again, it was an interpreter had said, you know, we could tick all of these and get a really high score because of our culture. You know, and I thought, oh, what's going on here? One of the ladies when she was being asked the question sort of laughed. I'm just normal, you know, why are you asking me these questions? Then it's the way the interpreter puts it across as well. No, and I think the language of EPDS for the Syrian families or Syrian women is maybe, I don't know if it needs to be changed […] because they don't talk about mental health as well.* (HVIV10)

Here, the HV is challenged by the interpreter about the validity of the tool she is using to assess Syrian women for PND. The EPDS is a validated tool used to assess for post-natal depression (Cox et al. 1987). The HV is concerned that the questions may not be being asked by the interpreter as intended. A translated EPDS version is available, but the HV may not be aware of this. However, others have suggested that the translated version has not been translated accurately (Firth and Haith-Cooper 2018). It is evident the education around assessment and support for depression and PND may be necessary to meet the needs of Syrian women.

Meeting cultural needs was very high on the agenda of every HV. They would endeavour to be respectful, going to great lengths to become informed, to search for information and the services that families needed. They were thirsty for knowledge. They aimed to provide optimum information and support, similar to how they provide services to other families.

7.3.5   Responding to child health and wellbeing issues

The HVs were confident with regard to the Syrian children's speech development. For tongue-tie concerns, these would be referred for a surgical procedure sometimes required to allow the tongue to move freely in very young children. They would also routinely allow children additional time for speech development when living in multilingual homes with English as a second language, and allow for first language vocalising in their assessment:

> *Where English is not their first language in the home, you know, it's important that they're starting to speak, well, they're making sounds, like vowel sounds, but they're kind of speaking their own language.* (HVIV2)

But, more than that, the individual child's circumstances needed to be considered, such as considering separation anxiety for assessment as a causal factor in speech delay, and this

they were familiar with. Furthermore, HVs were providing additional support for speech and language telephone assessments when a staged speech assessment process is needed. The first stage of the assessment takes place over the phone, and, due to the language barrier, the women were unable to manage the call. Consequently, the HV agreed to attend in person during a call:

> *They get the referral and then they ring the parents and have an assessment over the phone. So, that might be difficult for the mum, but I could put on the referral form that I could be there at the time that she states to ring, so it needs some liaison and careful planning.* (HVIV9)

These assessments could have an impact on HV time, travel and workload capacity to be in attendance.

As previously raised (Section 6.4.1, SWIV8), thalassaemia is a hereditary condition (Peters et al. 2012) which needs careful monitoring to reduce harm from iron overload, leading to heart and liver disease, and which can be fatal, and was a question raised from the vignette. Carriers of the disease need to be identified and they must avoid taking iron supplements. Treatment can include stem cell transplants. The best outcomes are observed when the condition is treated at an early age, so new-born babies require testing in populations most affected. Early screening and pregnancy screening is advised, as is genetic counselling for couples carrying the genes, as a preventative strategy. Timely referral is important, to advise accurately regarding diet, iron and vitamin supplements, and to help monitor the condition. However, few of the HVs had heard of the condition, and the few who had struggled to recall it or how it is managed and would instead refer on to the GP.

There was concern expressed about particularly high sugar levels in the diet of Syrian families, with implications for poor children's dental health and oral pain. Concerns about dental conditions and access to treatment have been raised in the literature (Saltaji 2015, Paisi et al. 2020). HVs helped families to register and engage with dental treatment, and referred to the children's healthy teeth project, ChildSmile. The HV plays an important role in promoting good dental health and in educating families (Scottish Government 2015).

7.3.6   Responding to mental health issues

Syrian refugee families may display particular mental health vulnerabilities as a result of loss and separation, trauma, displacement and social isolation (Killian and Agathangelou 2018; Orcutt et al. 2019). HVs work from a child-centred approach to practice in GIRFEC policy (Scottish Government 2020a) and need to recognise the impact of mental ill health of family

members on children, which is essential to their assessment (Appleton et al. 2021). Establishing the HV perceived role with mental health for adults and children is important. Any interventions they might take, plus their awareness of support services, has implications for their practice, training and capacity, and, ultimately, mental health outcomes. Mixed experiences and views were expressed. There was a recognition of mental health needs:

> *There were people who had good jobs, educated. Some of them were well educated. You know, and didn't have anything like that anymore and, you know, there was all these ... there was all these type of things like the men's, mood, depression, you know.* (HVIV4)

Most HVs were not aware of any specialist services available for trauma support. The HVs acknowledged that most families were suffering the loss of family members and friends, loss of home and identity, as well as the loss of the many new relationships formed since leaving Syria impacting on wellbeing:

> *The mum was very open and obviously became quite emotional when she just openly started speaking about how they had come up here, even the family and friends they'd left in Egypt, not just Syria.* (HVIV8)

Due to the lack of background information shared with the HVs, they were not certain, but they assumed that some suffered trauma symptoms. Questions were raised about the status of having lived in camps, suggesting that there may be associated stigma. Some HVs struggled with how to open a conversation about mental health:

> *It was going in not knowing anything about the families and not knowing the traumas that they had been through. You know, maybe what they've experienced and what they have come from. Some of them came from camps, and some of them haven't come from camps, and you feel as if maybe sometimes they think you're ... you need to know, so you need to ask. But I don't know if there is this, well if they come from a camp if it is sort of frowned upon or not looked upon nicely. So, it would have been nice to know exactly where they had come from.* (HVIV10)

It was acknowledged that mental health staff may not be adequately trained for dealing with the needs of Syrian refugee people, suggesting that the HVs had little confidence in them being able to effectively support those who are in need. There was fear of repeating the same questions, potentially damaging their mental health further. Moreover, concern about

potential disclosures raised HVs' anxieties about not being sufficiently educated to deal with needs:

> *I did feel inadequately prepared because it's not something I've dealt with in the past and I was quite hesitant about the fact that this lady might have had, or this family may have had significant trauma that I wasn't aware of. There were also perhaps issues with the fact that if they did divulge information to me that I maybe wouldn't know how best to deal with it. And I guess I do feel that I am unprepared. I'm not used to dealing with people with, you know, post-traumatic stress disorder, but I'm used to vulnerable children.* (HVIV7)

7.3.7   Responding to women's health and wellbeing issues

The literature showed that the health and wellbeing of Syrian women may be compromised by a number of factors with the potential to seriously impact health, and HVs were keen to respond appropriately. They agreed that they had a role in explaining the systems and procedures for screening regarding cervical smears and breast examinations and in helping women to access those services. They were aware of the need for sensitivity when asking questions about personal health when a partner was present. The HVs needed to tread carefully, to check the proper customs when addressing women's health issues in order to not to offend anyone (Baldwin and Johnson 2017), seeking and taking the opportunity to speak to the woman alone where possible:

> *I wasn't sure of the culture between mum and dad, whether mum is able to give me her free opinion and speak openly and honestly, I certainly felt dad answered more. Whether acceptable that women make decisions and plan. So, when I went, on that note, when I went back for my follow-up visit, dad was in bed, so I was able to, I asked her, I said, oh how did you get on with your health appointment and your smear? She hadn't gone, okay, so we booked another one then and there. So yes, and the other thing while dad was upstairs, because I had asked them at the removal in visit as well about contraception. That was again slightly awkward because you don't know whether it's appropriate, whether they are used to asking these things. But I did say via the interpreter, this is what I would ask all my families, so I apologise if it's in anyway, you know, offensive to your culture and please if it's some question you don't want to answer that's absolutely fine. I said that they would check her weight and they do her blood pressure, and we also spoke about emergency contraception that she can get from Boots at any*

time and via the GP, she did not know about this and she said to the interpreter that she didn't know. (HVIV9)

This HV was particularly aware of the woman's needs and eager to meet her expressed needs without embarrassment. Social isolation is a further area of concern and is exacerbated by the transport problems that the women encountered.

7.3.8   Social isolation concerns

The HVs were concerned about the Syrian women not speaking English, lacking confidence, having young children, and no extended family support or transport. Bringing Syrian people together was not always a positive solution, as disharmony could occur. The HVs worried that this could leave the women socially isolated, which could in turn have an impact on their health and wellbeing. Furthermore, social isolation may lead to tensions in the home, leaving some women vulnerable to domestic abuse. HVs routinely inquire about social isolation and domestic abuse at contact visits (Scottish Government 2015). They undertake a domestic abuse risk assessment if required, and when in a safe and suitable space, to discuss any issues raised (Scottish Government 2015).

7.3.9   Domestic abuse concerns

Raising the subject of domestic abuse is generally difficult, and, for the Syrian women, was further complicated when working with an interpreter, who can sometimes be relied on as a mediator (Wallin and Ahlström 2006; Maršanic et al. 2017). On occasion, the Syrian women would manage to obtain support for themselves, but sometimes covert approaches for safeguarding the woman and children were used, in particular when cultural and religious factors influenced decisions and actions. The complexities involved are numerous:

> *Also, obviously as health visitors now we ask about gender-based violence and we would normally … and I would say that was a difficult thing, a) to get mum on her own to ask that because we never, ever would ask that if dad was in the home but also culturally. I felt that that was a really difficult thing to communicate through an interpreter and a very difficult thing if you're going to Google Translate the questions. […] I think at one point the integration officer was a bit concerned that there perhaps could have been some domestic abuse going on.* (HVIV3)

Domestic abuse sometimes can be normalised within Syrian culture, especially in the context of family life. It can be ignored within a patriarchal family construct, with cultural or religious affiliations, and sometimes arise from fear or control (Pittaway and Bartolomei

2001). Being mismanaged in this way can prevent others questioning the behaviour and offering support to the woman. As a result, HVs can fear making incorrect decisions. Further, one HV reported religion as a conflicting factor between one couple with different religions from each other, where the husband spoke on behalf of his wife. Reports of domestic abuse were mentioned by a small number of HVs. Resettlement officers too had expressed concerns about domestic abuse when they would be called to assist. One woman who had agreed to participate in the study was unable to be approached following an assault by her husband when he ended up in court. Also, a child reported an issue at school. Similar situations to these can apply to any women exposed to domestic abuse. However, the HVs' concerns are regarding the knowledge of and accessibility of support for the Syrian women. This example resulted in a covert approach to visit the woman at home, when concern for her safety was an issue:

> *We had to have meetings in the health centre, and we said that we were doing some work on play with the younger child. We had some developmental concerns about the younger one, so we kind of masked it as that. But also, it was myself and the social worker meeting with mum and supporting her in how she could leave, basically […] mum didn't have access to a mobile phone either, so it all kind of had to be pre-planned and we had to send out like letters and stuff so that dad could see it was a genuine appointment. And we also had to be equipped for if dad decided to come with mum that we could quite quickly turn it into something else. It was quite difficult with the language barrier as well.* (HVIV6)

One HV suggests that there may be a need to be alert to heightened risk of domestic abuse:

> *I tried to do a wee bit of research. I was just, kind of, thinking about women's health and women's sexual health and sexual violence and all that, kind of, stuff you know, and I tried to bring that up at one of the meetings just, you know, about it being important that we know how to support these women because ... you know, women can become relieving machines for men, especially in these, kind of, situations.* (HVIV4)

It appears that some HVs lack confidence and could make unfounded assumptions of widespread abuse without adequate education. The HVs were worried about responding appropriately to domestic abuse situations and wanted to provide support. Also, many of the HVs spoke very positively of family relationships where husbands were very supportive.

Overall, the HVs were prepared to do anything they could to support families' health and wellbeing in a culturally sensitive way, whatever their needs. However, they need to be better educated to know the best way for this to be done.

7.4 You don't know what you don't know

This theme developed from a statement made by two HVs on separate occasions in relation to their education. They each recognised that they lacked knowledge and were ill-prepared in an area of practice unfamiliar to them when working with Syrian refugee families. Each stated, 'you don't know what you don't know', to express their analysis of this situation. They did not have the knowledge, but neither did they know, till then, that their practice might be inadequate as a result.

7.4.1 Health visiting service

HVs explained their own role and service to families at the first contact visit, which was important for the Syrian women's understanding, as some were confused with the role and assumed that they were doctors. Also, by liaising between the family and the GP practice, the HV helped to bridge communication:

> *I would make sure that they are registered with the GP and that I would speak to the practice manager and ask them, you know, if there was any outstanding health concerns because I would be going into visit. So, that there was the one person that could relay certain things.* (HVIV10)

HVs offer a range of service to all families with young children to help them raise their children healthy and well (Cowley and Whittaker 2021; Luker et al. 2017). The level of service offered with the time and frequency of visits is determined by the Health Plan Indicator (HPI) allocated (as discussed 2.3) (Isdscotland 2021).

7.4.2 HPI allocation

In most areas, HVs allocate from two levels: 'core', and 'additional', and a small number also allocate to a third 'intensive or vulnerable' category (Scottish Government 2015). The 'core' category allows for the universal pathway visits and occasional supplementary visits or short periods of additional support. The others allow for increasing contacts that are more tailored to need, including input from other health professionals. When time is needed to gather information for analysis prior to allocation 'U', for unknown category, this can be allocated for up to six months (Isdscotland 2021).

The additional definition is:

> *An additional HPI indicates that the child (and/or their carer) requires
> sustained (>3 months) additional input from professional services to help the
> child attain their health or development potential. Any services may be
> required such as additional HV support, parenting support, enhanced early
> learning and childcare, specialist medical input, etc.* (Scottish Government
> 2015)

Asking about the HPI allocation was intended to identify the level of service anticipated for
each family, and to trigger a conversation on the decision about the family needs,
expectations and resources applied. All HVs stated clearly that they would allocate additional
or vulnerable HPIs on first assessment because of the identified complex needs:

> *I'm saying they would be vulnerable initially, as was my experience that I
> classed them as vulnerable initially. Then, when they had health needs like
> the referral to speech, then they became additional but now two-and-a-half
> years down the line, they're core.* (HVIV3)

As time went on, this would be reassessed and updated. That said, there was no
consistency applied to the number and length of time of visits in addition to the universal
pathway; some HVs would visit monthly and others every eight or twelve weeks. Parenting
support is next considered, in being a central HV role.

7.4.3   Parenting support

The HVs remarked on the positive parenting they observed in the Syrian family households,
and on how parents prioritised their children's needs and were readily available to them. A
range of issues were raised, and recognition was given to the pivotal role of grandparents.
The families on the resettlement scheme did not have their grandparents with them, and
they were sorely missed, particularly as the families were isolated. This might be similar to
the experiences of many women who do not have family support readily available. One HV
discovered a child who had arrived much later from Syria when she visited the home. The
separation of the child from the mother would have implications for bonding and child
development:

> *Again, when the child was ... it's quite a complicated thing, the mum and the
> brother had come here without the child, and then the child arrived later,
> which we discovered, and because of the child not being with the mum, so
> initially there was attachment issues.* (HVIV10)

The HV role supporting parents is more challenging because of the language barrier and is not helped when materials are only available in English. The next quotation provides an illustration of how an autism diagnosis may be difficult for Syrian people to understand or accept. Struggles with retention of information also need further exploration, as do the stress and anxiety that could be generated in these circumstances:

> *But again, with the language barrier, and it's a big thing to take in when your child has been diagnosed with autism and, you know, thinking differently and doing things differently, and it's really, really, hard with this mum, really hard, I don't know how much she's actually retaining. So, you're having to repeat things a lot and then again, saying, I don't know anything about that, I haven't been told, and you think, oh, we did tell you, you know, but you've obviously got so much going on in your head, that's the same with British families as well, it's just how much they're retaining when you are speaking to them. Just trying to get stuff in Arabic as well, it's quite hard at the moment.* (HVIV10)

Resources for play and learning were limited in some Syrian family homes. Children could be under-stimulated. HVs provided toys and additional support, and these were welcomed. Early years education is well accepted in the UK, where children over the age of two years are entitled to a number of free hours at nursery. HVs helped families to apply for places. However, it was noticed that Syrian children could be too sleepy at nursery to learn, and the problem was identified as being late bedtimes. Further, parents could misunderstand the service provision, thinking it was a childminding service:

> *I thought that was maybe a cultural thing that maybe the children actually go to bed a lot later than we would put our children to bed. So, she hadn't realised it was like a pre-education setting so then it was trying to explain to her what this nursery environment actually was, and it wasn't a childcare, kind of thing […] so she had no idea about this preschool education.* (HVIV8)

Establishing routines with reasonable bedtimes was essential for children to engage positively with learning. Some bedtimes were as late as 10 or 11pm. Once these were rectified, the children adapted well and the parents were very proud of their children's achievements.

Disciplining children was an area of concern reported by HVs, particularly as smacking appeared to be common practice in Syrian families and has legal implications in Scotland:

> *Some of my families had come here they didn't know how to control their children, because they knew they couldn't hit them, and they had come from a culture where they give a child a slap. So, a lot of parents found that hard as well, you know, how to chastise my child, how to, you know, how do I control them? I'm not allowed to hit them.* (HVIV10)

This raised the issue that Syrian parents may need to adapt to Western ways of disciplining to keep within the law. HVs have a key child safeguarding role (Appleton et al. 2021), but, more often than not, when a suspected case for concern emerged in Syrian families, explanations of legal requirements, with a little support, helped to educate parents. The parents then modified their behaviour. This next HV recognised this:

> *A child concern put in by a member of education staff who should never have been in their house, but that's outwith their boundaries, and she put in a child concern that there was no fireguard on the fire and that the toddler was throwing things into the fire. Not throwing it, but, you know, just his parents were, kind of, taking the child away, but I think yes, I think it was a bit of an over-reaction in a way, rather than just speaking to us and letting us speak to the family and things like that, but this wee boy was a wee bit unruly you know, and he was allowed to be. I put in a support worker just to, kind of, help. You know, just for play to seem you know, how they can distract him and help him, kind of, act in a different way and he was like hitting the baby. Not hitting the baby, not going and punching her or anything, but just, you know, being a bit rough with the baby.* (HVIV4)

Providing a short period of additional HV support to families, similar to that offered to other families, can reap significant benefits (Cowley 2021). With this HV, the mother showed her gratitude by making them lunch. Furthermore, understanding and empathy from the HV regarding the complex experiences of the Syrian women made for a much more holistic assessment, and of setting realistic expectations. The expertise of HVs in assessing and responding to situations such as these, appropriately and in a timely manner, is dependent on information being shared with them (Appleton et al. 2021). The Named Person function of the role is next explored and may be useful in this regard.

7.4.4   The Named Person role

The role and function of the HV as the Named Person was explained to the Syrian women by a small number of HVs. Nonetheless, the HVs gave an ambivalent response to the role for the women, as most regard their role as a point of contact for families, signposting to the

relevant services, and making referrals when needed (Cowley and Bidmead 2021). It was suggested that the Named Person title was irrelevant, as it simply formalised existing HV functions.

The title of Named Person was seldom used, as it added a layer of complexity to explanations that most felt was unnecessary. HVs added that, despite being Named Persons, they were almost always omitted from all communications. HVs continue to request that agencies share information, and there appears to be general confusion about who informs whom:

> *So, they obviously thought that we would get the information through another service, and the other services probably thought we would be getting the information through the GPs.* (HVIV1)

The titles of Named Person and Lead Professional, another key role within GIRFEC policy to lead and manage complex or high-risk cases, do not seem to be clear, even within statutory agencies:

> *It's not just about Syrian families at all, it's about, what training people have done […] the nursery, you know, education staff, specifically. And some of the midwives, as well. But, aye, maybe education, and the Social Work, even sometimes, they get a bit confused between the role of Named Person and Professional Lead.* (HVIV2)

Confusion exists with professionals' understanding and execution of the Named Person role, and this seems to be an additional difficultly to explain to Syrian women and for them to understand. Being recognised as the family HV and the appropriate health person to contact was clearer for families. This helped their understanding, in making connections and integrating into the community.

7.4.5   HV support for integration

The ability to integrate into a new community and adapt to new ways of living while maintaining identity and making new friends is essential to the health and wellbeing of Syrian families. This requires a high level of coping strategies and resilience on their part to succeed. I was keen to hear how the women coped through this major transition and how the HVs helped. The HVs reported a range of impressions, remarking that coping with multiple agencies alone requires skill. Gaining employment was virtually impossible for the women, but welcoming communities who reached out helped families to engage and feel

included. Moving house several times, however, for some, before acquiring a permanent home, made integration more challenging:

> *Families who have, you know, been part of the resettlements, I think their resilience is quite astounding because they've left their war-torn country with no possessions, no money, no finances, no concept of where they're going to be put, they arrive in the UK and they're often moved around about three or four times. There're people in and out their lives, there's housing officers. There's asylum workers, there's health visitors, there's all these people and we're telling them they have to do this and this and it's all through an interpreter and I think that in itself is quite a resilient thing to be able to do.* (HVIV6)

Many women searched for services and their preferred foods, such as halal meats and flour. However, learning to speak English was a major challenge. Some were making good progress, but others lagged behind and struggled, remaining on the periphery. They stayed home or within safe and familiar friendship groups. The importance of establishing positive relationships is connected with gaining trust and confidence to venture out. This socialisation in new communities is challenging, but neither could it be assumed that Syrian people would wish to mix with each other in the safety of known cultures:

> *We're aware that, you know, we can't just assume, because they're from the one country, that they're going to gel. But some of the families, actually, here, are related. So, some of the parents are siblings. You know, it's like their own family. Even at that, though, it doesn't mean to say that they'll get along.* (HVIV2)

Childcare needs further impede the women's ability to participate in community activities, and some women avoided mixed-gender groups. Attending groups was recognised as a major step forward where they had opportunities to tell their own stories and talk about their life in Syria and their professions, and this helped make connections:

> *If they go to local groups, then that is a huge thing, but I don't think I have had any that, essentially, went out on their own that I can really focus on. Because every time I conduct a home visit, it feels as though that is their only environment. So, I guess that when they do go to local groups, then I do feel like a sense of achievement really, that we've managed to get them integrated into the community, but I've never found the families to go out on*

their own. […] there are things that I've thought, oh, that's pretty amazing. Or maybe even the stories of how they have arrived, where they have arrived. […] they have shared stories of how they've arrived. I mean, mothers who have been lawyers and they're now over here, or nurses and things like that.
(HVIV11)

Those who had professional careers in Syria, as lawyers and teachers, have these roles buried somewhere deep inside, invisible to outsiders. The women are being supported by professionals, yet are unable to reveal their own professional standing. This invisibility renders them isolated. The impact of this loss is further compounded by missing intellectual challenge and by not being able to make a valuable contribution to the workplace. The loss of their professional identity can contribute to loss of confidence and continued dependence on the resettlement officer some years later. Integration is further impeded with transport issues and not being able to drive. However, promising signs of integration are noted with a few women taking driving lessons.

The issue of employment is also important for supporting families financially, which is key to resilience and successful integration. Some families had opened their own small food businesses, and others engaged in voluntary work. But, for many, gaining employment was a distant dream until they had a reasonable grasp of the English language. Childcare needs were again an additional burden, preventing women seeking employment, but the confidence for all family members to mix in the community was improved if someone was in employment.

Difficulties arose sometimes with families needing to cope with negative remarks due to intolerant attitudes, such as negative comments from locals while out walking. Notably, family integration was bolstered when they felt that they had been positively received into the community:

So, she was quite emotional about it but has actually become really resilient and now saying that they're happy here. It's really just their whole demeanour, their whole presentation. They look happy, how they just communicate, even how they are with their son. They just seem like they're doing really well. They speak so positively about the area. They speak positively about the child's nursery placement that he's got. There's nothing really negative that's coming up so that they're not coping or dealing with.
(HVIV8)

There were HV expressions of frustrations at times with some of the families. But, interpretation, or reinterpretation, is key in this next illustration, where searching for support is viewed negatively when the family seek help from more than one person. The HV is frustrated to find that she is not the only one trying to help them with a problem. Yet, pursuing your goals, using all resources available, being determined and not giving up would be classed as strengths, demonstrating resilience:

> *It is very challenging at times, very challenging and they seem to go ... a Scottish way of saying it, is going round the houses sometimes, to get what they want, and I can go in and they can tell me a story or a scenario or an issue that they have, and then I realise once I've started the ball rolling that the ball has already been rolled by somebody else.* (HVIV10)

Practitioners were impressed with the ability of Syrian people to seek out whatever they need when it is a matter of urgency, and, in one case, the parents were proactive in getting a second opinion for the care they needed for a child. A sign of progress, demonstrated next, is where the need for additional support is reduced when the family 'got rid of the interpreter' themselves, raising their confidence in doing so, and the impact that this had – the relationship between the HV and the family is enhanced in being able to communicate directly with each other:

> *Since they've got rid of the interpreter and actually the housing support worker's no longer been needed for us to make appointments, that we've been doing it just between myself and the family, it's got a lot better. Actually, the family have contacted me on email asking about health things.* (HVIV8)

The majority of HVs recognised that they have an important role in helping families to integrate. Some felt this needs to be a staged approach, concentrating on core work early, following the families' arrival. Ensuring that families receive the services they are entitled to takes priority, rather than bombarding them with too much information, which can wait until they are more settled, helps. It is recognised that there are real benefits to early integration, which HVs can help with:

> *I think there's definitely a health visitor role. I think in terms of their wellbeing, they're not mentally deficient and if they're not integrated into the community they are not socialised. Yes, 100 per cent for every member of the family, not just the children. I would try and make sure the children are in school, that the wee one's in nursery, the mum and dad, is there anything we could get*

them to do, maybe volunteering or something? […] I definitely think that it's our responsibility, […] it's 100 per cent our role'. (HVIV11)

Concerns were expressed about who would pay for HV services should they be required to devote more of their time to integration issues. Nonetheless, HVs generally considered themselves as important for positive integration, and HVs expressed their desire to do more. However, there was a contrasting view expressed, in that the role fitted in more with the integration and support services:

> *I think it's quite difficult for the health visitor to do the integration […] I would be just making sure that they are aware of all the services that are available […] they have their support worker who was doing a lot of the integration work with the families anyway. So, as long as they have that person.* (HVIV1)

There was a strong wish expressed by most HVs to play a greater part in helping with integration. This was essentially to facilitate connections with community amenities and other key people. Being clear about how exactly HVs can help with integration was viewed as being key to supporting the women's access to services and becoming active in their communities. The HVs may be the only people noticing the Syrian women's hesitancy to mix in groups. For some women, HVs needed to accompany them there in the early days. Caution was also expressed when arranging groups of Syrian families to come together for activities, raising the potential for stigmatisation:

> *The resettlement team, I think, were starting to do some work around, sort of, parenting, sort of generic parenting work with some of the families. But my colleague […] and I, felt that, that might be appropriate for some families, I don't know. But it actually reinforces their separation, you know, it doesn't help them integrate.* (HVIV2)

Mechanisms to support integration need to be inclusive and must reside within already established groups where possible to aid integration. Finally, HVs' understanding of what is required, and being prepared to work effectively with Syrian families, involves consideration of how this might be included in their education.

7.4.6   HV experience and education

A one-year full-time post-graduate training programme must be completed by qualified nurses or midwives for NMC registration to practise as a HV (NMC 2004). Once qualified, the CPD programme for HVs varies across the UK. It also depends on meeting certain Health Board requirements and on HVs' individual preferences.

The eleven HV participants ranged from having three months to 28 years' experience in practice, with a mean of 10.5 years. Five were practising in rural locations, four of which were on the Scottish islands, two were in urban areas, and four with a mix of rural and urban communities. Ten were currently working with Syrian families, the other one had worked with them previously. One of the ten had experience from a previous post in England. Two HVs were involved with the families from their arrival, and several worked with the same families for over two years.

Eight HVs had received no relevant preparatory education, theoretical or experiential, in their training programme or as CPD. One had attended a conference, one had previous education from a family planning course, and one had undertaken equalities training. It may be the case others had attended equalities training, as it is mandatory, but they did not disclose this. The conference that one attended was the only training that any of the participants received that was specific to Syrian families. No education had been offered to the HVs in any of their current posts. The only accredited training known of were equalities and diversity online modules available from NHS Education Scotland.

HVs expressed concern at receiving minimal education and experience and all were keen to undertake more education. A very small number had experience of training in working with Roma or travelling families on which they felt they could draw. This is not to assume that all minority needs are the same. Rather, they may experience similar discrimination, stigmatisation and inequalities. Those who had worked abroad in relevant countries also felt better prepared than those without such experiences, but there were still gaps in their knowledge:

> *It was my experience of working overseas that helped equip me in working with the Syrian family on my caseload, especially understanding difficult cultural values and beliefs. However, it would have been of great benefit to have had some education/training on specific cultural and religious issues for Syrian families and also Muslim families.* (HVQ1)

At a conference, one HV heard about integrated teams providing collaborative support, which she recognised as best practice. It was useful therefore to ascertain what education they felt would benefit and enhance their practice in this area, and whether this should be delivered in HV training or as CPD.

In addition to having trauma and mental health education, the majority wanted cultural awareness-raising education, to include such topics as religious beliefs and practices, family

constructs and dynamics, foods and weaning, and working with interpreters. The HVs wanted these topics delivered in the HV training programme as well as within CPD to keep abreast of population trends. Online resources as well as face-to-face sessions were desired. Cultural awareness was the top subject requested:

> *Maybe just a bit more on cultural differences, and that is maybe something that would have to be included more in a health visiting course, possibly. Understanding of different cultures coming into a country. I think some kind of module or coursework-based, looking at the different cultures and how there is a more multicultural population now in Scotland than what we were used to in the past. And just having more, kind of, in-depth knowledge about that, so that we're prepared when we do have them in our caseload.*

> *I would be inclined to introduce it into the actual course of health visiting at some point. Just so that staff, you know, health visitors newly qualified are aware of that as well.* (HVIV1)

It was suggested that, without this education being introduced in training, HVs may go on working while being unaware of deficits in their practice. In contrast, having some experience first before engaging in further education, was also suggested:

> *Think it should be CPD because I don't feel that until you're in that environment, or until you've experienced being in someone's house and not knowing what to do, you would really pay much attention to it. I think it would just be something else that you're learning, and until you experience that you don't actually know what to do for a family.* (HVIV11)

Others suggested having families contribute to the education to make it more experiential in some way, and the learning more appropriate. An alternative suggestion for a protocol was made in recognition that HVs are already well trained to deal with and adapt to any situation they face (Cowley et al. 2007). Perhaps the development of a national protocol could offer some consistency.

7.4.7 'One thing'

The 'miracle' question, a requirement of the AI method, is intended to help participants think creatively to find new and exciting solutions. I asked the HVs to think about any possibilities and tell me 'one thing' which could help and support them working with Syrian families, refugees and asylum-seekers, more generally. Their answers complemented those to previous questions raised, which were as follows. Firstly, education, especially on supporting

trauma of refugees, was needed. Secondly, working within a consistent pathway or protocol was wanted. Thirdly, there was a need to improve information-sharing. Fourthly, a plea was made for translated resources and access to online information resources. Finally, although HVs are single points of contacts for families, it was recognised that they might benefit from a single point of contact for themselves, comprising a specialist or expert practitioner for obtaining guidance and support.

Specialist roles exist in some Health Board areas where people with expertise in a particular area of practice can offer guidance and support that HVs can access. For example, parenting and feeding advisors, perinatal mental health specialists, and child protection advisors. HVs with cases where they have had little experience before, such as with non-English speaking refugees, suggests access to additional specialist support at this time could be helpful.

Little support is available. Most were unaware of anyone within their Health Board, or in any national roles, to whom they could turn for relevant expertise. For guidance, the HVs indicated that they would approach local team leaders and managers, colleagues, or the Scottish Refugee Council. The resettlement officer, however, was the person they most relied on. Although some of these resources the HVs mentioned may be of assistance for other families on their caseloads, working with the Syrian refugee families both raised and heightened their need. A further suggestion was made to develop a more intensive HV service:

> *I honestly think it would be a special service […], I think if they could have it something like the Family Nurse Partnership to actually help families integrate into their community.* (HVIV1)

In recognition of the need to give additional time and of the benefit of intense home visiting, it was suggested that HVs might provide additional support for a period of time until the families settled. This mirrors the service delivered by the Family Nurse Partnership (FNP), where weekly home visits, coupled with a strict education regime, is delivered at each contact (Cowley and Bidmead 2021). The FNP has been positively appraised for the outcomes achieved (Olds 2006), but it is resource-intensive and is not available to everyone.

7.5   Summary

The findings from Cycle 2 show consensus for appropriate education to be made available for HVs to better meet the needs of the Syrian families. The HVs were disappointed to have been excluded from meetings held in preparation for Syrian families coming into their areas,

which resulted in them not being able to provide their service to families from arrival. This delayed forming early relationships with the women, which is a central tenet of their practice. There did not appear to be any protocol followed for the families moving in. Neither did there appear to be a policy for medical and health assessments on arrival. Working with interpreters and resettlement officers was challenging, and a lack of translated materials impeded the HVs' work. The cultural issues they encountered caused great anxiety, as they were concerned about getting things wrong and causing harm or offence. The HVs were particularly concerned about trauma, social isolation and domestic abuse, and about being able to support the women. Despite all the challenges the women faced, the HVs recognised the women's ability to provide well for their families and integrate as best they could, with some making huge efforts to make friends and become good neighbours, and found their resilience astounding. They felt that they had a clear role to play in helping the women integrate and desired more time to be able to do more.

Further interpretation of the findings presented in Chapters Six and Seven are summarised, synthesised and discussed next in Chapter Eight.

Chapter Eight: Discussion

This chapter draws together the key findings and analyses from both cycles, and considers these in relation to the initial study objectives, pertinent policies, relevant literature, theory and HV practice. Attention will be placed on where HVs could make a positive difference to Syrian women and children's health and wellbeing.

8.1   Accessing health care

The Syrian women expressed some satisfaction and gratitude with health care, but numerous frustrations were raised. Some related to service delivery, and others due to misunderstandings and health beliefs. They faced challenges due to language barriers, a poor understanding of the healthcare system, and had transport issues. A number of health issues needed to be followed up and opportunities for these to be raised with a health professional was lacking. Being unaware that the HV could support women's health was a missed opportunity where these concerns could have been managed more efficiently.

In common with Martzoukou and Burnett (2018) this research found that the information booklet or pack provided on arrival needs to be available in a digital form for ease of access. Also, there is scope for development of digital ways to improve communication to help the women ask for appropriate help. Furthermore, there was uncertainty about entitlements and health professional roles. It is evident that some of these challenges remain, three years on. The most significant is a high dependency on the resettlement officer, as accessing services through them was the easiest solution to obtaining immediate help. However, many of the women expressed a real desire to be independent. They were frustrated by the UK system, with the GP as gatekeeper, and wished to seek medical help from the professionals they felt they needed. Greenhalgh and Papoutsi (2018) give recognition to how challenges in understanding healthcare systems are especially difficult where English is not the first language. Furthermore, concern about language acquisition was especially worrying for reading and understanding prescriptions in English, where HVs were pivotal in explaining how to take the medicines safely. The implications of medication mistakes is a huge safety concern, and this may not be picked up by another person, such as a translator. The Syrian women were frustrated with the time it was taking for them to acquire English.

There was ongoing delay for the Syrian women in obtaining appointments, which caused vexation. This has been recognised by Mulvey (2013), who reported hesitance to register with a doctor due to delay with obtaining appointments. Abdulkadir et al. (2016) noted that people's ill health is exacerbated with appointment delays. Furthermore, there is a possibility

that the women could need these appointments more urgently if they are suffering from anxiety as a result of trauma (Yasmine and Moughalian 2016).

There was also a lack of confidence with medical diagnoses. Doctors, they felt, reached a diagnosis without adequate tests being undertaken. O'Donnell et al. (2007) reported similar concerns, where GPs did not request specialist opinions for migrants. Also, with dental care, time waiting for appointments caused pain and stress. Paisi et al. (2020) concur with this finding, noting that poor access to treatment exacerbates their discomfort. However, more concerning for the women were questions about the materials used in dental treatments. The women questioned their safety, and whether as refugees they were being treated with substandard materials. Evidence to support this fear was lacking. The health care systems they were familiar with in Syria before the war appeared to offer a service that was superior to that in the UK. Consequently, their expectations were high.

Transport was another area with significant difficulty impeding access to health care. Explaining the destination, finding their way there and back, with children in tow, and managing UK money to pay the fare on public transport, made this a complicated process. However, these same issues have been highlighted by Martzoukou and Burnett (2018), who acknowledged that, without easy access to transport, it was overly complicated to attend health services, and often resulted in wider social isolation issues. A resolution is needed to help increase attendance to improve uptake of healthcare (Martzoukou and Burnett 2018), Salman 2012). Many Syrian women were keen to drive, and some had started driving lessons as their English improved. This was an early indication of resilience, integration and independence. There could, however, be other immediate practical solutions, such as the development of a journey planning tool or app, and the distribution of bus passes for all.

8.2   Health services and professional roles

There was a lack of coherence with health services identified. No distinct process appeared to have been followed for what medical or health assessment they were to receive, or from whom, on arrival. The Syrian women had a poor understanding of professional roles and worried that they would incur costs without having a full grasp of which professionals the payments covered. Firth and Haith-Cooper (2018) discussed the significance of this concern being a reality, where women were hesitant in accessing support with PND due to anxiety about the cost. Furthermore, and congruent with O'Donnell et al. (2007) and Abdulkadir et al. (2016), the Syrian women understood their entitlement to access to a GP and some were aware of the process for referral to specialists. However, they were unclear on other entitlements, such as obtaining a second opinion and an interpreter.

The women were unaware that the HV was a nurse until it was explained by the HV themselves, as, initially, they thought they were doctors. Nonetheless, they recognised the HV role as being one for children only, so missed out on requesting support for themselves. This suggests that not all HVs may be informing the women of this function in a way that they understand, or that the HVs may not be considering women as individuals who are entitled to their own assessment and care plan, where need is identified.

The HV service for children was well received and appreciated. The HPI was initially allocated as 'additional' or 'vulnerable' and, in time, this was reassessed to 'core'. There was no consistency noted in patterns of visits outwith the pathway 'core' requirements, however, suggesting that there is scope for further inquiry, where explicit guidelines might be useful.

The parenting issues identified by the HVs were easily managed once explanation and support was provided for families. Safeguarding issues in relation to smacking and home safety complied with the law when parents understood the regulations. Children's safety in general is a further area where families could benefit from HV education, as promoting child safety is a fundamental HV role (Appleton et al. 2021). However, such education needs to be culturally sensitive (Markey et al. 2019; Markey and Okantey 2019).

The data gathered clearly indicate the need for improvements in communication when planning for refugee resettlement to include HVs where they could make a positive contribution. The majority of refugees entering the UK are young parents (Mulvey 2013), and the HV is a key worker (Cowley 2021). In a very recent report on integration, the social worker is prominently featured in 'Assisting the family or child to access the public services that they are entitled to, while being aware of specific vulnerabilities, i.e., health or trauma' (Hepburn 2020, p. 15). HVs have the responsibility for early identification of need as a Named Person, yet their role in this regard was not mentioned in this report by Hepburn (2020). Without recognition of the HV role for the wellbeing and protection of children, many instances of harm or potential harm could be missed (Appleton et al. 2021; Lawrence 2014; Quickfall 2014). The HVs were concerned that their role was not recognised or well understood, and they may be justified in reaching this conclusion. Some key government reports and policies, including the New Scots Refugee Integration Strategy 2018–2022 (Scottish Government 2018), fail to recognise the value of the HV role. Acknowledging the HV role in this context would help Syrian women receive the same non-stigmatising universal service as all other mothers.

This study highlighted that the functions of the Named Person role was enacted by the HV. Nonetheless, the HVs were clear that they carry out these duties with or without the Named

Person title, or formal expression of the Named Person function. Nevertheless, their practice as a Named Person was compromised in not being provided with pertinent information from partner agencies. Consequently, their early assessments may have been incomplete. Sharing information between agencies is a central feature of best practice in safeguarding children (Appleton et al. 2021). This could indicate a deficit in the application of the GIRFEC multiagency approach. It may be the case that the momentum for full implementation of the Named Person role was lost with the Supreme Court (2016) judgement and the Education Minister's withdrawal of the role from legislation (Black 2020). Furthermore, the Named Person role was not understood by the Syrian women, and the HVs felt that it was a step too far to try to explain it to them, particularly through a translator.

8.3   HV education needs

HVs felt that their education was inadequate for preparing them to work with Syrian women and children, and issues which Baldwin and Johnson (2017) note has been previously reported**.** The HVs expressed a need for education on prevalent illnesses, the impact of displacement on physical and mental health, exposure to war, and cultural issues. When HVs recognised symptoms of trauma, most had no one to turn to for guidance and support, and there was a lack of specific mental health services to refer on to. This impacted considerably on the HVs, as they were concerned about making mistakes and causing additional suffering or missing cues and not obtaining the necessary and appropriate help for those who needed it. Furthermore, knowledge regarding the impact that these conditions have on children was deemed to be essential (Almqvist and Brandell-Forsberg 1997). However, there were examples captured (Section 7.4.7 HVIV9) of exemplary practice, and it was evident that the HVs needed to be more confident in drawing on their own training and experience. However, in time, these pressures could have an impact on HV health (Drennan and Joseph 2005; Lawrence 2014).

It needs to be clear for HVs where and from whom to expect notification of Syrian family arrivals. Also, having access to an experienced specialist person with whom they can consult for immediate expert advice and guidance would increase their confidence in their decision-making practices.

Along with education on Syrian women's health and the need for screening, the HVs could ensure appropriate and timely referrals (Cowley 2021). For example, no one had considered that the women may need to be treated more urgently for sexual health issues. This is not about targeting these women to receive a different service to others, rather, it is being alert to any concerns raised, and responding promptly. The evidence shows that, because of

exposure to particular risks such as rape through war, the women may need more urgent treatment (Inhorn and Kobeissi 2006; Salman 2012). Furthermore, the HVs were also concerned about social isolation and domestic abuse and providing support to the women. The impact of each can be particularly harmful to children, and so needs to be monitored (Drennan and Joseph 2005). Hence, HVs need to know the nature of possible abuses that Syrian women may have been exposed to, to ensure that their practice is appropriate (Burchill and Pevalin 2012). The women may have no one to help them, and HVs lacked confidence in addressing any possible issues. Domestic abuse and mental health were major concerns where HVs felt out of their depth due to lack of cultural understandings, as recognised by Baldwin and Johnson (2017). Gender, race and social class can isolate women, resulting in them being vulnerable to abuse (Yasmine and Moughalian 2016). However, some of the issues faced by Syrian women may be difficult to comprehend, as they are unique to their experience (Burchill and Pevalin 2012).

Childhood conditions on which HVs' learning needs to focus include thalassaemia and diabetes, both of which were concerns raised by the women. Thalassaemia appears to be virtually unknown by the HVs, where identification is needed of this serious blood disorder. Hackett (2019) reported on thalassaemia, a condition prominent in people from the Middle East. Males and females may show symptoms or be a carrier, and babies can be born with the condition. In the UK, 1,200 people are thought to have the condition, and 300,000 will be carriers. I was unsuccessful in finding literature regarding thalassaemia and the HV role and education in the UK, highlighting an area that requires attention.

Diabetes is known to be prevalent in Syrian adults, and the Syrian women believe that there has been an increase in childhood diabetes following the war. Early research shows emerging concerns (WHO 2016). Tooth decay and speech delay were adequately addressed. However, education to recognise trauma-associated speech delay could be beneficial. Research shows that concerns about mental health symptoms in children may not present with mental health symptoms until a few years later (Almqvist and Brandell-Forsberg 1997). HVs are well placed to identify these concerns early (Lawrence 2014), which Maršanic et al. (2017) suggest is a very important first step in helping children when professionals recognise and refer early to appropriate treatment.

The NPM provides a comprehensive multi-agency model which allows HVs to assess, plan, action and review care for children. It supports and values a child-centred focus within a family construct. All HVs assessed the needs of children, some assessed siblings and parents, and others included grandparents in their assessments to ensure that their needs were not being overlooked. Cowley et al. (2013) promote the HV public health role in their

being able to enact care for all family members. The NPM is insufficient, however, to promote a more nuanced and culturally appropriate person-centred approach for adults, including Syrian women. An additional model, consistent with cultural requirements, could support a more tailored care plan, and better meet the Syrian women's needs. There is a risk however, that separately considering cultural needs could risk supporting unconscious racism, where the practitioner could, without fully realising it, discriminate against others or be stigmatising. The preference therefore would be to establish an intersectionality approach to ensure that the characteristics of all individuals are considered for the provision of holistic care (Yasmine and Moughalian 2016). To this end, applying elements from a tested cultural practice model, such as from those outlined previously (Section 3.10), could be advantageous, and is worthy of further inquiry (Leininger 2002; Jackson 2007; Papadopoulos et al. 2016; Banfield and Lackie 2009; Quickfall 2014).

8.4   Practice models

Adding cultural practice models to HV programmes could be one way to improve HV understanding and practice and to support culturally appropriate person-centred care. Each of the models considered here have their strengths and weaknesses. However, at this stage, there is insufficient evidence to suggest that any of these would be the right approach. Literature comparing models was weak, particularly over time, suggesting that further research is required. Besides, Truong et al. (2014) found little evidence that improving culturally competent practice alone achieved the intended outcome. Furthermore, conflation of the terms 'cultural competency' and 'cultural sensitivity' add to the confusion. Culley (2006) concurs, claiming that these terms mask the addressing of racism within the nursing profession, and this inadvertently, through homogeneous cultural group classification, adds to this negative discourse. Applying an intersectionality framework and being able to communicate with another person as an individual, being respectful of their specific characteristics and requirements, and showing empathy, is a preferred approach (Markey and Okantey 2019). High-level communication skills, such as body language, and expressions, such as hand gestures, all contribute to the provision of positive person-centred health care, which, along with individual preferences, HVs can learn more about, to meet cultural needs. Learning situations in practice need to be considered, and one such area is through 'cultural plunge' experiences, where practitioners submerge themselves in a cultural encounter through spending time with families or ethnic groups, for example (Houser 2008). These have shown to be effective in the development of empathy and to reflect critically (Houser 2008) and reduces anxiety from working with diverse people. However, there is a concern of the potential for stigmatising others, and so this needs to be very carefully planned (Lawrence 2014).

154

It was recognised that racism needs to be included in any model applied (Gerrish and Papadopoulos 1999), but that it should also be made explicit. Challenging racism and institutional racism should form part of any strategy for intercultural health visiting to become a reality. Gerrish and Papadopoulos, in as far back as 1999, emphasised that the ability to recognise racial prejudices and inequality, and to practice in an anti-discriminatory way, was key to effective care provision. These need to form the foundations for HV practice, and must be made explicit in future standards and incorporated within an intersectional framework for HV education (Markey and Okantey 2019).

8.5   Understanding and being understood

The Syrian women struggled to communicate. Their frustration was in being unable to speak, read or understand English, and they perceived that they were not being heard. Fassetta et al. (2016), in a study with asylum-seeking pregnant women in Glasgow reported on the significance of this language barrier on the mental health of women, which leaves them feeling isolated and depressed. This can have a detrimental impact on the health of the infant and other children. It is known that better outcomes are achieved by those who learn English (Baird 2012), so there is merit in attending English lessons. Self-esteem also improves in acquiring language skills, and this confidence propels people to attempt other challenges. However, learning English takes time. The ESOL classes were available in all areas, but on some days the women could not get to them, as numerous obstacles got in their way. These findings are consistent with those of Gürsoy and Ertaşoğlu (2019), who noted that, in Turkey, age and gender are important features of successful language acquisition. Younger people and men out working learned Turkish quicker than women, having more contact with those speaking Turkish. It might also be useful if some ESOL classes could be more flexible and available online so that the women could access them when it suited them.

8.6   The interpreter

The role of the interpreter was invaluable to the women and HVs, but working with interpreters was another area where HVs needed education. This has previously been recognised (Jackson 2007; Burchill and Pevalin 2012). Interpreters also provided assistance where cultural issues needed to be explained, acting as brokers (Maršanic et al. 2017). Nonetheless, concerns were raised regarding over-familiarity and trustworthiness. Similar issues have been raised (Wallin and Ahlström 2006), and O'Donnell et al. (2007) noted that these issues are compounded further when the interpreter acts as an advocate. Reducing the need for an interpreter was dependent on other means of communication, such as LifeLine or Google Translate. When women's understanding and spoken English improved

sufficiently, and they gained confidence, the input of interpreters could be reduced or ended. The meetings they had together then improved.

Access to an interpreter was generally available to most when needed, although the women struggled to access them directly, and HVs expressed problems with payments and bookings, where appointments could be cancelled as a result. However, the need for translated materials and obtaining translations also has to be addressed, and access must be made easier, to avoid time-wasting. Finally, medical letters being sent out to families in English is clearly unsatisfactory and needs urgent attention.

8.7   The resettlement officer

The Syrian women relied heavy on others for support, particularly the resettlement officer and volunteers. The resettlement officer role originally developed as a result of the haphazard and inconsistent approaches to meeting the needs of migrants that needed improvement (Wren 2004). The resettlement officer role was highly valued by the women and HVs. The women remained highly dependent on them up to three years after migration, largely as a result of communication needs, but also when needing lifts and help with accessing appointments. It did not appear to matter whether the resettlement officers were male or female. This role varies across the country, however, some have dual roles, such as housing officers, and this resource was in high demand. However, similar to the relationships with interpreters, the HVs did not have a clear idea of the role, which posed dilemmas when boundaries were unclear.

Drolet and Moorthi (2018) noted that those from resettlement schemes tended to depend on professional support, whereas those who were sponsored received assistance from a family sponsor. Sponsorship is an alternative model, prominent in Canada, where families are helped to settle. However, often the support was withdrawn early after arrival, and the migrants needed to become self-supporting very quickly. This early withdrawal appears to have been pivotal in their feeling settled quicker and in developing a sense of belonging (Drolet and Moorthi 2018).

It is difficult to see how the Syrian women and wider family could manage without support from the resettlement officer for some time. The HVs also relied on them as they had no other source of information and support. It may now be timely for resettlement officers to be educated in GIRFEC policy and the NPM, to better understand roles, so as to include HV services in supporting families from arrival. In turn, this may reduce the officers' own workload.

8.8   Gender theories

Gender theories could help illuminate Syrian women's needs where the refugee discourse often fails to separate male and female issues (Indra 1989). Feminist sociological theorists (Rose 2016) consider women's equality in the world where power determines whether they have a voice. The women will have experienced male leaders during war in Syria, and this creates a narrative, suggests Rose (2016), of fear. This continues on through displacement, where men again are in control, where the exploitation of women is prevalent, and continues into host countries where women's voices may not be valued (Yasmine and Moughalian 2016).

Many Syrian families promote a patriarchal structure, often supported through religion and politics (Al-Krenawi and Jackson 2014). Although women's rights in Syria had been progressing, since the civil war they have been eroded, increasing opportunities for risk and harm to women (Alsaba and Kapilashrami 2016). Furthermore, there is a lack of studies exposing the woman's situation (Al-Shdayfat and Hatamleh 2017). One reason could be that women select to remain silent, to avoid shaming the family and risk further abuse. Nonetheless, political, religious and ideological factors perpetuate the violence they are exposed to, and women increasingly are viewed as both a currency and a target (Alsaba and Kapilashrami 2016). The means to support women and mitigate risk in refugee camps and adjoining displacement countries is minimal (Yasmine and Moughalian 2016). Subsequently, women's strength and coping strategies are tested to the limit. It is not surprising, therefore, that, when settling in the host country, women may present with mental and physical health issues which are difficult to resolve, especially when barriers to health for them are complex. The Syrian women in this study, who presented with vague symptoms, or were unable to clearly express their needs, and who were being dismissed with minimal intervention, could be displaying these issues. Some symptoms may be denied by the women themselves, who wish to belong to this new world and to not to be seen as burden on services. The damage from the harms caused are much deeper than the symptoms they present, however, and they may not be adequately assessed.

The women could be better supported in discussions about routine health issues and by discussing any mental health problems with their HV. The home visit by the HV could provide the place for these issues to be raised first. Opportunities for the promotion of other health-enhancing activities, such as education and encouragement for uptake of cervical screening, could also be addressed by the HV. Furthermore, the issues of domestic abuse could be raised once the trusting relationship is established. But first, the women need to be made aware of the HV role for them.

It may be the case that less-than optimal person-centred care was provided to Syrian women, as HVs were unable to complete a full assessment, particularly when they were not cognisant of cultural needs, or did not have all the information to inform their assessment. The GIRFEC model, while it places the child at the centre and considers the child in the family context, may be insufficient to address the complex needs of Syrian women. For example, the GIRFEC model allows parental mental health issues to be considered in relation to their impact on the child (Scottish Government 2016). For women with mental health needs, such as PND, an additional plan needs to be created for those not already receiving mental health services, and this is not well addressed within the GIRFEC model alone. It was not clear how detailed the HV assessments were, but they did not apply a model which included assessment of cultural requirements, and the women are entitled to holistic person-centred care in their own right.

8.9   Home and cultural ways

A list of cultural preferences was expected from each woman following the question on cultural requirements, but this did not happen. Instead, most hesitated and explained that the HVs offered to take their shoes off at the door, and little else was required. Several requested female clinical professionals. One woman was clearly distressed when a male doctor and male interpreter observed her hair. The evidence gathered, however, suggests that the women may be minimising their needs. Explanations for this could include a wish by the women to avoid putting obstacles in the way of any additional support offered. They may not wish to appear ungrateful, or they may want to be viewed as becoming more like the locals, suggesting they wish to be less of a burden. Nonetheless, the women were not receiving culturally appropriate person-centred care if they could not freely express their wishes. Addressing the many influencing intersections revealed in this research study is necessary (Piacentini et al. 2018). Not having cultural needs met is a concern which McLean et al. (2012) claim can cost lives, when appointments are cancelled, or when families do not engage in the first place. Furthermore, grieving for what has been left behind in Syria may have an impact on the women's ability to recognise their needs or be confident in stating them.

8.10   Loss

Loss can be expressed and represented in many different ways (Hall 2011). In this study two metaphors were prominent: the sun, representing the Syrian homeland; and antibiotic prescribing, being about familiarity and healing.

The Syrian women felt that their views had not been taken into account when being prescribed medicines and treatments, some of which they viewed as being unsuitable to their needs. The medicines most frequently being requested were antibiotics, and this request was often declined by the GP. The reason for the refusal was not understood. The women felt that their needs were being ignored, leaving some feeling invisible when repeated requests were not heeded. Abdulkadir et al. (2016) recognised this invisibility, where people felt discriminated against, and challenged this idea from a human rights perspective. The complexity with refugees' understanding of how the NHS operates has been studied (O'Donnell et al. 2007), and these results showed that refugee requests made through an interpreter are fraught with multiple factors that influence success. Less concentration, however, is dedicated to solutions within the NHS for making positive improvements (Martzoukou and Burnett 2018).

Inappropriate antibiotic prescribing is a serious health matter, with particular issues for people from Syria which need to be taken into account. Resistance to bacteria from overprescribing antibiotics is now a global public health emergency (WHO 2020). In Syria, many self-medicate, as pharmacists can dispense without a doctor's prescription. This makes it very difficult to get support to heed warnings around resistance to antibiotics. Gu (2020) reported that ignorance regarding the purpose and harms of antibiotics is one of the key factors leading to continued pressure to prescribe. It may be the case that people are not grasping the serious harm to health, but the construction of the health-promoting message is a decisive factor. To engage people to listen and take action is reliant on how the message is constructed and delivered (Gu 2020). Roope et al. (2020, p. 9) concur, and claim that the content needs to be presented in a message of two parts: one made up of 'strong-fear-plus-empowerment'. This is to instil fear and at the same time trigger positive action to take the matter so seriously as to change behaviour. This may be a technique which could be incorporated into health-promoting messages, particularly those aimed at refugees arriving in Scotland.

Deeper strands from my analysis on antibiotics were important to consider. These represented loss and disempowerment. Antibiotic prescribing is a familiar Syrian medicine and so reminded the women of belonging in Syria, not Scotland. Another strand to the prescribing responses was one of disempowerment. In Syria, people decided for themselves where to source treatment and take medical advice, they were not required to go through a GP, as in the UK. Consequently, the role of the GP was viewed as preventing them from taking their own decisions on health. In turn, this had a negative impact on their self-esteem.

The Syrian women articulated a range of health and wellbeing issues. Some were receiving treatment or had undergone surgery. Others had applied home remedies to treat illness. There was general concern about their holistic health. They talked about lacking in good health and emphasised the importance of the sun for their health and wellbeing. The sun represented how distant and disconnected the women really felt in being far from their Syrian home, which negatively affected their health. Looking to the sun was looking back home to Syria, who and what had been left behind; it acted as a permanent reminder of home, of what was lost and missed. The women associated the sun with providing essential vitamins for their bones, a serious concern made worse by the poor sunlight in Scotland. But also, they associated the sun with maintaining a healthy weight, and with good health when pregnant. The lack of sun affected their mood, where longing to have more sun represented their longing for home.

8.11   Integration

> *Integration is a long-term two-way process of change that relates both to the conditions for and the actual participation of refugees in all aspects of life of the country of durable asylum as well as to refugees' own sense of belonging and membership of European societies.* (The European Council on Refugees and Exiles (ECRE) (1999) Position on the Integration of Refugees in Europe, cited in Ager and Strang (2008), p. 177)

This is a more comprehensive definition to that presented in the New Scots Refugee Integration Strategy 2018–22 (see Section 2.4) (Scottish Government 2018, p. 12), and more reflective of this discussion. Concepts associated with integration are useful and help to understand the challenges that Syrian women face with integration. These concepts are: liminality, citizenship, identity, and belonging, and are discussed next.

Integration happens over time. It cannot be rushed, and its meaning can only be determined by the individual who is integrating. In feminism, the term 'integration' originated from Black women for those affected by racial prejudice and oppression (Crenshaw 1989). It was used to expose and explain how powerful authorities control access to citizenship in American states (Crenshaw 1989). These same battles are faced by refugee women (Ager and Strang 2008). Intersectionality theory can help in understanding what it means for the refugee as an outsider being parachuted into and adapting to a new culture (Bastia 2014). The members of the already established community they join set the criteria for belonging. Time to learn English was a delay to the external integration of engaging in community by holding onto

what is familiar, essentially, their identity, and reflected challenges with shifting their internal position of beliefs, values and attitudes (Baird 2012). Integration, as expressed by one Syrian woman, meant that it was important for her to belong in the community. For another Syrian woman, it was to be less of a burden in this country. A third Syrian woman expressed her desire to be able to make her own decisions, to be independent. This space of liminality, inhabited between old and new countries, can be a state of limbo for the Syrian women – who reside in a space somewhere between displacement and returning home (Baird 2012). They may have little sense of belonging in Scotland and may not be sure how the future will unfold. As health professionals, HVs were unlikely to be aware of this dichotomy. In becoming a citizen, one would expect, would then help to seal this new identity, but citizenship holds different meanings for those on the refugee journey. This illustration demonstrated one woman's perception, what it means to her, in being equal within the host community:

> *I'm one of the citizens, like others.* (SWIV7)

Citizenship is important foremost for safety and security, but is also about obtaining rights and entitlements. The illustration above denotes the Syrian woman making a statement that she already is a citizen. She is not asking for it. She is displaying empowerment, positioning herself as an equal member of the community. Citizenship, claims Yuval-Davis (1997), comprises many facets related to family, community, and country, where rights can be different depending on your status and wealth. The wider determinants of poverty and culture also feature, and some of these issues may continue to pervade the Syrian women's lives for some time. Unemployment, social housing and having little money is a reality for most. Drolet and Moorthi (2018) pointed out that many Syrian people's expectations can be high. With little money, however, they are limited in attaining the same living standards they had previously, which may make their desires unachievable and add to them feeling excluded. Furthermore, the language barrier impedes making important social connections. Ultimately, citizenship is about the entitlement to remain indefinitely in a country, and the opportunity to settle and belong (Ager and Strang 2008; Yuval-Davis 1997).

Identity is a human right which is influenced by refugee status and the meaning attributed to being a refugee. The narrative on integration is often negative, which Kebede (2010) notes has a negative impact on self-perception, where labels applied to people can be both stigmatising and humiliating. The term 'refugee' is one such concept that the Syrian women endure, which may continue for some time with the potential to last forever. There are implications for the identity of those so 'labelled', in how they feel, their position in the world and for future generations. The traditional symbolic interactionist approach views the world

as always being in a state of change (Blumer 1969, cited in Kebede 2010, p. 7) and compares this to an individuals' identity also being in constant change, being redefined. It is particularly challenging for second-generation refugees, who have inherited the label, and often struggle with tensions between two cultures (Kebede 2010). The term refugee suggests outsider. So, to gain a sense of belonging in a new community, there is a need to challenge this concept by constructing a new identity. Ager and Strang (2008) suggest friendships, particularly people being friendly to them, as being important for making connections to feel integrated, and belong. To be able to fit in and belong in a community is important for the Syrian women. They made every effort to welcome new friends and professionals.

8.12 Belonging

A sense of belonging, suggests Ager and Strang (2008), is only aligned with integration when friendships are established beyond their own ethnic groups. The Syrian women had established some friendships beyond their own ethnicity, suggesting they had been accepted by people outwith their ethnic group. The 'belongingness hypothesis', a concept raised by Baumeister and Leary (1995), is recognised as being central to people's wellbeing, which, when interrupted, can have devastating effects on physical and mental health. For people of refugee status, the need to feel this belonging could be connected to feelings of safety. According to Maslow (1943), belonging will only be achieved when the essential need for food, safety, shelter and water are first satisfied. Baumeister and Leary (1995) go further, claiming that the drive for human belonging can be considered equal to the need to eat. For Syrian women, the bonds connecting close family and friends may no longer exist, and, consequently, the need to seek 'belongingness' to meet this human need is crucial. These friendships, then, help to redefine identity (Drolet and Moorthi 2018). Children and young people fare much better when the family has this sense of belonging (Correa-Velez et al. 2010), as they are particularly sensitive to discrimination and racial prejudice. 'Belongingness' can secure their mental health, particularly where pressure to conform to host country ways conflicts with parents' demands for loyalty to family traditions.

Belonging can be symbolised in different ways. The drink I was served in the china tea set carried from Syria took pride of place in the new family home. This china tea set represented so much more than just serving cups. It resonates with how migrant women create 'domestic spaces' that mirror those of their homeland, keeping alive the place where they feel they belong (Longhurst et al. 2009). One might associate china tea sets with memories of home and of family gatherings. They often represent the era of their origin and culture from where they were designed. Öğüt (2009) explains the ritual involved in serving tea, the associated

practices steeped in family tradition and culture, as well as across time, geography and generations. The meaning of serving tea is embedded into the psyche of many cultures, where identities are formed on such repetitive practices and passed on to children. The familiar traditional likes and dislikes develop the sense of knowing and belonging within families which hold them together. The power manifested from this routine is significant. Longhurst et al. (2009) highlight the importance of the senses when adapting to new places, in absorbing new experiences. Becoming familiar with new tastes and smells is important for integration, but bringing familiar tastes and smells into the new home, as with the Syrian women, contributes to a new sense of belonging. Sharing these tastes makes a welcoming contribution to new communities, in anticipation of being accepted. In the UK we associate taking out the best china with serving those who are important to us. Ashworth (2014) recognised the added value of drinking tea with patients affected by dementia when conducting qualitative interviews. Accepting the tea, then sitting with the participant drinking the tea, encouraged relaxation, which reaped benefits for building positive relationships. These offerings in the family home form an important feature in building new connections while maintaining identities and remaining connected to home.

The HVs in the study each explained being offered refreshments during visits, and some made time and others found it difficult to refuse. But no one suggested that this event could be about facilitating belonging and supporting integration. As the HVs gained a better understanding of what is happening when being offered tea, this would, in most cases, I would suggest, assist them to make these choices. Accepting the tea, forming a ritual, could help to cement the relationship (Baumeister and Leary 1995). Allowing for additional time, the HVs could share conversations where they would get to know the women and, in turn, the women could feel valued (Drolet and Moorthi 2018). Furthermore, this could create a space where sensitive conversations could be raised, an element previously found to be severely lacking (Al-Shdayfat and Hatamleh 2017).

The HV relationship with clients is well understood for building trust and promoting engagement with services (Cowley et al. 2013; Pound 2013; Malone et al. 2016). What is not known, however, is that how this relationship is enacted has the potential for HVs to contribute to Syrian women acquiring a sense of 'belonging'. Through 'bonds', 'bridges' and 'links', HVs can help make connections between the old and the new country (Ager and Strang 2008). The HV's relationship with the Syrian women, although a professional one, forms bonds, which may be closer and more intimate than some friendships and acquaintances, where confidential issues and health-promoting conversations take place. Allowing time for tea during the home visit could create a space where the relationship could

flourish. O'Donnell et al. (2007) highlighted the value that is placed on the home visit from HVs by refugees. Furthermore, HVs promote belonging through facilitating bridges with services and links to communities, supporting integration. The HVs expressed a clear desire to contribute more to integration, recognising that their community position and skills were highly relevant. What was lacking was sufficient time and permissions from managers. The 'belongingness hypothesis' (Baumeister and Leary 1995) further suggests that people think differently when they have formed good relationships, and this cognitive aspect could be important for HVs to instil positive health behaviours from which the women's health could benefit. The relationship with the HV can continue for many years, with longer-term benefits to women (Cowley and Bidmead 2021). This relationship could be pivotal for nurturing belonging and, in turn, facilitating emotional healing. This is worthy of investment and further inquiry.

Some of the Syrian women explicitly stated that they had few visitors. HVs are well placed as home visitors, to validate this need for friendship to help fulfil their need for belonging. Awareness-raising of this nature feature in the relationship with the HVs, and it would be important to indicate how the HV could make a difference. Over time, this may help close gaps between UK citizens and refugees as outsiders. Furthermore, HVs themselves could benefit from enhanced job satisfaction, in that they could feel they were doing something worthwhile in making this positive contribution to Syrian women's lives, where currently some HVs feel inadequate.

8.13   Summary

It is evident from this study that there is a lack of knowledge about the benefits to Syrian women and children that may be achieved from the provision of additional support by HVs to improve health outcomes. To improve their access to health care, the women wished to be better informed and have quicker access to doctors and referral appointments without delay. Having clarity on the HV role could help the Syrian women with their health care needs and their access to health services. It was also important to consider the service provision within the policy context of GIRFEC and person-centred care, and within the Scottish Refugee Integration Strategy. The evidenced suggests that not all the objectives in these policies were being achieved for Syrian women and children.

Multiagency practice and the sharing of relevant information is at the heart of GIRFEC policy (Scottish Government 2020a). As such, the HV expects to be central to the team around the child, and to receive appropriate information and be invited to meetings (Cowley 2021). Accordingly, HVs would contribute to the preparation for the families' arrival and provide

ongoing support to families. Mostly, they would be in a position to deliver the universal HV service to the Syrian women and children from the time of arrival. This is the service they deliver to every other family in Scotland (Scottish Government 2015).

There was little appetite from HVs for including the title and role of the Named Person in explanations of their role to Syrian women. HVs felt that it was unnecessary and would be difficult to grasp. They described the functions of the Named Person role as being integral to the role of the HV.

The HVs spoke very positively about their work with the Syrian families. They felt they had formed good relationships and believed they were valued by the families. Most were aware that they needed education, especially on supporting refugees who had experienced trauma, to work within a consistent pathway or protocol, improving information sharing, with a plea for translated resources and access to online information. And, although HVs are single points of contacts for families, it was recognised that they might benefit from a single point of contact for themselves, in the form of an expert practitioner.

Furthermore, recognising cultural needs within an intersectionality framework is important to enable HVs to challenge outdated attitudes and to deliver appropriate person-centred care (Markey and Okantey 2019). This study suggests that the health outcomes for Syrian women and children could be improved through forging closer relationships with HVs at the earliest stage of arrival, through improved education of HVs, and with effective management support.

8.14   Conclusion

This study involved a small number of Syrian women and HV participants to consider the HV role in improving health outcomes for Syrian women and children. The idea for the subject arose from meeting with groups of HVs who indicated that they did not feel prepared to manage diverse caseloads, in particular for working with refugees and asylum-seekers. As a lecturer on a programme for training HVs, I realised that we had a programme deficit and there may be a need to develop the curricula in this regard. At the same time, Syrian families were arriving in Scotland under the resettlement scheme, and I was unaware of any education to support HVs in preparation for this new area of practice. The research findings have informed the possible steps for future action, outlined below. These are expressed as provocative propositions in AI (Reed 2007) to reflect the intended actions needed for change.

Provocative propositions:

- HV representation to be involved in pertinent national and local policy working groups
- HVs to be involved locally in pre-planning meetings for new arrivals
- HVs to better explain their role to Syrian women, in particular their role for women
- Cultural education for HVs to be developed within an intersectionality framework

Next stage of the study:

- Syrian women as co-researchers
- Stakeholder group to include Syrian women and HVs
- Stakeholders to consider the evidence and plan for improvements to the HV programme to incorporate academic and practice learning needs

Further research:

- Research into 'the space' created with HVs having tea with Syrian women.
- The HPI was allocated as 'additional' or 'vulnerable' and in time this was reassessed to 'core'. There was no consistency noted with additional visiting patterns, suggesting scope for further inquiry

This chapter has summarised and discussed the findings. Moving on, Chapter Nine concludes this thesis.

Chapter Nine: Reflexive Account

This final Chapter begins with the study strengths and limitations, and moves on to present a reflexive account of the project, including its impact and implications for practice. The planned steps in taking the findings forward into the next phase are then considered, and a short summary completes this chapter. Following on after the appendices is the manuscript of an academic article, ready for publication.

9.1   Study strengths and limitations

The study has contributed to my understanding of Syrian women, their strengths and needs, and working with migrant and vulnerable groups. It has deepened my twenty-five years' experience, knowledge and understanding of contemporary health visiting practice.

Strengths

I wished to ensure that no questions would raise traumatic memories for the Syrian women or to make the HVs feel that they were not trained to deliver an effective service to the Syrian families. The AI approach to the study, I believe, supported the study ethos I intended. With the AI approach, questions were posed from a positive angle, where participants could recognise and build on their strengths rather than to focus on problems. However, this has been an area critiqued within AI approaches where the positive bias arising from questions needs careful management (Grant and Humphries 2006; Van Der Haar and Hosking 2004; Bushe 2012). I therefore ensured that the participants were empowered to speak freely, which included them raising issues they were concerned about and where they needed answers. In turn, this provided an opportunity for the participants' voices to be heard. I regarded empowering the Syrian women through giving them a voice as a strength of the model, as promoted by Cooperrider and Whitney (1999). This important input was captured in the selected quotations, in the analysis, and in the discussion, and will also contribute to future education planning.

A further strength of the study was using a creative method, working in small groups with the Syrian women. I learned about working intuitively and inventively from the development of the petite co-creation groups in Cycle 1. Together we co-created the case scenario vignette which informed the questions for discussion in Cycle 2. These small groups were a successful model that I would be keen to replicate and further develop in the future. Being unable to meet with larger numbers of women at the same time, due to many demands on their time, this model evolved to facilitate the inclusion of the Syrian women at times they could meet. The first group constructed the fictional family and the three other groups

contributed content. It is through trialling novel ways to gather data that learning ensues about what is possible, about what works, and how knowledge is built. Hughes and Huby (2004) encourage innovative methods such as vignettes to engage participants and to ensure their inclusivity. Bradbury-Jones et al. (2014) promote a range of ways that participants can do this, such as their own work developing focus group vignettes with data from interviews with migrant men.

These developments in methods work within the iterative approach for AI, which allows for organic advancement of the study within the overall study parameters to answer the research questions. However, this fluidity was particularly challenging as a novice researcher making decisions about what could be done without breaching regulations. The guidance from supervisors was highly valued throughout these turbulent decision-making times.

Another strength of the research was, when working with an interpreter there was adequate time for translation in these petite co-creation groups. The small number of participants allowed time for all voices to be heard and for this information and the responses to be translated. It is recognised that smaller groups can help participants to feel less self-conscious in speaking than they may have done in a larger group. But it is also important to acknowledge the importance of having the time for translation and a response. Different styles of interpreting can reduce the time and financial burden of interpreter costs, but taking time to interpret accurately and truthfully is important to capture the true meaning (Wallin and Ahlström 2006). In addition, focusing on a creative task rather than asking direct questions during these sessions established a fun and relaxed atmosphere where I was able to observe the women interact. The strength was in helping the women to feel comfortable, included and heard.

These co-creation groups could have further utility in areas discussing sensitive subjects, where participants are neuro-divergent, or may have learning or sensory impairments.

The methods selected for this study enhanced inclusivity by enabling the Syrian women to contribute to both cycles of the research. It was their questions about particular family members from the vignette which were posed to the HVs in Cycle 2. This brought authenticity to Cycle 2, which would not have been achieved without their input. This authenticity added to the robustness and truthfulness of the study (Bradbury-Jones et al. 2014). Furthermore, the telephone interviews in Cycle 2 minimised the time burden for HV attendance and enabled wider HV representation from the rural and island areas, as well as as the more urban HVs. There were also no travel or accommodation costs. All interviews

and groups were arranged at mutually agreed times with the HVs, which further supported their inclusivity.

Limitations

The key limitation of the study was with the time allocated for completion, as this was an academic study. A larger study, with additional time, could have answered many more questions, some arising through the study, such as enquiry into 'the space' created in having tea and meaningful conversations with the Syrian women, to record their stories. In the study the participants contributed information they recalled and felt comfortable with, which may have been subjective and at the expense of more nuanced or sensitive information that they did not feel able to share. As an interpreter was used, it is possible that this may have impeded discussions. Interpreters invariably add challenges to data collection, such as with questions of translating accurately and truthfully for both researchers and participants (Wallin and Ahlström 2006). There is always the possibility of such information being filtered (Williams 2005).

Having a Syrian woman trained as a co-researcher could have added robustness to the study by having a researcher from 'inside' the key group of interest. It is recognised that this can be advantageous for gathering data from ethnic groups where the researcher can use insider knowledge to probe deeper in areas of interest (Bryman 2008). This person could have brokered the cultural issues and been able to communicate directly with the Syrian women without the need for an interpreter. However, there was no budget for this and in any case the women I met were not yet proficient enough in English to be trained as co-researchers. This would be something I would consider in future projects.

Recruitment in Cycle 1 was based on a convenience sample, but I could have explored intersectionality more incisively if I had been able to include women from different educational and professional backgrounds. But this doctoral study was constrained by resources and capacity which limited these possibilities that could be pursued in a larger funded study.

A further issue which might be viewed as a limitation was that the HVs and Syrian women participants were not working together in dyads. Piacentini et al. (2018) were privileged to work in this way, and reported how advantageous and insightful it was to interpret data from the participants. Dyads are useful tools for exploring interrelationships, and Wahn et al. (2020) suggest that there are gains in working with pairs, or even further gains in working with triads in research. This approach could have had the potential to have provided data on

the efficacy of this relationship. This may have provided insights for service improvement. I did consider this, but it was overly complicated to arrange and financially too much of a burden as a student, and it would have been especially difficult for gathering data in rural and island communities. I would have needed additional time and funding to travel, as well as funding the expense of having an interpreter available. It is also likely that it would have been more difficult to ensure that quotes were not attributable when researching in small communities where there are small numbers of HVs as well as refugee women. Furthermore, the participants may not have contributed so frankly had they been paired. There is also scope to widen data collected in the future to triangulate the data gathered from the Syrian women and HVs with that collected from GPs. This might provide additional insights into the Syrian women's health perceptions alongside GPs' opinions of consultations. This could help to inform the HV role as an educator.

The numbers of participants in the study (n=23) may be viewed as a limitation. However, the intention was to gain knowledge of the participants' lived experiences, not for the findings to be generalisable. Qualitative studies such as AI are known to concentrate more on the depth of detail as opposed to the analysis of larger volumes of data (Reed 2007). Miles and Huberman (1994) claim that qualitative research has the ability to reveal and explain social contexts and express data in captivating and meaningful ways that numerical forms cannot.

9.2   Implications for practice

This study was completed as part of my journey towards the awarding of a Doctorate in Nursing. It has explored the role of the HV providing support to Syrian women and children to improve their health outcomes. The study topic was identified from the recognition that there may be a deficit in HV education to meet cultural practice needs. In order to augment HV training and CPD education, it was useful to hear the views of Syrian women and HVs directly from them.

The data thus far will be further analysed and considered in the next cycle to develop curricula content. Already, HV trainees, previous students, and managers have stated that adding an awareness-raising session to the current curriculum is changing HV practice. Practitioners are consciously seeking information and making efforts to understand cultural needs more generally.

The study design was created to meet the explicit requirements for both individual groups of participants to be able to contribute with the necessary support and with minimum burdens. However, I had not anticipated how difficult it would be to meet with the Syrian women individually or for them to attend a group work session. Their time pressures were immense

and very challenging, even when transport, childcare and an interpreter were arranged. The women constantly juggled ESOL classes, school, childcare, housekeeping and cooking, meetings regarding housing, and other appointments.

It was invaluable, however, having their contribution. The number of issues they raised, particularly during the preparation of the vignette, resulted in the development of a powerful tool for data collection in Cycle 2. Conducting this exercise revealed their personalities through the fun and laughter they brought to the task. Had I developed this myself, the authenticity would have been missed. In future, when they feel ready, there is an opportunity to invite some Syrian women to be trained as co-researchers, involved from the outset in research design, as interviewers and group facilitators, and to contribute to the analysis, thus raising their profile, and giving more credit to their skills.

Due to one Syrian woman's medical condition, I conducted two interviews at her home. These were the final two interviews conducted for Cycle 1 and turned out to be much improved on previous interviews, as the women were very relaxed in their own home and there was no time pressure. Longhurst et al. (2009) share this notion of home interviewing, where women are in charge of their own space, allowing them to take the lead.

For myself, I enjoyed these interviews more and was also more relaxed. The richness of the visit remains in my memory. The women were so welcoming and were delighted that I visited them at home. I will carry forward very positive memories, in particular the story of the china tea set carried from Syria, I may never have otherwise heard. I have reflected on the ethical guidance that I followed. In future, I would ask the women where they would like to be interviewed. This then would mean that the women would be in greater control of the research interactions, and it would remove pressure on them in terms of time, transport, school times and childcare, and would demonstrate a greater partnership between the researcher and the researched.

The literature from HVs in practice has never contributed to the wider body of nursing knowledge to the extent it could and should. This can be due to some methods being more difficult to execute in people's homes where they practise. Having tested the AI method and noted how Longhurst et al. (2009) utilised the kitchen as a space and home cooking as a vehicle for gathering evidence, I believe these, or similar, methods would be consistent with how HVs' practice. This raises possibilities for HVs to conduct research in their workplace and may be a suitable method for the Syrian women, who like to be in charge of their kitchen.

Evidence of early impact from the study has already been possible. The study was displayed in the University of Stirling art gallery as a representation of research supporting people in exile.

Photograph 1: My research project on display

This display was open to the public and was on show during a refugee open day, which several hundred people attended.

The artwork from the Syrian women's art class I was invited to attend was also on display.

Photograph 2: Unpacked home from home

The suitcase represents the uprooting and displacement from home. Unpacking their stories, the postcard story books represent the women's individual journey meanings.

Furthermore, I developed an introductory education session to raise awareness of cultural issues for HV trainees, which was evaluated well, and which has been added to the HV curriculum as an interim measure until the evidence is available for curriculum development. I have delivered this session on two occasions at another university to their trainee HVs, where it was also evaluated positively. I was interested to see whether this session had influenced the trainee HVs' learning, translating into practice, so I conducted an evaluation three months after one teaching session (see the Template in Appendix 13, and the Report in Appendix 14). The feedback suggests that some improvement in practice was observed for those who attended. The data collected will help inform the stakeholder group analysis going forward.

A number of dissemination routes will be explored, and publications prepared. Firstly, the integration managers for the Syrian women and the HV managers will receive a summary account of the research, and the thesis will be placed in the university repository. Presentations and posters will be submitted to pertinent conferences and publications will be submitted to an HV journal and a relevant international journal. Furthermore, several social media platforms, such as Twitter, will be exploited to disseminate the findings of my work.

9.3   Next steps

For the next phase, a stakeholder group will be established to review the data and to plan ahead for the implementation of the findings and for a further research cycle. Representation will be invited from HVs in practice and their leaders, trainee HVs, Syrian women and academic staff. The cultural practice models will be studied further, with the potential to take one or more of the elements forward for testing in practice. This will be incorporated within the student individual learning portfolio. The portfolio is the trainee HVs' evidence of learning, where experience from practice is gathered. Over time, a 'needs-based' portfolio will be developed by spending periods of time in cultural encounters and producing reflective accounts.

The intention would be for the evidence gained here and developed in the further studies to form part of the HV course fulfilment requirements. This will support those HVs who reported a preference for learning in practice and to inform the new NMC standards when they are published. The next stage will continue the exploration of intersectionality with the stakeholder group, to gain alternative views into how best to employ cultural concepts within the programme. There may be an opportunity to invite contributions from other ethnic minority groups. These findings should provide further evidence to take forward for the development of the HV programme and subsequently for practice.

9.4   Concluding statement

This thesis marks the end of two cycles of Appreciative Inquiry research to improve health outcomes for Syrian women and children through exploring the HV role. An additional phase to develop an educational component to add to the HV programme will follow. There is scope for further research using Appreciative Inquiry as a way of engaging participants in research, particularly participants who may not have opportunities to present their views by other means. As the Syrian women's spoken English has greatly improved over time, I anticipate being able to include participant co-researchers in the next stage and may not require an interpreter. This would add to the robustness of the research design and its execution, as well as level the power balance between researcher and participants as stakeholders. Being a small qualitative study, the findings have limited generalisability. Despite this, they may be of benefit to Health Boards and institutions involved in HV education and may encourage further research.

My knowledge contribution is that HVs may provide an improved route to better health and wellbeing for Syrian women and children, and this has yet to be fully realised. HVs may be the only health professional visiting the family home who can identify need and facilitate access to appropriate health services. But further, the HV role is founded on establishing positive relationships. This function could pave the way to the 'belongingness' the women seek in integrating, settling and building new lives. Forming meaningful reciprocal relationships could make the difference to Syrian women's health and wellbeing from feeling welcomed and valued. HVs sharing tea served by the Syrian women in their 'china tea sets' during the home visit in many ways symbolises the development of this important relationship.

Photograph 3: The coffee I was served in the china tea set carried from Syria

"I long, as does every human being, to be at home wherever I find myself."

Maya Angelou

References

Abdulkadir, J., Azzudin, A., Buick, A., Curtice, L., Dzingisai, M., Easton, D., Frew, C., Glinski, J., Holliday, D., Knifton, L., McLaughlin, D., Quinn, N. and Ramsay, D. (2016) *What do you mean, I have a right to health? Participatory action research on health and human rights.* Glasgow: Health and Social Care Academy, Centre for Health Policy, University of Strathclyde. Available: https://strathprints.strath.ac.uk/58209/ [Accessed: 26 March 2018].

Abu-Ras, W. and Abu-Bader, S. (2009) Risk factors for depression and posttraumatic stress disorder (PTSD): the case of Arab and Muslim Americans post 9/11. *Journal of Immigrant and Refugee Studies*, 7 (4), pp. 393-418.

Abubakar, A., Aldridge, R. A., Devakumar, D., Orcutt, M., Burns, R., Barreto, M.L., Dhavan, P., Fouad, M.F., Groce, N., Guo, Y., Hargreaves, S., Knipper, M., Miranda, J.J., Madise, N., Kumar, B., Mosca, D., McGovern, T., Rubenstein, L., Sammonds, P., Sawyer, S.M., Sheikh, K., Tollman, S., Spiegel, P., and Zimmerman, C. (2018) The UCL–*Lancet* Commission on Migration and Health: the health of a world on the move. *The Lancet*, 392, pp. 2606-2654. Available: http://dx.doi.org/10.1016/S0140-6736(18)32114-7 [Accessed: 20 June 2020].

Abushaikha, L. and Massah, R. (2012) The roles of the father during childbirth: the lived experiences of Arab Syrian parents. *Health Care for Women International*, 33 (2), pp. 168-181.

Ager, A. and Strang, A. (2008) Understanding integration: a conceptual framework. *Journal of Refugee Studies*, 21 (2), pp. 166-191.

Al-amer, R.M., Ramjan, L., Glew, P., Darwish, T.T., Randall, S. and Salamonson, Y. (2018) A reflection on the challenges in interviewing Arab participants. *Nurse Researcher*, 26 (1), pp. 19-22.

Al-Fahoum, A.S., Diomidous, M., Mechili, A., Archangelidi, O., Theodoromanolakis, P., and Mantas, J. (2015) The provision of health services in Jordan to Syrian refugees. *Health Science Journal*, 9 (2), pp. 1-7.

Al-Krenawi, A. and Jackson, S.O. (2014) Arab American marriage: culture, tradition, religion, and the social worker. *Journal of Human Behaviour in the Social Environment*, 24 (2), pp.115-137.

Al-Modallal, H., Zayed, I.A., Abujilban, S., Shehab, T. and Atoum, M. (2015) Prevalence of intimate partner violence among women visiting health care centers in Palestine refugee camps in Jordan. *Health Care for Women International*, 36 (2), pp. 137-148.

Al-Shdayfat, N., and Hatamleh, R. (2017) Syrian refugee women's reasons for not reporting violence: an exploratory study. *International Journal of Nursing Education,* 9 (4), pp. 96-100.

Almqvist, K. and Brandell-Forsberg, M. (1997) Refugee children in Sweden: post-traumatic stress disorder in Iranian pre-school children exposed to organised violence. *Child Abuse & Neglect*, 21 (4), pp. 351-366.

Alsaba, K. and Kapilashrami, A. (2016) Understanding women's experience of violence and the political economy of gender in conflict: the case of Syria. *Reproductive Health Matters*, 24 (47), pp. 5-17.

Altschuler, J. (2013) Migration, illness and health care. *Contemporary Family Therapy*, 35 (3), pp. 546-556.

Antonovsky, A. (1996) The salutogenic model as a theory to guide health promotion. *Health Promotion International,* 11 (1), pp. 11–18.

Appleton, J.V., Harrison, J. and Mumby-Croft, K. (2021) *Safeguarding children: a public health imperative.* In: S. Cowley and K. Whittaker, eds. *Community public health in policy and practice.* 3rd ed. London: Elsevier Health Sciences, pp. 263-292.

Arksey, H. and O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8 (1), pp. 9-32.

Arthur, S., Mitchell., Lewis, J. and McNaughton Nicholls, C. (2014) Designing fieldwork. In: J. Ritchie, J. Lewis, C. McNaughton Nicholls and R. Ormston. *Qualitative research practice.* 2nd ed. London: Sage Publications Ltd., pp. 147-176.

Ashworth, R. (2014) More than just a cup of tea: everyday cultural practices and interactions in research. *Generations Review,* 24 (3), pp. 4-10.

Attiah, J. S. (2015) Appreciative inquiry: a tool for transforming the University for Development Studies. *Global Educational Research Journal*, 2 (12), pp. 185-194. Available from: http://www.springjournals.net/full-articles/springjournals.netglobalarticlesindex=4seniwoliba.pdf?view=inline [Accessed 14 October 2021].

Axelsson, E. and Hedman-Lagerlöf, K. (2019) Cognitive behaviour therapy for health anxiety: systematic review and meta-analysis of clinical efficacy and health economic outcomes. *Expert Review of Pharmacoeconomics and Outcomes Research*, 19 (6), pp. 663-676.

Azizi, S., Hosseini, S., B. and Basavaraju, C. (2017) Syrian women refugees and their human rights' protection – recent events and challenges. *EPRA International Journal of Economic and Business Review,* 5 (3).

Baird, M.B. (2012) Well-being in refugee women experiencing cultural transition. *Advances in Nursing Science*, 35 (3), pp. 249–263.

Baldwin, S. and Johnson, M.R.D. (2017) Working with diverse communities. In: K.A. Luker, G.A. McHugh, and R.M. Bryar, eds. *Health visiting: preparation for practice.* 4th ed. Chichester: John Wiley & Sons Ltd., pp. 220-251.

Banfield, V. and Lackie, K. (2009) Performance-based competencies for culturally responsive interprofessional collaborative practice. *Journal of Interprofessional Care*, 23 (6), pp. 611-620.

Barter, C. and Renold, E. (2000) 'I wanna tell you a story': exploring the application of vignettes in qualitative research with children and young people. *International Journal of Social Research Methodology*, 3 (4), pp. 307-323.

Bastia, T. (2014) Intersectionality, migration and development. *Progress in Development Studies,* 14 (3) pp. 237-248.

Baumeister, R. and Leary, M. (1995) The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117 (3), pp. 497-529.

Bender, D., Lui, K.Y.G. and Holyoke, P. (2017) Five opportunities for healthcare leaders to better support person-and family-centred care in long-term care settings. *Healthcare Management Forum*, 30 (1), pp. 20-25.

Biavati-Smith, A. (2017) *Speech development in bilingual children*. Edinburgh: Word Steps Speech and Language Therapy. Available: https://www.edinburgh-speech-therapy-wordsteps.co.uk/speech-development-in-bilingual-children/ [Accessed: 8 November 2020].

Black, G. (2020) Scotland's Named Person scheme: a case study of Article 5 of the United Nations Convention on the Rights of the Child in practice. *International Journal of Children's Rights*, 28 (3), pp. 571-587.

Bradbury-Jones, C., Taylor, J. and Herber, O.R. (2014) Vignette development and administration: a framework for protecting research participants. *International Journal of Social Research Methodology*, 17 (4), pp. 427-440.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), pp. 77-101.

Braun, V. and Clarke, V. (2013) *Successful qualitative research.* London: Sage Publications Ltd.

Bronfenbrenner, U. (1979) *The ecology of human development.* London: Harvard University Press.

Bryman, A. (2008) *Social research methods.* 3rd ed. Oxford: Oxford University Press.

Burchill, J. and Pevalin D. (2012) Barriers to effective practice for health visitors working with asylum seekers and refugees. *Community Practitioner*, 85 (7), pp. 20-23.

Burchill, J. and Pevalin, D. (2014) Demonstrating cultural competence within health-visiting practice: working with refugee and asylum-seeking families. *Diversity & Equality in Health and Care*, 11 (2), pp. 151–159.

Bushe, G.R. (2012) Appreciative inquiry: theory and critique. In: D. Boje, B. Burnes, and J. Hassard, eds. *The Routledge companion to organizational change*. Oxford: Routledge, pp. 87-103.

Chalmers, K.I. and Whittaker, K.A. (2017) Approaches to supporting parents. In: K.A. Luker, G.A. McHugh, and R.M. Bryar, eds. *Health visiting: preparation for practice*. 4th ed Chichester: John Wiley & Sons Ltd., pp. 127-169.

Chen, S., Huang, F. and Zeng, W. (2017) Comments on systematic methodologies of action research in the new millennium: a review of publications 2000–2014. *Action Research*, 16 (4), pp. 341-360.

Children (Scotland) Act 1995. Available: https://www.legislation.gov.uk/ukpga/1995/36/contents [Accessed 12 November 2021].

Children and Young People (Scotland) Act 2014, Part 18. Available: https://www.legislation.gov.uk/asp/2014/8/part/18 [Accessed: 3 February 2021].

Children and Young People (Scotland) Act 2014. Available: https://www.legislation.gov.uk/asp/2014/8/contents/enacted [Accessed: 3 February 2021].

Christmann, K. (2012) *Preventing religious radicalisation and violent extremism: a systematic review of the research evidence*. London: Youth Justice Board for England and Wales. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/396030/preventing-violent-extremism-systematic-review.pdf [Accessed 25 October 2021].

Clarke, P.N., McFarlane M.R., Andrews, M.M. and Leininger, M. (2009) Some reflections on the impact of the culture care theory by McFarland & Andrews and a conversation with Leininger. *Nursing Science Quarterly*, 22 (3), pp. 233-239.

Coghlan. A.T. Preskill, H. and Tzavarasd Catambas, T. (2003) An overview of appreciative inquiry in evaluation. In: H. Preskill, and A.T. Coghlan, eds. *Using Appreciative Inquiry in Evaluation*. San Francisco: Jossey-Bass Wiley Education, pp. 5-22.

Coles, E., Cheyne, H., Rankin, J. and Daniel, B. (2016) Getting it right for every child: a national policy framework to promote children's well-being in Scotland, United Kingdom. *The Milbank Quarterly*, 94 (2), pp. 334-365.

Condon, L. and Thomas, A.J. (2021) Planning public health strategies. In: S. Cowley, and K. Whittaker, eds. *Community public health in policy and practice*. 3rd ed. London: Elsevier Health Sciences, pp. 71-84.

Cooperrider, D. L. and Whitney, D. (1999) Appreciative inquiry: collaborating for change. San Francisco: Berrett-Koehler Communications, Inc.

Cooperrider, D. L. and Whitney, D. (2005) *Appreciative inquiry: a positive revolution in change*. San Francisco: Berrett-Koehler Publishers, Inc.

Correa-Velez, I., Gifford, S. and Barnett, A. G. (2010) Longing to belong: social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Social Science & Medicine*, 71 (8), pp. 1399-1408.

Cowley, S. (2021) Health needs assessment. In: S. Cowley, and K. Whittaker, eds. *Community public health in policy and practice*. 3rd ed. London: Elsevier Health Sciences, pp. 103-130.

Cowley, S. and Bidmead, C. (2021) Relationships and partnership working for public health. In: S. Cowley, and K. Whittaker, eds. *Community public health in policy and practice*. 3rd ed. London: Elsevier Health Sciences, pp. 131-158.

Cowley, S. and Whittaker, K. (2021) *Community public health in policy and practice*. 3rd ed. London: Elsevier Health Sciences.

Cowley, S., Caan, W., Dowling, S. and Weir, H. (2007) What do health visitors do? A national survey of activities and service organisation. *Public Health*, 121 (11), pp. 869-879.

Cowley, S., Whittaker, K., Grigulis, A., Malone, M., Donetto, S., Wood, H., Morrow, E. and Maben, J. (2013) Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families. Department of Health Policy Research Programme. London: King's College, National Nursing Research Unit. Available: http://www.kcl.ac.uk/nursing/research/nnru/publications/index.aspx [Accessed: 15 August 2020].

Cox, J.L., Holden, J.M., and Sagovsky, R. (1987) Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*, 150, pp. 782–786.

Crenshaw, K. (1989) Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1 (8), pp. 139-168.

Creswell, J.W. (2009) *Research design*. 3rd ed. London: Sage Publications, Inc.

Cross, A., Cheyne, H., Simon, A., Whitford, H., McInnes, R., Humphrey, T., Bryers, H., Deery, R., and Rankin, J. (2012) *Right from the start: a scoping study of the implementation of the GIRFEC practice model within maternity care in three contrasting sites across Scotland*. University of Stirling and Glasgow Caledonian University.

Culley, L. (2006) Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, 13 (2), pp. 144-153.

Doi, L., Jepson, R., and Hardie, S. (2017) Realist evaluation of an enhanced health visiting programme. *PLoS ONE,* 12 (7). Available: https://doi.org/10.1371/journal.pone.0180569 [Accessed: 16 May 2020].

Drabble, L., Trocki, K., Salcedo, B., Walker, P. and Korcha, R. (2016) Conducting qualitative interviews by telephone: lessons learned from a study of alcohol use among sexual minority and heterosexual women. *Qualitative Social Work: Research and Practice*, 15 (1), pp. 118-133. Available: https://doi.org/10.1177/1473325015585613 [Accessed: 23 August 2020].

Drennan, V.M. and Joseph, J. (2005) Health visiting and refugee families: issues in professional practice. *Journal of Advanced Nursing*, 49 (2), pp. 155-163.

Drolet, J. and Moorthi, G. (2018) The settlement experiences of Syrian newcomers in Alberta: social connections and interactions. *Canadian Ethnic Studies*, 50 (2), pp. 101-120.

Ellis, B., Kia-Keating, M., Yusuf, S.A., Lincoln, A. and Nur, A. (2007) Ethical research in refugee communities and the use of community participatory methods. *Transcultural Psychiatry*, 44 (3), pp. 459-481.

European Convention on Human Rights (1953) The Convention for the Protection of Human Rights and Fundamental Freedoms. Available: https://www.echr.coe.int/documents/convention_eng.pdf [Accessed 12 November 2021].

European Directive General Data Protection Regulations (GDPR) 2018. Available: https://ico.org.uk/about-the-ico/who-we-are/scotland-office/ [Accessed: 29 February 21].

Evans, J.M.M., Ireland, A.V., Cameron, D.M., Clarke, K.M., and Eades, C.E. (2021) Postpartum opportunistic advice in primary care for women who have had gestational diabetes: a qualitative study of health care professionals' views. *BMC Family Practice*, 22 (1), Art. No.: 209. https://doi.org/10.1186/s12875-021-01558-x [Accessed: 9 November 21].

Fassetta, G., De Lomba, S., and Quinn, N. (2016) *A healthy start? Experiences of pregnant refugee and asylum seeking women in Scotland*. Glasgow: British Red Cross.

Finch, H., Lewis, J., and Turley, C. (2014) Focus groups. In: J. Ritchie, J. Lewis, C. McNaughton Nicholls and R. Ormston, eds. *Qualitative research practice*. 2nd ed. London: Sage Publications Ltd., pp. 212-242.

Finch, J. (1987) The vignette technique in survey research. *Sociology*, 21 (1), pp. 105-114.

Firth, A. and Haith-Cooper, M. (2018) Vulnerable migrant women and postnatal depression: A case of invisibility in maternity services? *British Journal of Midwifery*, 26(2), pp. 78-84.

Garfield, R. (2008) The epidemiology of war. In: B.S Levi and V.W Sidel, eds. *War and public health*. 2nd ed. New York: Oxford University Press, pp. 23-36.

Gerrish, K. and Papadopoulos, I. (1999) Transcultural competence: the challenge for nurse education. *British Journal of Nursing*, 8 (21), pp. 1453-1457.

Gholizadeh, L., Digiacomo, M., Salamonson, Y. and Davidson, P. M. (2011) Stressors influencing middle eastern women's perceptions of the risk of cardiovascular disease: a focus group study. *Health Care for Women International*, 32 (8), pp. 723-745.

Godfrey, M., Young, J., Shannon, R., Skingley, A., Wooley, R., Arrojo, F., Brooker, D., Manley, K. and Surr, C.A. (2018) The Person, Interactions and Environment Programme to improve care of people with dementia in hospital: a multisite study. *Health Services and Delivery Research*, 6 (23). Available: https://doi.org/10.3310/hsdr06230 [Accessed: 9 September 2020].

Grant, M. J. and Booth, A. (2009) A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, 26 (2), pp. 91-108.

Grant, S. and Humphries, M. (2006) Critical evaluation of appreciative inquiry. *Action Research*, 4 (4), pp. 401-418.

Greenhalgh, T., Papoutsi, C. (2018) Studying complexity in health services research: desperately seeking an overdue paradigm shift. *BMC Medicine*, 16 (95). Available: https://doi.org/10.1186/s12916-018-1089-4 [Accessed: 2 December 2020].

Gu, Y. (2020) Raising awareness of antimicrobial resistance: comment on 'Reducing expectations for antibiotics in primary care: a randomised experiment to test the response to fear based messages about antimicrobial resistance'. *BMC Medicine*, 18 (108). Available: https://doi.org/10.1186/s12916-020-01576-z [Accessed: 8 September 2020].

Gunn, M. (2016) Equity in care: How culturally competent is the health visitor? *Journal of Health Visiting*, 4 (4), pp. 192-199.

Gürsoy, E. and Ertaşoğlu, L. (2018) Syrian refugees' perception of barriers and bridges towards integration into *Turkish society. Language, Culture and Curriculum*, 32 (2), pp. 128-141. Available: https://doi.org/10.1080/07908318.2018.1542000 [Accessed: 11 July 2020].

Gustafson, D. L. (2005) Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science,* 28 (1), pp. 2–16.

Hackett, K. (2019) The blood disorders that nursing students are failing to learn about. [Blog], 21 October. Available: https://rcni.com/nursing-standard/newsroom/analysis/blood-disorders-nursing-students-are-failing-to-learn-about-153701 [Accessed: 9 September 2020].

Hall, C. (2011) Beyond Kübler-Ross: Recent developments in our understanding of grief and bereavement. *InPsyc*, (33) 6. Available: https://psychology.org.au/for-members/publications/inpsych/2011/dec/beyond-kubler-ross-recent-developments-in-our-und [Accessed: 11 October 2021]

Hammad, S. Alunni, A. Alkhas, T. (2018) Reflections on the potential (and limits) of action research as ethos, methodology, and practice: A case study of a women's empowerment programme in the Middle East. *Action Research*, 17 (2) 1-24.

Hammond, S.A. and Royal, C. (1998) *Lessons from the field*. New York: Practical Press.

Hart, C. (2006) *Doing a literature review.* London: Sage Publications

Harvey, M. and Land, L. (2017) *Research methods for nurses and midwives.* London: Sage.

The Health Foundation (2016) *Person-centred care made simple: what everyone should know about person-centred care*. London: The Health Foundation.

Heaslip, V. and Smith, S. (2016) Working with people from diverse cultures: cultural competence a knowledge domain or a way of being? *International Journal of Therapy and Rehabilitation,* 23 (11), pp. 553-554.

Hebebrand, J., Anagnostopoulos, D., Eliez, S., Linse, H., Pejovic-Milovancevic, M. and Klasen, H. (2016) A first assessment of the needs of young refugees arriving in Europe: what mental health professionals need to know. *European Child & Adolescent Psychiatry*, 25 (1), pp. 1-6.

Hepburn, E. (2020) *Migrant integration in Scotland: challenges and opportunities*. Insight 54. The Institute for Research and Innovation in Social Services (IRISS). Glasgow: IRISS. Available: https://www.iriss.org.uk/resources/insights/migrant-integration-scotland-challenges-and-opportunities [Accessed: 9 September 2020].

Higginbottom, G.M.A, Evans, C., Morgan, M., Bharj, K.K., Eldridge, J., Hussain, B. and Salt, K. (2020) Access to and interventions to improve maternity care services for immigrant women: a narrative synthesis systematic review. *Health Services Delivery Research*, 8 (14).

Home Office (2017) *Syrian vulnerable persons resettlement scheme (VPRS): guidance for local authorities and partners*. London: Home Office. Available: www.gov.uk/government/publications [Accessed: 30 January 2020].

Home Office (2018) *Funding instruction for local authorities in the support of the United Kingdom's resettlement programmes.* London: Home Office. Available: https://www.gov.uk/government/publications/uk-resettlement-programmes-funding-instruction-2018-to-2019 [Accessed: 30 January 2021].

Houser, N.O. (2008) Cultural plunge: a critical approach for multicultural development in teacher education. *Race Ethnicity and Education*, 11 (4), pp. 465-482.

Hughes, R. and Huby, M. (2004) The construction and interpretation of vignettes in social research. *Social Work and Social Sciences Review*, 11 (1), pp. 36-51.

Hugman, R., Bartolomei, L. and Pittaway, E. (2011) Human agency and the meaning of informed consent: reflections on research with refugees. *Journal of Refugee Studies*, 24 (4), pp. 655-671.

Indra, D. (1989) Ethnic human rights and feminist theory: gender implications for refugee studies and practice. *Journal of Refugee Studies*, 2 (2), pp. 221-239.

Inhorn, M.C. and Kobeissi, L. (2006) The public health costs of war in Iraq: lessons from post-war Lebanon. *Journal of Social Affairs,* 23 (90), pp. 13-43.

Isdscotland (2020) https://www.isdscotland.org/ (now part of Public Health Scotland). [Accessed 24 October 21].

IIsdscotland (2021) Child Health Systems Programme Pre School Available: https://www.isdscotland.org/Health-Topics/Child-Health/Child-Health-Programme/Child-Health-Systems-Programme-School.asp [Accessed 9 October 2021].

Israel. M, and Hay, I. (2010) *Research ethics for social scientists.* London: Sage Publications. Ltd.

Jabbour, S., Fouad, M.F., Leaning, J., McKay, D., Nasser, R., Rubenstein, L.S., Sparrow, A., Spiegel, P., Tarakji, A., Waldman, R., Hallam, R., Mukwege, D., and Tayara, G. (2018) Death and suffering in Eastern Ghouta, Syria: a call for action to protect civilians and health care. *The Lancet,* 391. pp. 815-816. Available: http://dx.doi.org/10.1016/ S0140-6736(18)30008-4 www.thelancet.com [Accessed: 19 December 2020].

Jackson, A.K. (2007) Cultural competence in health visiting practice: a baseline survey. *Community Practitioner*, 80 (2), pp.17-22.

Jacobsgaard, M. (2003) Using appreciative inquiry to evaluate project activities of a nongovernmental organisation supporting victims of trauma in Sri Lanka. In H. Preskill and A.T. Coghlan, eds. *Using appreciative inquiry in evaluation*. San Francisco: Jossey-Bass Wiley Education, pp. 53-62.

Kaur, J. and Atkin, N. (2018) Nexus between domestic violence and child protection: multidimensional forms of oppression impacting on migrant and refugee women in Australia. *Australian Social Work*, 71 (2), pp. 238-248.

Kebede, S. S. (2010) *The struggle for belonging: forming and reforming identities among 1.5–generation asylum seekers and refugees*. Working Paper Series, 70. Oxford: Refugee Studies Centre, Department of International Development, University of Oxford.

Kelm, J. (1998) Introducing the appreciative inquiry philosophy. In S.A. Hammond and C. Royal, eds. *Lessons from the field*. New York: Practical Press, pp. 161-172.

Killian, K.D. and Agathangelou, A.M. (2018) The wake of war: relationships among gender, trauma, resources, and traumatic stress in refugee families. *Journal of Feminist Family Therapy*, 30 (3), pp. 129–154.

Korstjens, I. and Moser, A. (2018) Series: practical guidance to qualitative research. Part 4: trustworthiness and publishing. *European Journal of General Practice*, 24 (1), pp. 120-124.

Kvale, S. and Brinkmann, S. (2009) *Interviews*. 2nd ed. London: Sage Publications Ltd.

Lau, W., Silove, D., Edwards, B., Forbes, D., Bryant, R., McFarlane, A., Hadzi-Pavlovic, D., Steel, Z., Nickerson, A., Van Hooff, M., Felmingham, K., Cowlishaw, S., Alkemade, N., Kartal, D. and O'Donnell, M. (2018) Adjustment of refugee children and adolescents in Australia: outcomes from wave three of the Building a New Life in Australia study. *BMC Medicine,* 16 (157). Available: https://doi.org/10.1186/s12916-018-1124-5 [Accessed: 6 May 2020].

Lawrence, D. (2014) Working with refugees and asylum seekers: the role of the health visitor. *Journal of Health Visiting*, 2 (2), pp. 72-78.

Leaning, J. (2001) Ethics of research in refugee populations. *The Lancet*, 357, pp.1432-1433.

Leininger, M. (2002) The theory of culture care and the ethnonursing research method. In: M. Leininger, and M.R. McFarland, eds. *Transcultural nursing*. 3rd ed. New York: The McGraw-Hill & Company Inc., pp. 71-98.

Leininger, M. and McFarland, M.R. (2002) *Transcultural nursing*. 3rd ed. New York: McGraw-Hill & Company Inc.

Longhurst, R., Johnston, L. and Ho, E. (2009) A visceral approach: cooking 'at home' with migrant women in Hamilton, New Zealand. *Transactions of the Institute of British Geographers*, 34 (3), pp. 333-345.

Lorek, A., Entholt, K., Nesbitt, A., Wey, E., Githinji, C., Rossor, E. and Wickramasinghe, R. (2009) The mental and physical health difficulties of children held within a British immigration detention centre: a pilot study. *Child Abuse & Neglect*, 33, pp. 573–585.

Love, J. and Norton, D. (2015) The effect of migration on the attitudes of circumcised women to female genital mutilation. *Journal of Health Visiting*, 3 (12), pp. 666-675.

Luker, K.A., McHugh, G.A. and Bryar, R.M., eds. (2017) *Health visiting: preparation for practice*. 4th ed. Chichester: John Wiley & Sons Ltd.

Lundberg, P.C. and Gerezgiher, A. (2008) Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean immigrant women in Sweden. *Midwifery*, 24 (2), pp. 214-225.

MacKinnon, K. (2021) *Refugee Histories*. Scottish Refugee Council Available: https://www.scottishrefugeecouncil.org.uk/refugee-histories/ [Accessed: 15 November 2021].

Malone, M., Whittaker, K. A., Cowley, S., Ezhova, I. and Maben, J. (2016) Health visitor education for today's Britain: messages from a narrative review of the health visitor literature. *Nurse Education Today*, 44, pp. 175-186.

Markey, K. and Okantey, C. (2019) Nurturing cultural competence in nurse education through a values-based learning approach. *Nurse Education in Practice*, 38, pp. 153-156.

Markey, K., Tilki, M. and Taylor, G. (2019) Resigned indifference: an explanation of gaps in care for culturally linguistically diverse patients. *Journal of Nursing Management*, 2 (7), pp.1462-1470.

Maršanic, V.B., Franic, T. and Curkovic, K.D. (2017). Mental health issues of refugee children: lessons from Croatia. Eur*opean Child & Adolescent Psychiatry*, 26, pp. 377–381.

Martzoukou, K. and Burnett, S. (2018) Exploring the everyday life information needs and the sociocultural adaption barriers of Syrian refugees in Scotland. Journal of Documentation, 74 (5), pp. 1104-1132. Available from: https://doi.org/10.1108/JD-10-2017-0142 [Accessed: 7 June 2020].

Maslow, A.H. (1943) A theory of human motivation. *Psychological Review*, 50 (4), pp. 370-396. Available: https://psychclassics.yorku.ca/Maslow/motivation.htm [Accessed: 9 September 2020].

McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., van Lieshout, F. and Wilson V. (2015) Person-centredness – the 'state' of the art. *International Practice Development Journal*, 5 (1).

McKeown, J.K.L., Fortune, D. and Dupuis, S.L. (2016) "It is like stepping into another world": Exploring the possibilities of using appreciative participatory action research to guide culture change work in community and long-term care. *Action Research*, 14 (3), pp. 318-334.

McLean, M., Al Yahyaei, F., Al Mansoori, M., Al Ameri, M., Al Ahbabi, S. and Bernsen, R. (2012) Muslim women's physician preference: beyond obstetrics and gynaecology. *Health Care for Women International*, 33 (9), pp. 849-876.

McNiff, J. (2017) *Action research: all you need to know*. London: Sage Publications Ltd.

Meiqari, L., Hoetjes, M., Baxter, L. and Lenglet, A. (2018) Impact of war on child health in northern Syria: the experience of Médecins Sans Frontières. *European Journal of Pediatrics*, 177(3), pp. 371-380.

Mercy Corps (2021) *The facts: what you need to know about the Syria crisis*. Available: https://europe.mercycorps.org/en-gb/blog/quick-facts-syria-crisis [Accessed: 11 September 2020].

Miles, M.B. Huberman, A.M. (1994) *Qualitative data analysis: an expanded sourcebook*. London: Sage Publications.

Mishra, P. and Bhatnagar, J. (2012). Appreciative inquiry: models and applications. *Indian Journal of Industrial Relations*, 47 (3), 543-558.

Mittlemark and Bull (2013) The salutogenic model of health in health promotion research. *Global Health Promotion*, 20 (2), pp. 30–38.

Modigell, I., Fernandes, C., Al Samman, S. and Yamin, A. (2020) *Hidden hunger in Syria: a look at malnutrition across Syria, with a focus on under-twos*. Save the Children. Available: https://reliefweb.int/report/syrian-arab-republic/hidden-hunger-syria-look-malnutrition-across-syria-focus-under-twos [Accessed: 13 November 2020].

Montgomery, E. (1998) Refugee children from the Middle East. *Scandinavian Journal of Social Medicine*, 54, pp. 1-154.

Morton-Miller, A. R. (2013) Cultural competence in nursing education: practicing what we preach. *Teaching and Learning in Nursing,* 8, pp. 91-95.

Mulvey, G. (2013) *In search of normality: refugee integration in Scotland*. Final report. Edinburgh: Scottish Refugee Council.

Narayanasamy, A. and White, E. (2005) A review of transcultural nursing. *Nurse Education Today,* 25, pp. 102–111.

Nursing and Midwifery Council (2004) Standards of proficiency for public health nurses. London: NMC. Available: https://www.nmc.org.uk/standards/additional-standards/standards-of-proficiency-for-specialist-community-public-health-nurses/ [Accessed: 26 June 2017].

Nursing and Midwifery Council (2018) *The Code: professional standards of practice and behaviour for nurses and midwives*. London: NMC. Available: https://www.nmc.org.uk/standards/code// [Accessed: 1 January 2019].

O'Donnell, C.A., Higgins, M., Chauhan, R. and Mullen, K. (2007) "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. *BMC Health Services Research*, 7 (75), pp. 1-11. Available: https://doi.org/10.1186/1472-6963-7-75 [Accessed: 8 September 2020].

Öğüt, Ş. T. (2009) Material culture of tea in Turkey: transformations of design through tradition, modernity and identity. *The Design Journal*, 12 (3), pp. 339-363.

Olds, D.L. (2006) The nurse-family partnership: an evidence-based preventive intervention. *Infant Mental Health Journal*, 27 (1) pp. 5-25.

Olsson, E. and Lau, M. (2015) When one size does not fit all: using participatory action research to co-create preventive healthcare services. *Action Research*, 13 (1), pp. 9-29.

Orcutt, M., Rayes, D., Tarakji, A., Katoub, M., Speigel, P., Rubenstein, L., Jabbour, S., Alkhalil, M., Alabbas, M. and Abbara, A. (2019) International failure in northwest Syria: humanitarian health catastrophe demands action. *The Lancet*, 394 (10193), pp. 100-103. Available: http://dx.doi.org/10.1016/ S0140-6736(19)31564-8 [Accessed: 6 September 2020].

Paisi, M., Baines, R., Burns, L. Plessas, A., Radford, P., Shawe, J. and Witton, R. (2020) Barriers and facilitators to dental care access among asylum seekers and refugees in highly developed countries: a systematic review. *BMC Oral Health*, 20 (337).

Papadopoulos I. Tilki M. Taylor, G. (1998) *Transcultural care: a guide for healthcare professionals*. Dinton: Mark Allen Publishing Ltd.

Papadopoulos, I., Shea, S., Taylor, G., Pezzella, A. and Foley, L. (2016) Developing tools to promote culturally competent, compassion, intercultural communication in healthcare. *Journal of Compassionate Health Care,* 3 (2). Available: https://doi.org/10.1186/s40639-016-0019-6 [Accessed: 21 June 2020].

Peters, M., Heijboer, H., Smiers, F. and Giordano, P.C. (2012) Diagnosis and management of thalassaemia. *British Medical Journal*, 334-e228, pp. 1-7. Available at: https://doi.org/10.1136/bmj.e228 [Accessed: 4 February 2020].

Piacentini, T., O'Donnell, C., Phipps, A., Jackson, I. and Stack, N. (2018) Moving beyond the 'language problem': developing an understanding of the intersections of health, language and immigration status in interpreter-mediated health encounters. *Language and Intercultural Communication*, 19 (3). Available: https://doi.org/10.1080/14708477.2018.1486409 [Accessed: 17th October 2021].

Pittaway, E. and Bartolomei, L. (2001) Refugees, race, and gender: the multiple discrimination against refugee women. *Refuge*, 19 (6), pp. 21-32.

Pound, R. (2013) Influences on relationship-based health visiting, part 2: discovering the need for balance through a new epistemology. *Journal of Health Visiting*, 1 (9), pp. 522-528.

QSR International Pty Ltd. (2018) NVivo (Version 12). Available: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home [Accessed: 23 October 2021].

Quickfall, J. (2014) Cultural competence in practice: the example of the community nursing care of asylum applicants in Scotland. *Diversity & Equality in Health and Care*, 11 (3), pp. 247-253.

Reavell, J. and Fazil, Q. (2017) The epidemiology of PTSD and depression in refugee minors who have resettled in developed countries. *Journal of Mental Health*, 26 (1), pp. 74-83.

Reed, J (2007) *Appreciative inquiry: research for change*. London: Sage Publications. Inc.

Registrar General (2017) Annual report of births, deaths and marriages for Scotland. Edinburgh: Scottish Government. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2017/section-3-births [Accessed: 31 January 21].

Reid, K. (2020) *Syrian refugee facts, FAQs and how to help*. World Vision. Available: http://www.worldvision.org/refugees-news-stories/syria-refugee-crisis-faq-war-affecting-children [Accessed: 23 September 2016].

Renzaho, A.M.N. and Oldroyd, J.C. (2014) Closing the gap in maternal and child health: a qualitative study examining health needs of migrant mothers in Dandenong, Victoria Australia. *Maternal Child Health,* 18, pp. 1391-1402.

Richards, L. and Gundel, S. (2017) *Best practice for community involvement in the Syrian Vulnerable Persons Resettlement Programme.* Refugees Welcome Scotland.

Robson, C. (2011) *Real world research: a resource for social scientists and practitioner-researchers*. Chichester: John Wiley & Sons Ltd.

Roope, L.S.J., Tonkin-Crine, S., Herd, N., Michie, S., Pouwels, K.B., Castro-Sanchez, E., Sallis, A., Hopkins, S., Robotham, J.V., Crook, D.W., Peto, T., Peters, M., Christopher C. Butler, C.C., Sarah Walker, A.S., and Wordsworth, S. (2020) Reducing expectations for antibiotics in primary care: a randomised experiment to test the response to fear-based messages about antimicrobial resistance. *BMC Medicine*, 18 (110). Available: https://doi.org/10.1186/s12916-020-01553-6 [Accessed: 9 September 2020].

Rose, M. (2016) Feminist theory and the European refugee crisis. *Conspectus Borealis*, 1(1) 9.

The Royal College of Nursing (2017) Report re Scottish Parliament Education and Skills Committee Children and Young People (Information Sharing) (Scotland) Bill August 2017. Available: file:///C:/Users/kmc4/Downloads/Children-and-Young-People-Information-Sharing-Scotland-Bill-Written-Evidence.pdf [Accessed: 9 October 2021].

Salman, K. (2012) Health beliefs and practices related to cancer screening among Arab Muslim women in an urban community. *Health Care for Women International*, 33 (1), pp. 45-74.

Saltaji, H. Oral health consequences of the crisis in Syria. *British Dental Journal*, 219 (49). Available: https://doi.org/10.1038/sj.bdj.2015.586 [Accessed: 24 October 2020].

Scott, M. (2016) Midwives help refugees make new lives in New Zealand. *Midwifery News*, pp. 32-32.

Scottish Government (2001) *For Scotland's children*. Edinburgh: Scottish Executive.

Scottish Government (2010a) The healthcare quality strategy for NHS Scotland. Edinburgh: The Scottish Government. Available: www.gov.scot/Publications/2010/05/10102307/0 [Accessed: 18 February 2021].

Scottish Government (2010b) *A guide to implementing Getting it right for every child: messages from pathfinders and learning partners.* Edinburgh: The Scottish Government. Available: https://www.webarchive.org.uk/wayback/archive/20180530002413/http://www.gov.scot/Topics/People/Young-People/gettingitright/publications/implementation-guide [Accessed: 9 October 21].

Scottish Government (2015) Universal Health Visitor Pathway in Scotland: pre-birth to pre-school. Available: http://www.gov.scot/Resource/0048/00487884.pdf [Accessed: 3 February 2021].

Scottish Government (2016) *GIRFEC national practice model.* Children and Families Directorate. Available: https://www.gov.scot/publications/girfec-national-practice-model/ [Accessed: 9 September 2020].

Scottish Government (2018) New Scots Refugee Integration Strategy 2018–2022. Available: https://www.gov.scot/publications/new-scots-refugee-integration-strategy-2018-2022/ [Accessed: 27 March 2018].

Scottish Government (2019) *Getting it right for every child: ministerial statement.* Available: https://www.gov.scot/publications/getting-right-child/ [Accessed: 9 October 2021].

Scottish Government (2020a) *Getting it right for every child (GIRFEC).* Available: https://www.gov.scot/policies/girfec/ [Accessed: 9 September 2020].

Scottish Government (2020b) *Getting it right for every child (GIRFEC): Named Person.* Available: https://www.gov.scot/policies/girfec/named-person/ [Accessed: 9 September 2020].

Sevinç, S. and Kiliç, S.P. (2016) Reasons for the admittance of Turkish and Syrian patients in internal medicine clinic. *International Journal of Caring Sciences*, 9 (1), pp. 155-164.

Shafiei, T., Small, R. and McLachlan, H. (2015) Immigrant Afghan women's emotional well-being after birth and use of health services in Melbourne, Australia. M*idwifery*, 31 (7), pp. 671-677.

Sharafi. N., Adib-Hajbaghery, M. and Najafi, M. (2019) Cultural knowledge in nursing: a concept analysis. *International Journal of Nursing Studies*, 99. Available: http://dx.doi.org/10.1016/j.ijnurstu.2019.103386 0020-7489/ [Accessed: 10 January 2021].

Sharp, C., Dewar, B. and Barrie, K. (2016) *Forming new futures through appreciative inquiry*. Insight 33. The Institute for Research and Innovation in Social Services (IRISS). Available: https://www.iriss.org.uk/resources/insights/forming-new-futures-through-appreciative-inquiry [Accessed: 24 March 2018].

Sigerson, D. and Gruer, L. (2011) *Asset-based approaches to health improvement.* Edinburgh: NHS Health Scotland.

Smith, L. (2018) *Integrated assessments in children's services*. ESSS Outline. The Institute for Research and Innovation in Social Services (IRISS). Available: https://www.iriss.org.uk/resources/esss-outlines/integrated-assessment [Accessed 9 October 2021].

Smith, M. (2017) Health visiting: context and public health practice In: K.A. Luker, G.A. McHugh and R.M. Bryar, eds. *Health visiting: preparation for practice*. 4th ed. Chichester: John Wiley & Sons Ltd., pp. 52-84.

Soares, A.A. and Tzafalias, M. (2015) Europe gears up to attend to refugees' health. *Bulletin of the World Health Organization*, 93 (12), pp. 822-823.

Steiner, P.M., Atzmüller, C. and Su, D. (2016) Designing valid and reliable vignette experiments for survey research: a case study on the fair gender income gap. *Journal of Methods and Measurement in the Social Sciences*, 7 (2), pp. 52-94.

Stradling, B., MacNeil, M. and Berry, H. (2009) *Changing professional practice and culture to get it right for every child: an evaluation of the development and early implementation phases of getting it right for every child in Highland: 2006–2009*. Edinburgh: Scottish Government.

Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. Education and Debate. *British Medical Journal,* 322 (13).

The Supreme Court: Judicial Committee of the Privy Council (2016) The Christian Institute and others (Appellants) v The Lord Advocate (Respondent) (Scotland) Judgement. Available: https://www.supremecourt.uk/cases/uksc-2015-0216.html [Accessed: 9 November 2020].

Trajkovski, S., Schmied, V., Vickers, M. and Jackson, D. (2013) Implementing the 4D cycle of appreciative inquiry in health care: a methodological review. *Journal of Advanced Nursing*, 69 (6), pp. 1224-1234.

Truong, M., Paradies, Y. and Priest, N.C. (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research*, 14 (99). Available: https://doi.org/10.1186/1472-6963-14-99 [Accessed: 20 January 2018].

Tsai, T-I. Luck, L. Jeffries, D. et al. (2018) Challenges in adapting a survey: ensuring cross-cultural equivalence. *Nurse Researcher*. Available: https://doi.org/10.7748/nr.2018.e1581 [Accessed: 2 February 2021].

UN High Commissioner for Refugees (UNHCR) (1951) *Convention and protocol relating to the status of refugees* (the United Nations Refugee Convention). Available: https://www.unhcr.org/uk/3b66c2aa10 [Accessed 12 November 2021].

UN High Commissioner for Refugees (UNHCR) (2016) The 10-point plan in action- glossary. Available: https://www.refworld.org/docid/59e99eb94.html [Accessed: 10 November 2020].

UN High Commissioner for Refugees (UNHCR) (2018) 'Refugees' and 'Migrants': frequently asked questions (FAQs). Available at: https://www.refworld.org/docid/56e81c0d4.html [Accessed: 10 November 2020].

United Nations Convention on the Rights of the Child (UNCRC) (1989) Available: https://www.unicef.org.uk/what-we-do/un-convention-child-rights/ [Accessed: 9 September 2020].

The Universal Declaration on Cultural Diversity (2002) *International Journal of Cultural Property*, 11 (1), pp. 129-136.

Urquria, M.I., O'Campo, P.J. and Heaman, M.I. (2012) Revisiting the immigrant paradox in reproductive health: the roles of ethnicity and duration. *Social Science & Medicine*, 74, pp. 1610-1621.

Ussher, J.M., Rhyder-Obid, M., Perz, J., Rae, M., Wong, T.W.K. and Newman, P. (2012) Purity, privacy and procreation: constructions and experiences of sexual and reproductive health in Assyrian and Karen women living in Australia. *Sexuality & Culture*, 16 (4), pp. 467-485.

Van der Haar, D. and Hosking, D.M. (2004) Evaluating appreciative inquiry: a relational constructionist perspective. *Human Relations*, 57 (8), pp. 1017-1036.

Wahn, B., Czeszumski, A., Labusch, M. Kingstone, A. and Konig, P. (2020) Dyadic and triadic search: benefits, costs, and predictors of group performance. *Attention Perception and Psychophysics*, 82, pp. 2415-2433.

Wallin, A.M. and Ahlström, G. (2006) Cross-cultural interview studies using interpreters: systematic literature review. *Journal of Advanced Nursing*, 55 (6), pp. 723–735.

Walton, L.M., Akram, F. and Hossain, F. (2014) Health beliefs of Muslim women and implications for health care providers: exploratory study on the health beliefs of Muslim women. *Online Journal of Ethics*, 10 (2) 5. Available: http://dx.doi.org/10.18785/ojhe.1002.05 [Accessed: 9 September 2020].

Watkins, J.M., Mhor, B.J. (2001) *Appreciative inquiry*. San Francisco: Jossey-Bass/Pfeiffer.

Webster, S., Lewis, J., Brown, A. (2014) Ethical considerations in qualitative research. In: J. Richie, J. Lewis, C. McNaughton Nicholls and R. Ormston, eds. *Qualitative research practice*. 2nd ed. London: Sage Publications, pp. 77-107.

Williams, L. (2005) Interpreting services for refugees: Hearing voices? *International Journal of Migration, Health and Social Care*, 1 (1), pp. 37-49.

World Health Organization (1946) Defining health. In: K.A. Luker, G.A. McHugh and R.M. Bryar, eds. (2017) *Health visiting: preparation for practice*. 4th ed. Chichester: John Wiley & Sons Ltd., pp. 57.

World Health Organization (2016) Global report on diabetes. Geneva: WHO Press. Available: https://www.who.int/publications/i/item/9789241565257 [Accessed: 13 June 2020].

World Health Organization (2020) *Antibiotic resistance.* Available: https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance [Accessed: 13 June 2020].

Wren, K. (2004) *Building bridges: local responses to the resettlement of asylum seekers in Glasgow*. Glasgow: Scottish Centre for Research on Social Justice.

Yasmine, R. and Moughalian, C. (2016) Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. *Reproductive Health Matters*, 24 (47), pp. 27-35.

Yuval-Davis, N. (1997) Women, citizenship and difference. *Feminist Review*, 57 (1), pp. 4-27.

Appendices

Appendix 1: 'My world triangle'

Situated within the National Practice Model (Scottish Government 2016) and on its own below.
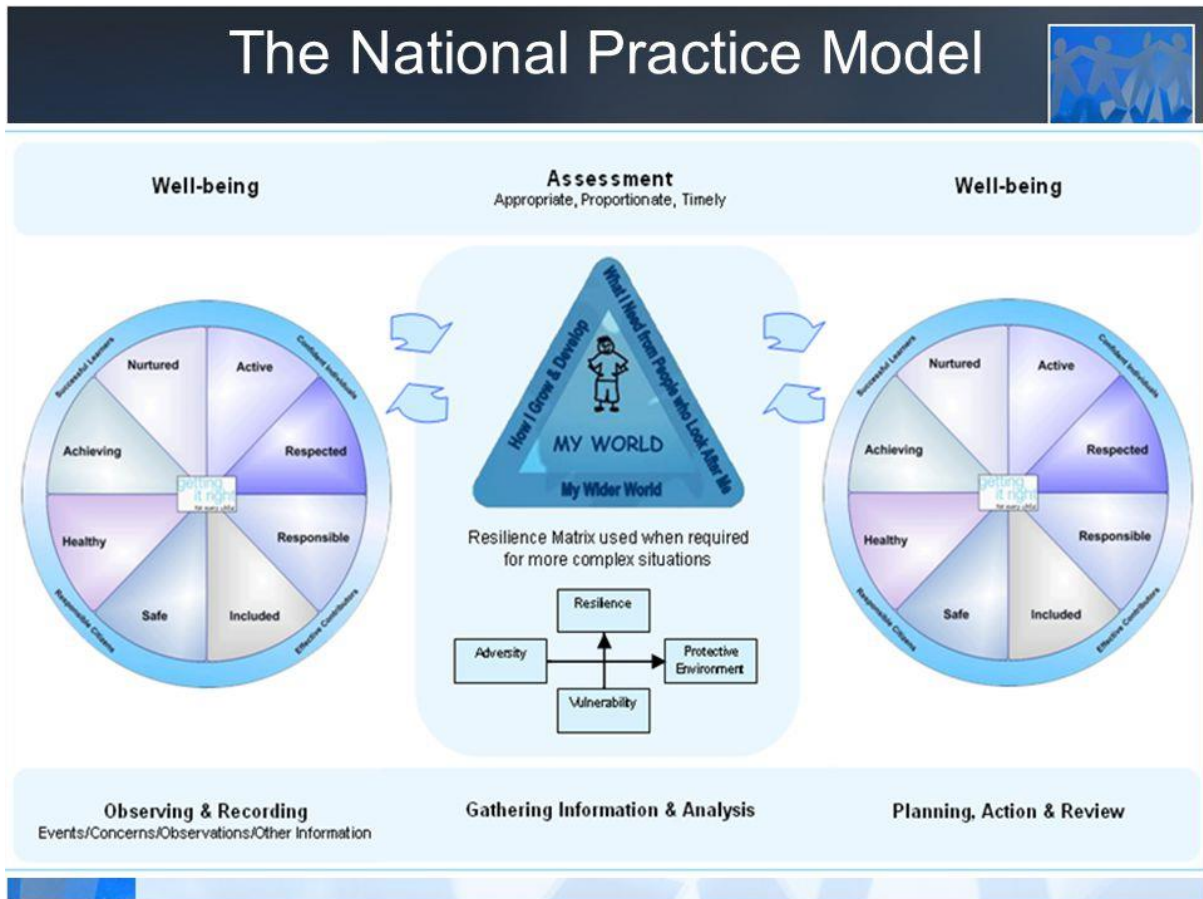
Appendix 2: Literature search flow diagram

```
┌─────────────────────────────┐      ┌─────────────────────────────┐
│  Records identified through │      │  Additional records         │
│  database searching         │      │  identified through other   │
│  (n=34944   )               │      │  sources (n=3)              │
└──────────────┬──────────────┘      └──────────────┬──────────────┘
               │                                    │
               ▼                                    ▼
┌───────────────────────────────────────────────────────────────────┐
│  Very large searches (over 200) not saved, search refined. Records │
│  after 1st screening: non-relevant titles and duplicates removed   │
│  (n=135+3)                                                         │
└───────────────────────────────────┬───────────────────────────────┘
                                    │
                                    ▼
┌───────────────────────────────────────┐      ┌──────────────────────┐
│  Eligible for 2nd screening of         │      │  Following reading   │
│  abstracts (n=138)                     │─────▶│  abstracts (n=89)    │
└───────────────────────────────────────┘      └───────────┬──────────┘
                                                            │
                                    ┌───────────────────────┘
                                    ▼
┌───────────────────────────────────────────────────────┐
│  Full-text excluded, with reasons (n=44)              │
└───────────────────────────────────┬───────────────────┘
                                    │
                                    ▼
┌───────────────────────────────────────────────────┐
│  Studies included (n=45)                          │
│  Qualitative (n=16)                               │
│  Quantitative (n=11)                              │
│  Discussion (n=11)                                │
│  Systematic reviews (n=5)                         │
│  Mixed methods: (n=2)                             │
└───────────────────────────────────────────────────┘
```

Appendix 3: Cycle 1 Topic guide

UNIVERSITY *of*
STIRLING
Cycle 1 Topic Guide

Study Title: Improving access to health care for Syrian refugee women and children.

Semi-structured Interview Question guide for Syrian women.

I am keen to understand your experience of coming to Scotland and how you found your way through health services in this country. Such as, registering with a doctor, midwife or dentist, and about your experience of getting help from health services for any health advice or concerns for you or your family. This could be for children's development, mental health worries, women's health and pregnancy, or physical health concerns. I am also interested in whether the services in Scotland are what you are familiar with and whether or not they meet your needs.

I have a few questions to ask you, please take your time and ask me to explain anything you need. Can I start by asking about yourself? I don't need your name or address or details of any of your family members.

Allocated CODE:

Can you tell me?

Your age	
Marital status	
Any children sex/age	
Any other household members/ages	
How long in Scotland	

1. You were given a welcome pack on arrival in Scotland which contained information about health services here.

   Can you tell me about that information pack and how you made use of it?

2. How did you find out about getting access to health care?

3. The health service has many departments and people to help with health concerns. I am interested to hear about the people who have helped you to understand who you need to go to for your health matters?

4. Can you describe to me how you would express these sort of health issues, in your own words, and where you would go for advice and assistance?

   a) headache
   b) a family member with vomiting
   c) a burn on an arm

    d) low mood, sadness, possibly depression

    e) child with asthma

    f) a worry your child was not sleeping

    g) a child with speech delay

    h) contraception

    i) pregnancy

    j) health screening such as smear

    k) family member with diabetes

    l) parent with hearing loss

5. I am interested to know if the health care that you get suits your needs as a Syrian woman. Is there anything that we should take into account that would make it easier for you to access services? E.g. is there anything about your religion or culture that you would wish to be observed by health care staff? Explore: visiting the woman's home; women attending surgery/clinic; in-hospital stays.

6. How could these preferences be best communicated to health professionals?

7. How do you make appointments to get the health care that you or your family needs?
Thinking about the last time you had a health care appointment, can you tell me about travelling to any health service appointments and how you find your way to the health centre, clinics or hospital?

Questions only for those with young children

8. You have children under school age. Can you tell me what you understand about the health visiting service? And your contact with the health visitor? What has been your experience with health visitors so far?

9. Were the advantages of the health visitor role as Named Person explained to you? If so how?

And for all participants:

10. Knowing what you know now, what would have been useful to learn about the health service when you first arrived in Scotland?

Thank you.

Appendix 4: Cycle 2 Health Visitor Questionnaire

UNIVERSITY *of* **STIRLING** **Cycle 2 Health Visitor Questionnaire**

This study is interested in your work with Syrian refugee families who have migrated to Scotland via the Syrian refugee resettlement scheme.

Thank you for agreeing to take part in this study and to completing this questionnaire. This questionnaire should take around 15 minutes of your time. Please **do not** include any personal details about yourself or your clients.

When complete please return to the researcher in the stamped-addresses envelope provided as soon as possible and before XXX.

Some questions need a yes/no/ don't know or NA (not applicable) answer – please circle your answer.

Others ask you to free text. Include any detail you feel may be helpful for this research, and continue overleaf should you need.

1.	**Introduction questions:** How long have you been practicing as a health visitor? ....
2.	Which type of community do you work in? *Circle answer:* urban, rural or island?

3.	**The following questions are regarding your experience.**
	
	a) Are you currently working with Syrian families who arrived in Scotland through the Syrian resettlement scheme?
	    yes/no
	
	or
	
	b) Have you previously worked with Syrian families?
	    yes/no/NA
	
	c) Overall how much experience do you have working with Syrian families?
	    Please explain...

4.	**The following questions are regarding your education/training**

	a) Have you received any education, training or preparation for working with diverse populations? yes/no

5.	a) Did this include working with refugees and asylum seekers generally?
	
	    yes/no
	    and
	
	b) Syrian refugee families more specifically?
	    Please explain….

6.	a) Was this during your training to become a health visitor?
	    yes/no/NA
	    or
	b) For your continuous professional development working as a health visitor?
	    yes/no/NA
	    Please expand……..

7.	a) If you have not attended any relevant training was training offered to you? yes/no/NA b) If yes, can you explain why you did not attend?

8.	a) Have you undertaken any relevant academic accredited modules for working with diversity?
	
	    yes/no
	
	    If so, please explain…….
	
	b) Are you aware of any modules for working with diversity?
	
	     If so, please explain…….

9.	1. Have you ever worked abroad?
	    yes/no
	
	    If yes, please explain?

Thank you for participating in this study and for your time, it is very much appreciated.
Please add any information you feel is relevant to this study…

Appendix 5: Cycle 2 Topic guide including case scenario vignette

UNIVERSITY *of* STIRLING

Cycle 2 Topic guide
Health Visitor telephone interview questions

Thank you for agreeing to this interview. It should take around 35-45 minutes.
I shall start by asking you some questions regarding your experience working with Syrian refugee families, then we will have a discussion on a case scenario. The questions from this have been generated by Syrian refugee women.
Please let me know anytime you need to have a break, or if you need me to clarify any questions.

Preparation for working with Syrian refugee families.

1.	Can you tell me about your experience of working with Syrian refugee families?
2.	Can you tell me how you prepare for Syrian families coming onto your caseload?
3.	a) Can you tell me generally about the sorts of issues you have supported Syrian families with? b) What did you do to help them? c) How do you know if that was helpful?
4.	We know that refugees more generally can have complex health issues and been exposed to trauma. Where did/do you source information and support for the Syrian refugee families when needed?

Health visitor role

5.	a) How do the Syrian families contact you as the single point of contact you being their Named Person? b) How does this role or could this role help your work with the Syrian families?
6.	How do you enact your responsibility as Named Person for helping families to access health care?
7.	a) What other types of information, if any, do *you* consider you would have benefited from to support the Syrian refugee families on arrival? b) What skills, if any, do you consider *you* would have benefited from developing to support these families?

Case scenario discussion. We are now moving into the next section of the interview. I shall read you a short case scenario, and ask you some questions raised from this. Ask me to repeat any parts you wish or any further explanations. Here I wish to encourage a frank discussion so please feel free to expand on any areas you feel would be helpful or worthy of discussion.	

Case Scenario: You have been notified the Burjiti family are arriving from Syria next week through the Syrian resettlement scheme and are allocated to your caseload. This family consists of:

Grandfather, Issam, age 85, who has high blood pressure and is diabetic

Grandmother, Soad, age 70, who has a heart condition and arthritis

Father, Motaz, age 35, who has depression

Mother, Hoda, age 30, who is pregnant and needs dental care

and three children:

Foziaheh, a girl, age 12, who has thalassaemia

Ferial, a girl, age 10, who is healthy

Abdo, a boy, age 2, who is healthy but has a speech delay

8.	I am interested in you telling me in your own words what you do, if anything, in preparation for their arrival? *Prompts* a) Who you might network with? b) Who introduces you to the family? c) Who explains your role and the health visiting service to the family? d) How you communicate with the Syrian families and them with you from arrival? e) What information do you give them? f) When do you give it? g) How do you deliver it? h) How do you get information re their health status? i) Do you undertake a family assessment? j) If so which family members are included? k) Who, if anyone conducts health assessments for each of the family members?
9.	a) How do you know what measures, if any, regarding cultural preferences need to be considered? b) How do you assess, address and manage these for home visits? And clinics? c) How do you know whether you can shake hands or need to remove/cover shoes?

10.	The family tell you of the health conditions of each family member, already mentioned. I am going to ask you some questions related to these issues. a) You identify health needs for the grandfather during your visit related to his diabetes. Would you address this? If so how? b) You have been told that Ferial, age 10 is tired all the time. Would you address this? If so how? c) The mother, Hoda, informs you she is pregnant, approximately 12 weeks. Can you tell me what advice and guidance, if any, you would give? Would you suggest at this initial contact about accessing screening for a smear and breast examination? Hoda is interested about her bone health, what advice, if any, would you suggest? She asks you what choices she has for where she can go for help. What advice, if any, would you suggest? d) Hoda is keen to know if her children are developing correctly, about dental care for the children, and about getting a check for tongue tie for Abdo. What advice, if any, would you suggest? e) The father, Motaz, complains of failing eyesight and you notice he appears to be in low mood what advice if any, would you suggest? f) Where would you advise the family to go to find out about transport to attend appointments?
11.	Do you think the health visitor has a role with helping the family integrate into the community? If so how and what could the health visitor help with?
12.	Who can you go to and ask for guidance and support about working with Syrian refugee families?
13.	Can you tell me what education, if any, you feel would be of benefit to health visitors for their work with migrant families, refugees and asylum seekers more generally?
14.	If so, when should they have this education? a) During health visitor training? b) Or as continuing professional development CPD?
Finally 15.	If you could have one thing which could help and support you in your role working with Syrian families, refugees and asylum seekers more generally, what would you suggest?

Thank you for participating in this study and for your time, it is very much appreciated.

Appendix 6: Cycle 1 Participant Information Sheet

UNIVERSITY *of* STIRLING

Participant Information Sheet   Cycle 1

Title of Study:

Improving access to health care for Syrian women and children.

2,000 Syrian people are settling in Scotland and it is known that these families can have health and social care needs. Women may be pregnant or need child health and development advice, or treatment for health conditions for themselves or their family. It is unclear if the Syrian women access appropriate and timely health care, and the ability to do this is important for their health and wellbeing and that of their families.

This study is being undertaken by Kate Clarke, part of a Doctorate in Nursing from the University of Stirling. Kate has a nursing and health visitor background, teaches on the health vising programme at The University of Stirling, and is interested in how health visitors can best support families.

The aim of this study is to improve health for women and children who are settling in Scotland as part of the Syrian refugee resettlement scheme.

This study wishes to find out about Syrian women's experience of accessing health care in Scotland. Also, to hear about their experience of contact with health visitors and their views about what could help them improve their access to health care. Also, to hear the best way for health professionals to respect their religious and traditional practices when providing health care.

Please read through this information sheet fully. If you have any concerns or questions, or if you would like some further information please do not hesitate to contact me (details below).

Purpose of the study:

To improve health through better access to health care for Syrian women and children.

Do I have to participate?

Taking part in this study is entirely voluntary. You will be asked to sign a consent form after you have read this information sheet and have had the opportunity to ask any questions that you might have about the study. After signing the consent form you are free to change your mind and withdraw from the study at any point without explanation. If you do this then any interview material will be removed the study, and no further information will be collected. If you took part in a discussion group, your contribution will be removed where possible to identify this.

What will be involved in taking part?

You will be invited to attend an interview and a discussion group where you will be asked some questions about accessing health care. You will not be asked any personal details about you or your family's health. This should last approximately 35-45 mins. You will also be invited to join a discussion group for around 2 hours with the researcher to help plan questions for the next stage of the project when the researcher will be interviewing health

visitors. Both the interview and the discussion group for you will take place at the same time and place as a women's group that you attend. The times for interview and discussion group will be planned with your group leader. An interpreter will be present to help translate if necessary.

Are there any possible benefits from taking part?

You may benefit through discussing your own experience, but you personally may not benefit from any developments as a result of the study. You could however help improve access to health care for other families.

If there is a problem who shall I contact?

If you have questions or concerns about any part of the study, or require some more information, please don't hesitate to contact me by email: Kate Clarke k.m.clarke@stir.ac.uk or telephone 01786 466350

Alternatively you may wish to speak with my supervisor Dr Fiona Harris via fiona.harris@stir.ac.uk

However, should you wish to contact someone independent of the study, you should contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport via jayne.donaldson@stir.ac.uk.

Will my personal details be kept confidential?

No personal data will be collected. All the data collected will be stored on computers securely and in accordance with the Data Protection Act (2018) and stored at the University of Stirling for a period of 10 years. The data held will be anonymous and confidential. Access to this data will only be available to myself and my supervisor.

Thank you for considering helping with this study, the thought and time you have given to consider this research invitation is appreciated.

Appendix 7: Cycle 2 Participant information sheet

UNIVERSITY *of* STIRLING

Participant Information Sheet Cycle 2   Appendix 7

<u>Title of Study</u>:

Heath visitor role improving access to health care for Syrian women and children.

As a health visitor working with Syrian refugee families (or previously having worked with these families) who have come to Scotland via the Syrian refugee resettlement programme you are invited to participate in this research.

2,000 Syrian people are settling in Scotland and it is known that these families can have health and social care needs. Women may be pregnant or need child health and development advice, or treatment for health conditions for themselves or their family. It is unclear if the Syrian women access appropriate and timely health care, and the ability to do this is important for their health and wellbeing and that of their families. There also could be cultural traditions and practices which could affect or impede their ability to engage with health services.

This study is a 3 cycle action research study, and this information sheet relates to cycle 2.

This study is being undertaken by Kate Clarke as part of a Doctorate in Nursing from the University of Stirling. Kate has a nursing and health visitor background, teaches on the health visiting programme at The University of Stirling, and is interested in how health visitors can best support families.

The aim of this study is to improve health for women and children who are settling in Scotland as part of the Syrian refugee resettlement scheme.

Cycle 1 of the study asked out about Syrian women's experience of accessing health care in Scotland; about their experience of contact with health visitors and their views about what could help them improve their access to health care. Also, to hear the best way for health professionals to respect their religious and traditional practices when providing health care.

Cycle 2, this cycle, is about finding out from health visitors their work with Syrian refugee families. This will take the form of completing a short questionnaire and a telephone interview using semi-structured questions. The time required will be 15 minutes for completing the questionnaire and 30-40 minutes for the telephone interview.

Cycle 3 will be the development of an educational intervention for health visitors.

Please read through this information sheet fully. If you have any concerns or questions, or if you would like some further information please do not hesitate to contact me (details below).

<u>Purpose of the study</u>:

To improve health through better access to health care for Syrian women and children.

<u>Do I have to participate?</u>

Taking part in this study is entirely voluntary. You will be asked to sign a consent form after you have read this information sheet and have had the opportunity to ask any questions that you might have about the study. After signing the consent form you are free to change your mind and withdraw from the study at any point without explanation. If you do this then any interview material will be removed from the study, and no further information will be collected.

<u>What will be involved in taking part?</u>

You will be sent a short questionnaire in the post for completion and invited to a one to one telephone interview with the researcher where you will be asked questions about your work with Syrian refugee families. This will last around 30 to 40 minutes. The time for the interview

will be planned with you for a time convenient for you. The interview will be audio recorded and this recording will be allocated a code which will not be attributable to you. The recording will be deleted once the information is written up. Any comments you make during the interview or statements from the questionnaire which may be used in the study will be not be attributed to you.

Are there any possible benefits from taking part?

You may benefit through discussing and contributing your own experience and by being involved in the research process, but you personally may not benefit from any developments as a result of the study. You could however help improve access to health care for Syrian refugee families, benefit trainee health visitors' and professional development for health visitor colleagues.

If I wish to take part what happens next?

You will be asked to contact a telephone number for the researcher and leave your contact details. The researcher will then contact you to arrange to talk through what will be required from you in the study and the consent process where you will have an opportunity to ask any questions. Once you are satisfied and agree to participate, a postal address to your workplace will be requested by the researcher for sending the questionnaire to. Together with the researcher you will agree a contact telephone number and time for the telephone interview to take place which will be agreed at a time convenient for you.

If there is a problem who shall I contact?

If you have questions or concerns about any part of the study, or require some more information, please don't hesitate to contact me by email: Kate Clarke k.m.clarke@stir.ac.uk or telephone 01786 466350

Alternatively you may wish to speak with my supervisor Dr Fiona Harris via fiona.harris@stir.ac.uk

However, should you wish to contact someone independent of the study, you should contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport via jayne.donaldson@stir.ac.uk.

Will my personal details be kept confidential?

Minimum personal data will be collected. All the data collected will be stored on computers securely and in accordance with the Data Protection Act (2018) and stored at the University of Stirling for a period of 10 years. The data held will be anonymous and confidential. Access to this data will only be available to myself and my supervisor.

Legal basis for processing personal data.

As part of the project, we will be recording personal data relating to you. This will be processed in accordance with the General Data Protection Regulation (GDPR). Under GDPR, the legal basis for processing your personal data will be public interest.

The research will be published in a doctoral thesis, as well as a peer reviewed journal. It may also be presented at academic or professional conferences. You will not be identifiable in any report/publication/presentation.

The University of Stirling is committed to making the outputs of research publically accessible and supports this commitment through our online open access repository STORRE. Unless publisher requirements prevent us this research will be publicly disseminated through our open access repository

Your rights.
You have the right to request to see a copy of the information we hold about you and to request corrections or deletions of the information that is no longer required.

You have the right to withdraw from this project at any time without giving reasons and without consequences to you. You also have the right to object to us processing relevant personal data however, please note that once the data are being analysed and/or results published it may not be possible to remove your data from the study.

You have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (https://ico.org.uk/concerns/).

The University's Data Protection Officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to data.protection@stir.ac.uk in the first instance.

Thank you for considering helping with this study, the thought and time you have given to consider this research invitation is appreciated.

Appendix 8: Cycle 1 Consent form

UNIVERSITY of STIRLING

CONSENT FORM   Cycle 1

Improving access to health care for Syrian women and children.

Name of Participant/Volunteer: ....

Principal Investigator (P.I.):   Kate Clarke...   ....

Please Initial Boxes

I have read the Information Sheet about above study and have had the opportunity to ask questions about it. I understand what will be involved in participating in this study.	
I agree to participate in a semi-structured interview and a discussion group.	
I understand that I can withdraw from the study without giving a reason. This will not affect my use of community groups or services. I understand taking part in the study is entirely voluntary.	
I agree to audio recording the interview or discussion group. I understand this recording will be deleted once the information has been written up. _Sample recordings and transcripts may be accessed for quality assurance._	
I understand that this study has been approved by the University of Stirling Research Ethics Committee and may be of no benefit to me personally. The Committee may wish to inspect the data collected at any time as part of its monitoring activities.	

I consent to participate in the study:

Participant Name: ....

Signature: ....   Date: ..../......./...........

Principal Investigator Name:

        ....

Signature: ....   Date: ..../......./...........

Appendix 9: Cycle 2 Consent form

UNIVERSITY *of* STIRLING

CONSENT FORM Cycle 2   Appendix 9

Health visitor role improving access to health care for Syrian women and children.

Name of Participant/Volunteer:

Principal Investigator (P.I.): Kate Clarke…………………………………………………

Please Initial Boxes

I have read the Information Sheet about above study and have had the opportunity to ask questions about it. I understand what will be involved in participating in this study.	
I agree to complete a questionnaire and participate in a one to one telephone interview	
I understand that I can withdraw from the study without giving a reason without any penalty. I understand taking part in the study is entirely voluntary.	
I agree to audio recording the interview. I understand this recording will be deleted once the information has been written up.	
I understand that this study has been approved by the University of Stirling Research Ethics Committee (NICR) and the Research and development department for your health board and may be of no benefit to me personally. The Committee may wish to inspect the data collected at any time as part of its monitoring activities.	

I consent to participate in the study:

Participant Name:

Signature:…………………………………………………………Date:………/……/…………

P.I. Name……………………………………………………………………………………..

Appendix 10: Cycle 1 Confidentiality statement for interpreter or a support person

UNIVERSITY *of* **STIRLING**

Study: Improving access to health care for Syrian women and children.

Confidentiality statement re Interpreter service

I ...NAME...attending an interview or focus group to interpret in the above study.

I agree to keep confidential *all* information I hear at the individual interview and/or focus groups I attend.

Interpreter Signature

Date

Researcher signature:

Date

Appendix 11: Cycle 1 Ethical approval

JE/JM

27 April 2018

Kathleen Clarke
Faculty of Health Sciences and Sport
University of Stirling
Stirling
FK9 4LA

UNIVERSITY *of* **STIRLING**

NHS, Invasive or Clinical Research (NICR)
Committee

Room G10
Pathfoot Building
University of Stirling
Stirling   FK9 4LA

Tel: +44 (0) 1786 467390
Email: nicr@stir.ac.uk

Dear Kathleen

Augmenting health outcomes for Syrian refugee women and children in Scotland with exploring the enhanced health visitor role as Named Person in facilitating access to health care
NICR (17/18) Paper 40

Thank you for your submission which was discussed at the Committee meeting on 24 April.

I am pleased to advise that your study has been granted approval, and wish you and your team all the best.

May I remind you of the need to inform NICR (nicr@stir.ac.uk) prior to making any amendments to this protocol, or any changes to the duration of the project and provide notification of study completion. A site file of all documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the NICR webpage at:
http://www.stir.ac.uk/research/integritygovernanceethics/researchethics/formsandguidance/

Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

NICR 17/18 – Paper No 40
Please quote this number on all correspondence

Yours sincerely

Dr Josie Evans
(Depute Chair)

c.c.   Fiona Harris (supervisor)
        Andrew Watterson (supervisor)

Appendix 12: Cycle 2 Ethical approval
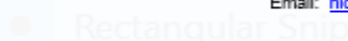
JE/MM

26 September 2018

⬤Kate Clarke

UNIVERSITY of STIRLING

NHS, Invasive or Clinical Research (NICR) Committee

Room G10
Pathfoot Building
University of Stirling
Stirling   FK9 4LA

Tel: +44 (0) 1786 467390
Email: nicr@stir.ac.uk

Dear Kate

Heath visitor role improving access to health care for Syrian women and children
NICR 17/18 – Paper No 55

Thank you for your email of 21 August 2018 which included the following attachments:

- IRAS Form
- CV Andrew Watterson
- CV Fiona Harris
- Sponsorship Letter
- Participant Information Sheets
- Indemnity Letter
- Consent Form
- Governance Framework Requirements

I am pleased to advise that Cycle 2 of your study has been granted approval, and wish you and your team all the best. This approval is conditional upon R & D approval/permission from the Health Boards in question (if required). Please send a copy of these approvals to NICR on receipt.

You might also wish to consider framing your participant information sheet as an invitation.

May I remind you of the need to inform NICR (nicr@stir.ac.uk) prior to making any amendments to this protocol or associated documentation, or any changes to the duration of the project and provide notification of study completion. A site file of all documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the NICR webpage at:
http://www.stir.ac.uk/research/integritygovernanceethics/researchethics/formsandguidance/

Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

NICR 17/18 – Paper No 55

Yours sincerely

Appendix 13: Teaching session feedback template

UNIVERSITY *of* STIRLING

Evaluation 22.5.19

Evaluation: Cultural Sensitivity in Health Visiting Practice

Can you please think back to the session on introduction week and provide feedback on the session and whether you have had the opportunity to implement any of the learning in practice or academic work.

Topic	Keep	Let go	other
1. Word meaning group exercise			
Comment:			
2. Group discussion: cultural competence			
Comment:			
3. Transcultural nursing theory			
Comment:			
4. How will you become a culturally intelligent health visitor? To take away points from activity			
Comment:			
5. 5 steps model for cultural competency			
Comment:			
6. Poll to think about your current understanding of culturally sensitive practice before and after session			
Comment:			
Please circle:			
7. I have/ have not applied this learning in practice			
Please expand:			
8. I have/have not used this knowledge in my academic work			
Please expand:			
9. Additional comments:			

Thank you! 😊

Appendix 14: Three-month evaluation report re teaching session 22.5.19

UNIVERSITY *of* STIRLING

Evaluation: Cultural Sensitivity in Health Visiting Practice

Report from think back to session on introduction week with feedback on the session and whether students have had the opportunity to implement any of the learning in practice or academic work.

Topic	Keep	Let go	other
1. Buzz words group exercise	22	1	
Comment: It made you think about the meaning you give to words. Good way to start.			
2. Group discussion: cultural competence	22		1
Comment: Allowed you to determine your own cultural competence. Would be beneficial further on in the session.			
3. Transcultural nursing theory	23		
Comment:			
4. How will you become a culturally intelligent health visitor? activity	23		
Comment: Good to work as a group to get ideas. Good to be aware of what you do not know.			
5. 5 steps model for cultural competency	23		
Comment:			
6. Poll to think about your current understanding of culturally sensitive practice	22	1	
Comment: Made you think about what you had taken from the session			

1

Please circle:			
7. I have/ have not applied this learning in practice yes x 19 no x3 blank x1			

Please expand:

Mindful of culture during visits. Diverse caseload.

Used when advising about weaning.

Helpful for understanding cultural differences when children transferring to primary school.

I have partially applied it in practice.

More culturally aware.

Used regularly.

Not only because I have not had the opportunity otherwise would have.

Not been relevant to date.

Working with families where English not first language.

8. I have/have not   used this knowledge in my academic work   yes x19   no x 2   blank x2

Please expand:

Discussed during reflective time with practice teacher.

Using critically analysis of whether studies are culturally appropriate for Scottish families.

Some of the learning content I was able to apply in my academic work.

Better understanding of different groups when they are highlighted in studies.

Used within reflective accounts.

First essay in understanding/interpreting child's world.

9. Additional comments:

Provided 'food for thought' useful session.

Session perhaps too early in the course as lots of information in first semester.

Haven't used yet but certainly more diverse cultures within our society therefore is beneficial. Unsure re timing, probably best early in programme to enable it to be included perhaps in public health essay.

Better further on in the programme, too much in week one.

Would like more time spent on the model.

I have definitely used what I have learned on this session in practice as it has made me more aware when dealing with families from other cultures.

This has brought culture to the forefront of my mind.

I think that maybe further on in the module would be useful as the first week there is a lot to take in.

A good introductory session.

Well placed.

Aspects of the session could be revisited later in the semester.

I think this is a good topic to be more aware of going into practice.

I feel its place in the course schedule was appropriate.

Increased awareness of cultural sensitivity and related to this practice.

Developed my awareness and understanding of cultural issues relating to practice.

Helped keep me aware of cultural sensitivities within practice.

Very relevant for in practice, many families on my mentors caseload from different cultures and this really brought theory and practice together. I feel this is very necessary to have in the course. Week 1 was appropriate as the information is applicable from first commencing visits with support or independently.

I have said keep it all as I can't remember these slides.

More mindful of cultural competencies maybe a bit later in Sem. 1 when we have a little more experience in practice.

I have not had the opportunity to use this to date due to my caseload. It will be helpful form the future.

If possible different religions – explain their values and principles more. For example, Muslim culture and religion recommends breastfeeding until 2 years of age. What behaviour is viewed as culturally appropriate, determining lines between for example, male dominated cultures/households and when line is crossed into domestic abuse.

3

Article for Publication

Improving health outcomes for Syrian refugee women and children: an Appreciative Inquiry study on the role of the health visitor

Author

Kathleen M. Clarke

Faculty of Health Sciences and Sport,
University of Stirling,
Stirling, FK9 4LA,
United Kingdom

Tel. no: 01786 466350
Email: k.m.clarke@stir.ac.uk
Twitter kclarke3

Abstract

Syrian families can have poor health outcomes and face challenges accessing care. Few studies have considered the health visitor role in improving the health and wellbeing of Syrian refugee women and children. The health needs of the women need to be understood within their cultural context, but these may not be familiar to health visitors.

A two-cycle research study using Appreciative Inquiry was undertaken in Scotland. Twelve Syrian women from two support groups participated in Cycle 1 interviews and in co-creating a vignette that was used in Cycle 2. Eleven health visitors from three Health Board areas contributed to Cycle 2 participating in a telephone interview.

Thematic analysis generated six themes related to the lived experience of Syrian women: 'rabbits in the headlights', 'loss of home', 'reclaiming home'; and health visiting practice: 'thrown in at the deep end', 'above and beyond', and 'you don't know what you don't know'. A range of health concerns and challenges impeded access to health care. These include: complex systems, unclear professional roles, appointment delays and transport. Despite experiences of multiple loss and social isolation, the women showed resilience although the language barrier often hampered integration.

Health visitors had not been included in pre-arrival meetings for Syrian families and usually had limited knowledge of Syrian society and culture. As well as facilitating access to health care, through 'bonds, bridges and links', health visitors potentially could promote Syrian women's 'belonging' and wellbeing. Training for health visitors should draw on an intersectionality framework in order to challenge homogenous and stereotypical notions of what it means to be a Syrian refugee woman and meet their care needs.

This research may provide a constructive route for health visitors to better contribute to improved health and wellbeing for Syrian women and children and will inform health visitor education and practice.

Keywords: Appreciative Inquiry, health visitor, health care access, cultural care, Syrian refugee, vignette.

Background/Literature review

Millions of Syrian people are dispersed throughout the world with over 3,000 now resident in Scotland. The Syrian Vulnerable Persons Resettlement Scheme (Home Office 2017) provides a safe route of entry to the UK, which in collaboration with United Nations High Commissioner for Refugees (UNHCR) (2016) grants leave to remain in the UK for 5 years.

The protracted Syrian civil war of almost ten years duration has meant for some children having been born into conflict. Families initially live in shanty towns and camps following dispersal where staying alive is the principal objective. Sanitation is poor, food is scarce, of deficient quality and disease spreads readily. Health issues are known to include infectious diseases, chronic conditions and exhaustion (Orcutt et al. 2019). Inclement weather and malnutrition impact further on their health, worsened without adequate clothing and shelter. Furthermore, mental ill health results from exposure to trauma, manifesting in post-traumatic stress disorder (PTSD) (Killian and Agathangelou 2018).

Women and children form a high percentage, 80%, of Syrian migrants (Modigell et al. (2020), with 4.6 million people being subjected to malnutrition, where 74% are children. This is severely impacting on children's growth and development, with 137,000 under-fives affected by wasting, and one in eight children having stunted growth. Additionally, one in three pregnant women are severely low in iron and other essential nutrients, which poses a serious risk to the development of a healthy foetus.

It is evident that Syrian women and children arriving in the UK may have been exposed to serious additional health and wellbeing issues. For women there are particular concerns about sexual health and cervical screening (Inhorn and Kobeissi 2006), smoking (Al-Fahoum et al. (2015), social isolation, stress and mental health; as well as some being exposed to domestic abuse (Yasmine and Moughalian 2016; Killian and Agathangelou (2018). There are concerns about children's general health and development and their immunisation status (Meiqari et al. 2018); as well as exposure to trauma where symptoms may not become evident for many years (Maršanic et al. (2017). Children's trauma may not be recognised by parents, which heightens the need for health visitors to be alert to respond appropriately. This could be significant for children's ability to recover and lead successful lives.

The health of Syrian refugees is a major public health concern (Orcutt et al. 2019). And access to appropriate and timely health care has been a major problem since leaving Syria and remained an unresolved barrier yet to overcome (Al-Fahoum et al. 2015).

Health visitors are a key profession to make early contact with families arriving in Scotland. They are registered nurses or midwives with additional public health education. They oversee child development in the early years, working closely with families in their own home, supporting their health and wellbeing. Families may depend on the health visitor identifying and understanding their health needs within their cultural context, but these may not be familiar to the health visitor.

No literature was identified specific to health visitor work with Syrian refugee families. The wider literature reports that health visitors feel underprepared for the task of providing health care to refugee families, compromising their promotion of health enhancing behaviours (Lawrence 2014). Appropriate health visitor education may be required to ensure Syrian women and children receive person-centred care compliant with their ethnicity and vulnerability. The role of the health visitor in this context had yet to be explored. The aim of the study was: *To explore the health visitor role in improving health outcomes for Syrian refugee women and children.*

Methods

A two-cycle study was undertaken following Appreciative Inquiry methods (Cooperrider and Whitney 1999). Appreciative Inquiry is not a problem and solution focused method. Rather, it recognises what is already working and builds from there. Making meaning from qualitative data progresses knowledge advancement. The model followed (Diagram 1).

Diagram 1 Appreciative Inquiry 4D model.
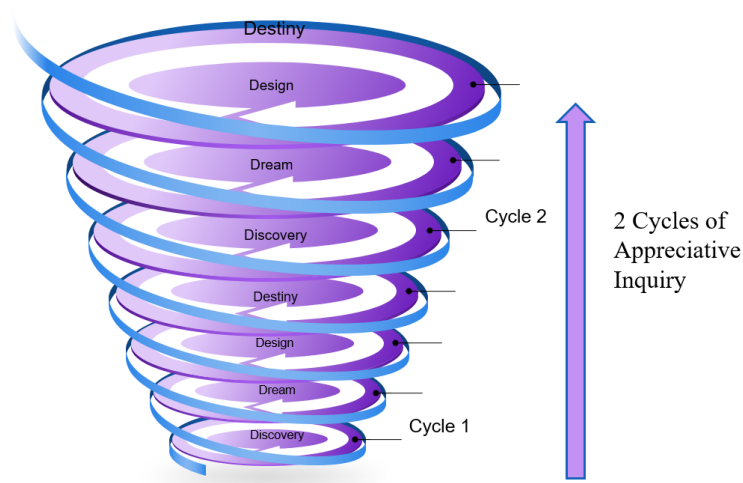
The Appreciative Inquiry model applied (Diagram 1) formed an upward spiral capturing the 4 stages followed: Discovery, Dream, Design and Destiny; which together comprise one study cycle. The starting point is at the bottom of the spiral with the study idea, leading into Discovery, Stage 1. Each stage of the upward journey has a purpose in progressing the project. When one cycle is complete it continues on into the next. It is an iterative process, so there can be some overlap between stages and cycles. The study progresses upwards through each of the four stages gathering knowledge along the way, this knowledge informs further progression. On completion of Cycle 1, Cycle 2 begins. The model (Diagram 1) shows two cycles of research. The top loop, Destiny Cycle 2, does not necessarily mean the end, the next cycle can begin. The increase in size of the loops represents growing knowledge with study progression.

Data collection

Data collection was completed between September 2018 and April 2019. Table 1 outlines the data collection process.

Table 1: Data collection within the Appreciative Inquiry (AI) model.

Cycle 1: AI stages	Data collection	Method
Discovery	Semi-structured one to one interviews	With 12 Syrian women participants. Questions framed in an appreciative inquiry style.
Dream	Petite co-creation groups	Four groups with 2-3 participants (8) achieved two outcomes: data for development of a fictional family case vignette and questions for Cycle 2.
Design	Interpretation and development for Cycle 2	Interpretation and creation of the fictional family case vignette and development of questions for Cycle 2.
Destiny	Data analysis	Immersed in the data; thematic analysis of the findings.
Cycle 2: AI stages	Data collection	Method
Discovery	Questionnaire	Completed by 11 health visitor participants.
Dream	Individual telephone interviews	Same health visitors (11), semi-structured questions in an appreciative inquiry style.
Design	Family case vignette developed from Cycle 1	Same health visitors (11) continued onto a strengths-based case vignette discussion with questions developed from Cycle 1.
Destiny	Data analysis and recommendations	Thematic analysis of all data.

Participants and context

Syrian women were the participants in Cycle 1. Their average time living in Scotland was two years three and a half months, ranging from six months to three years. The youngest was 26 years of age and the eldest, 59. The mean age was just under 34 years of age. All except one was of childbearing age, two had never had any children. Two of the women were widowed, one was single and the remaining nine were married. The women had thirty-two children in total.

Health visitors were the participants in Cycle 2. Eleven took part and ranged from having three months to 28 years' experience in practice, with a mean of 10.5 years. Five were practising in rural locations, four being the Scottish islands, two in urban areas and four with a mix of rural and urban communities.

Eight health visitors had received no relevant preparatory education, theoretical or experiential, in their training programme or as Continuing Professional Development (CPD). One had attended a conference; this was the only training any received specific to Syrian families. One had previous migrant education from a family planning course, and one had noted attending equalities training.

Ethical considerations

Ethical tensions can arise with regard to including or excluding refugees in research, particularly relating to exploitation of vulnerable groups (Leaning 2001; Hugman et al. 2011). Every endeavour was taken to maximise confidentiality and anonymity, minimal personally identifiable information was collected. All participants completed a consent form and consent was assimilated within the study as a continuous process, an important feature in Appreciative Inquiry (Reed 2007). The relationship of the participant with the researcher also poses ethical issues (Webster et al. 2014). The Appreciative Inquiry approach facilitates a more equal balance between researcher and participants through involving them in the research process. A human rights perspective was taken to support those who wished to contribute, with child care, transport, and an interpreter provided; and with respect for prayer times.

Ethical approval was sought and granted from The University of Stirling ethics committee, NICR (NHS Invasive Clinical Research) for each cycle and access permissions were

granted. All data were managed in line with European Directive General Data Protection Regulations (GDPR) 2018.

Thematic Analysis

Thematic analysis, an instrument with which to dissect and study qualitative data was conducted. Patterns and meanings were considered to make sense of the data and six themes were generated (Braun and Clarke 2013).

Quality Assurance

An interpreter and translated materials were provided, and two random digital recordings were cross-checked against the transcriptions by an Arabic speaking researcher, in Cycle 1. Tsai et al. (2018) suggest this is very important with translations and communicating between differing cultures. In Cycle 2, two pilot tests of questionnaires and interviews were undertaken.

The Findings

Codes used in data collection:

HVQ Health visitor questionnaire

HVIV Health visitor interview

SWIV Syrian woman interview

The findings are situated in the thematic framework, Diagram 2, developed from Cycle 1: 'rabbits in the headlights', 'loss of home', and 'reclaiming home', and Cycle 2: 'thrown in at the deep end', 'above and beyond' and 'you don't know what you don't know'; each with an explanatory definition.

Diagram 2: Six Themes

Cycle 1

Rabbits in the headlights

'Rabbits in the headlights' is defined as 'to be so frightened or surprised that you cannot move or think'. This expression was utilised by a health visitor to describe her experience observing Syrian families' struggles on arrival in Scotland.

The women spoke of their health needs, of difficulties obtaining care and with how their needs were not understood. Not having information about professional roles, including the health visitor, made clear at the outset was problematic. The majority of women understood the health visitor monitored children's health and development and appreciated them being available when needed. However, they understood the health visitor role for children only. The women were not aware health visitors were also available for their health needs. Transport was difficult, expensive and bus passes were distributed in some areas but not in others. However, language was expressed as the major barrier encountered:

'*A week ago, I had an appointment for an MRI scan. So, integration worker took me there, drove me there and integration worker managed everything for me and the language barrier is the biggest problem'.* (SWIV10)

The time delay waiting for appointments was a major frustration for the women, where often they needed to wait weeks to be seen. It was explained that appointments in Syria can be made and attended on the same day. Emergency care delay, particularly for children, was very worrying:

'It's very bad for my children. I need…now he's tired, I need a doctor now. This is a big problem here. In my country I go, I can go to a doctor any time. Any time I can get a doctor; not the same here. And when we go into hospital, it's two…twice I take my son. Emergency. He's very tired, but I wait in hospital three or four hours before I see a doctor. It was about five hours you need to wait before you see the doctor'. (SWIV1)

The urgency and desperation in this woman's voice is compelling. Frustration also exists when having been seen by the GP and the referral has been made to a specialist, this takes additional time. Also, it can be unclear when to expect follow-up. Moreover, there is a lack of awareness of heath choices particularly in relation to women's health. One woman explained she was waiting on surgery over six months for a prolapsed uterus which was causing

discomfort. Another woman expressed little confidence in a diagnosis for her husband. She felt the GP had made a hasty diagnosis without proper investigative tests or consideration of all the facts.

The women spoke of home remedies they used before ever going to a doctor and a range of health beliefs were expressed. For instance, the importance of the sun for health and wellbeing was emphasised. The illustrations below the sun represents home, this shows the woman missing and longing for home:

'We Syrian women, have lived and grown up in the Arab world. That means in the Middle East we had sun, we had many treatments that we don't need here. Let's say we need vitamins, we need vitamin D, we need the sun. […] The sun, all year we have the sun […] Yes, the biggest doctor is the sun'. (SWIV10)

The women may be feeling disconnected, distant from home and lost in this strange country.

Loss of home

The 'loss of home' theme emerged from an interview which took place in a Syrian woman's home. This was a very warm and welcoming home but where the loss of the Syrian home and way of life was palpable.

Research suggests growing up in a war zone and displacement could affect mental health and wellbeing. For children this could potentially manifest in disturbed sleep or behaviour. However, the women disclosed their own sleeping issues when asked about their children's needs, as this illustration shows:

*'No worries my children sleep good. **I don't sleep well** I go to GP […] I am only sleeping 3-4 hours […] I have tablets'.* (SWIV2)

One woman expressed concerns about being prescribed sleeping pills when as a lone parent she won't take them because of her childcare responsibilities. The women felt they were not listened to. No one expressed concerns about children not sleeping.

There was uncertainty for how to manage low mood, and most would not access professional help unless really concerned and would not be sure how to go about that. The words used in the next illustration are particularly moving expressions of one woman's grief:

'We cry. We cry. […] If you can cry, if you can. […] When I feel like I miss my mum, I miss my sister, my family, so I just put on a video and watch them and start to cry'. (SWIV4)

She repeats 'We cry' signifying her felt sadness without her mother and sister in particular, but she is really missing her whole family. She frequently watches them on video and looks at photographs for consolation. The women were experiencing significant losses and depression. They appeared to have difficulty articulating their feelings and were receiving little support.

Cultures and traditional practices are important for health visitors to understand, particularly as home visiting is a key function of their practice and they can support women to obtain their preferences. This illustration is where one woman explains how she felt when males attended, she being a wearer of the Hijab, when she inadvertently showed her hair and worried about what to do:

'It would be nice for the respect because I have got the Hijab; obviously, I need a female doctor and female interpreter. Just for the last, I had a problem with my hair and I wasn't lucky because the doctor and interpreter were both male and I was embarrassed to cancel it. I had to show my hair, but I wasn't very comfortable.' (SWIV3)

The Syrian women were not always sure how to make requests to meet their needs and may be fearful of asking.

In the home from where this theme developed, I was served Arabic coffee from a china tea set which had been carried from Syria, and had belonged to the woman's late father. She had carried that tea set all the way to Scotland. The Syrian people arriving here through the resettlement scheme are displaced, may be fragile and feel broken, perhaps needing care but many are also resilient, rather like china. This theme represented the fragility of the displaced Syrian people, the continuity of and preciousness of their lives.

Reclaiming home

'Reclaiming home' developed as a theme influenced by the progress I observed the women make with English language acquisition, and over time settling into their communities. I recognised the relationships they were forming; the new homes being created and the

aspirations they had for the future. This socialisation appears pivotal to their integration, their identity, sense of self and belonging, and ultimately how they reclaim home.

This next woman really warmed to Scotland and the Scottish people. She reached out to neighbours inviting them for coffee and to try her food. What is interesting is that she explains the relationship with her neighbours' makes her feel 'normal' and this is partly due to her warm and welcoming nature. 'I'm one of the citizens, like others' compounds her need to feel she belongs, and she is proactive in ensuring that she succeeds.

'And in my street, all my neighbours are friendly. I feel understand? The neighbour just made me feel normal […] yes, I'm one of the citizens, like others. […] They like my food and […] coffee or something, you know'. (SWIV7)

An illustration given is of a woman's journey and the progress she has made towards managing the health care system herself, becoming independent:

'In the beginning, Integration worker would just ask if we needed anything, you know, he was making us an appointment, but now we just go to the health care and ask for appointment.' (SWIV3)

In additon, this example provides a bold statement demonstrating a growth in confidence:

'*So, before it was council now I am in charge'.* (SWIV10)

Some women were taking driving lessons and together these indicators were signs of the women settling in their new communities.

Cycle 2

Thrown in at the deep end

The theme 'thrown in at the deep end' explains the predominant expressed views of health visitors regarding their perceived readiness for working with Syrian refugee families. It denotes anxiety from having little or no information:

'I was very unprepared for meeting the Syrian family I had been allocated. The worker involved with their care would not even disclose the names of the family members I was going to visit. I arrived at their home with no knowledge on culture, beliefs, names of the family. I had no idea what health information had been given or not given to the family. I did not know if they knew what a health visitor was'. (HVQ8)

This family had been several weeks in their new home before the health visitor heard about them. The planned communication with the resettlement officer never transpired.

Many refugees had little personal information, some arrived without any records not even a date of birth. Furthermore, there was some confusion around whose responsibility it was to complete health and medical assessments.

Communicating with Syrian families to arrange a first contact meeting was a tricky process and the initial approach was treated with trepidation by those with little experience of multicultural caseloads. The most successful way found were messages relayed via the resettlement officer. Health visitors recognised that for many of the women gaining confidence to speak English was an issue for them, not their understanding of English. Nevertheless, there can be serious implications especially when it relates to medicines:

*'I remember quite a lot of support being required sort of explaining through an interpreter obviously what the prescription was and what to actually do with the prescription. Then the whole thing about the…of course, the prescription being written in English and explaining how the medication was to be taken regardless of whether it was vitamins or whether it was antibiotics or what'. (*HVIV3)

Confidentiality was raised as a concern with interpreters. One example given was where the health visitor having established a positive relationship with one woman who confided in her, later discovered the interpreter had breached confidentiality:

'I'm here to support you as well as the children. You can speak to me about anything. You can share with me what you want. You don't have to if you don't want to share anything that's absolutely fine, but I'm here to help you cope with your new situation and she seemed to, kind of, understand that and take it on and then I get a call from my manager […] to do with the conversation I'd had with this lady in private with the interpreter. The interpreter had gone to the resettlement officer or to someone and shared something'. (HVIV4*)*

There were expressions that interpreters could be rather forward during contacts to the point of taking over and directly answering questions or anticipate a question and ask the women ahead of the health visitor request. On occasions when visits took place without interpreters and support workers satisfaction is evident. The skills of the interpreter as well as the ability of the health visitor to work with them was vital to the success of the meeting. When the interpreter was no longer needed both the families and the health visitors found these visits much more productive. In addition to oral translations, written materials needed translated and obtaining these was additional work to acquire them or have them translated.

Working with resettlement personnel was reported by the health visitors as generally positive. Awkward situations arose however when the officers attended the home visit with the health visitor and an interpreter. This made raising more sensitive conversations very difficult. The reliance of the Syrian women on the resettlement officer, however, continued on two and three years' post-arrival.

Above and beyond

The 'above and beyond' theme represents the different ways health visitors helped families and the lengths they were prepared to go to ensure they had support and access to appropriate services; especially where they wished they could be of more help but felt inadequate, and also to ensure cultural needs were addressed.

The women needed immediate advice on arrival to minimise racism in some communities. For example, the identity of Syrian women in smaller communities being recognised by their clothing can make them stand out, particularly when groups out and about are all dressed in black. Health visitors helped explain how people did not mean any harm, were curious but friendly. They were alert to community comments both positive and negative, and attempted to dispel myths.

Some health visitors accompanied families and gave lifts, helping to obtain urgent medical appointments and in this instance taking a parent to the pharmacy:

'I do remember doing a home visit and I did actually walk round with dad to the chemist because I what I was explaining to the dad was too complex because it was really about either getting a prescription from the pharmacist or asking for this particular thing. So I mean, that's the sort of thing I would never normally do with another family'. (HVIV3)

Another health visitor wrote letters to help families to take to services.

A number of entitlements are available to Syrian families but are not always clear even for the professionals, such as, paying interpreters, transport and childcare. The result is many families do not use the services which could make a positive difference to their health, being fearful of financial implications. The health visitors supported many entitlements and grant applications as well as sourced food parcels, clothing and furniture.

There was consensus by health visitors of their role explaining screening procedures for cervical smears and breast examinations and helping women to access those services. They were aware of the need for sensitivity when asking questions about personal health when a partner was present. They needed to tread carefully, to check the proper customs in order not to offend anyone. Social isolation and domestic abuse particularly concerned some of the health visitors and they would go to exceptional lengths to manage risk, sometimes being involved in covert proceedings. Raising this topic was very challenging via an interpreter. This woman shared her concerns with the health visitor:

'I tried to go when dad wasn't there and spoke to mum about it and she showed me, you know, some marks on her arm and the violence was quite physical and verbal at times' (HVIV6)

The health visitors were worried about responding appropriately to domestic abuse situations. However, they also spoke very positively of family relationships where husbands were very supportive. It appears also, with a lack confidence there is a risk some could make unfounded assumptions without adequate education:

'I tried to do a wee bit of research. I was just, kind of, thinking about women's health and women's sexual health and sexual violence and all that, kind of, stuff you know, and I tried to bring that up at one of the meetings just, you know, about it being important that we know how to support these women because you know, women can become relieving machines for men, especially in these, kind of, situations'. (HVIV4)

You don't know what you don't know

This theme developed from a statement made by two HVs on separate occasions in relation to their education. They each recognised they lacked knowledge and were ill-prepared in an

area of practice unfamiliar to them when working with Syrian refugee families They did not have the knowledge, but neither did they know till then, that their practice may be inadequate. This theme provides insight into the challenges health visitors experienced.

The health visitors spoke highly of the Syrian women's adaptability and resilience in what they were coping with, such as multiple house moves and with many professionals. However, they reported that childcare needs impede the women's ability to participate in community activities, so many were isolated. Attending groups was recognised as a major step forward where they had opportunities to tell stories and talk about their previous lives as professionals, which helped make connections.

Some health visitors struggled with how to open a conversation about mental health. Most expressed fear of repeating questions, potentially further damaging their mental health. Furthermore, concern about potential disclosures raised health visitor's anxieties about not being sufficiently educated to deal effectively with needs:

'I did feel inadequately prepared because it's not something I've dealt with in the past and I was quite hesitant about the fact that this lady might have had or this family may have had significant trauma that I wasn't aware of. There were also perhaps issues with the fact that if they did divulge information to me that I maybe wouldn't know how best to deal with it. And I guess I do feel that I am unprepared. I'm not used to dealing with people with, you know, post-traumatic stress disorder but I'm used to vulnerable children'. (HVIV7)

It was noticed that the children could be too sleepy at nursery to learn, and the problem was identified as late bedtimes. Establishing routines with reasonable bedtimes was essential for children to engage positively with learning. Health visitors took time to understand parenting styles and provided explanations and support. This was important. Another area noted of concern was disciplining children particularly as smacking appeared to be common practice:

'So, a lot of parents found that hard as well, you know, how to chastise my child, how to, you know, how do I control them? I'm not allowed to hit them'. (HVIV10)

Health visitors have a key child safeguarding role, but more often than not, when explanations of legal requirements were given helped to educate parents the parents modified their ways. Furthermore, providing a short period of additional support to families, similar to that offered to other families, could reap huge benefits.

Health visitors' experienced dilemmas with offers of tea, coffee or food, a key feature when visiting Syrian families, and had mixed views about accepting the offers. This hospitality on the surface seems a reasonable and straightforward offer to accept, but it is much more complex than it appears, with the potential for offending if refused:

I guess then I would have had maybe a conversation afterwards with the integration officer and he must have reassured me that, oh, yes, that's what you do when you go into somebody's home in a Syrian, Arabic family and it would be considered very rude not to take a drink. So in spite of the fact that it was very strong coffee or very strong black tea then I took a drink'. (HVIV3)

Health visitors were concerned about accepting offers, spending more time than with other families, and the visits becoming too social. Next, consideration of the family's customs was important to think about before a home visit, going so far as to consider what to wear:

'So, in terms of my preparation it was to think about cultural things, such as, obviously not shaking the dads hand, although I did stupidly offer my hand out and then he. And he was very polite and I can't believe I made that faux pas. […]. I mean, it never felt that he was being patriarchal, for example. So, just be mindful of cultural things, such as taking my shoes off, thinking about what I was going to be wearing that day. Obviously, I don't walk around with short skirts on'. (HVIV5)

The *'faux pas'* situation clearly embarrassed the health visitor when she attempted to shake the father's hand. Nevertheless, this health visitor considered a number of measures to honour the family's preferences. But there also is a need to identify the religion, as non-Muslim men may be fine with shaking hands. As well as challenging assumptions, it is recognised that there is a need to be open minded.

Sensitivity to Syrian family's cultural and traditional ways in their practice was perceived as being less than optimal by the health visitors themselves. The degree of felt ability depended on whether they had previous experience, or had worked abroad; but also, on their position on whether they viewed these families as needing care different to other non-English speaking families on their caseloads. For instance, those who worked with Iranian families could draw on their experience of weaning advice. However, those who had experience still expressed need for supplementary education.

In addition to receiving trauma and mental health education, the majority wished for cultural awareness raising education, to include religious beliefs and practices, family constructs and dynamics, on foods and weaning, and working with interpreters; delivered in the health visitor training programme as well as continuing professional development to keep abreast of population trends. Online resources as well as face to face sessions were desired. Cultural awareness was the top subject requested and it was suggested to have experiential practice.

Discussion

It was evident from this study there is a lack of knowledge about the benefits to Syrian women and children from support of health visitors to improve health outcomes. The women discussed a number of health concerns and barriers to care. They wished to be better informed, have quicker access to doctors, and referral appointments without delay. These delays may be different to those experienced by the general population, these delays could potentially add stress through re traumatisation (Killian and Agathangelou 2018). Furthermore, the women needed to feel listened to and have their requests heard. They were unaware the health visitor was a nurse until it was explained by the health visitor themselves. But they recognised the health visitor role for children only, so missed out on requesting support for themselves. Clarity on the health visitor role could help their own health care needs and better access to health services.

The health visitors spoke very positively about their work with the Syrian families. They felt they had formed good relationships and believed they were valued. All health visitors were aware they needed further education.

As a key professional for families, the health visitor expects to receive appropriate information and be invited to meetings for Syrian families. Accordingly, they would contribute to preparation and provide ongoing support to families. But mostly, they would be in a position to deliver the universal health visitor service to the Syrian women and children from the time of arrival, the service they deliver to every other family in Scotland. This could help reduce dependency on the resettlement officer and potentially support women earlier with their health care needs.

The health visitor relationship with clients is well understood for building trust and promoting engagement with services (Cowley et al. 2013; Pound 2013; and Malone et al. 2016). What

is not known however is, how this relationship is enacted has the potential for health visitors to contribute to Syrian women acquiring a sense of 'belonging'. Through 'bonds', 'bridges' and 'links' health visitors can help make connections between the old and the new country (Ager and Strang 2008). The health visitor relationship with the Syrian women, although a professional one, forms bonds, which may be closer and more intimate than some friendships and acquaintances, where confidential issues and health promoting conversations take place. Furthermore, health visitors promote belonging through facilitating bridges with services and links to communities, supporting integration. Allowing time for tea at the home visit, could create a space where the relationship could flourish.

The health visitors in the study each explained being offered refreshments at visits, some made time, and others found it difficult to refuse. The health visitor's better understanding what is happening when being offered tea, would, in most cases I would suggest, assist them to make these choices. Accepting the tea, forming a ritual, could help to cement the relationship (Baumeister and Leary 1995). Allowing for additional time in the early days, the health visitors could share conversations where they would get to know the women and, in turn, the women could feel valued (Drolet and Moorthi 2018). This could create a space where sensitive conversations could be raised (Al-Shdayfat and Hatamleh 2017).

Conclusions

Visiting families in their home to deliver care is where health visitors have expertise. It allows health visitors the opportunity to assess children and women in the home situation and provide support therein.

This study suggests that health visitor understanding of the needs of Syrian women and children could be improved with augmented education, where health visitors could feel more confident to identify and discuss health concerns, particularly issues arising from exposure to war, and deliver person-centred care to meet the health and cultural requirements of Syrian women and children. Cementing the relationship through taking time to share tea in the early days could be pivotal to enhancing integration and wellbeing.

It is anticipated that this study will contribute to the limited evidence base for health visitors who work with Syrian women and children, and potentially with other refugee and asylum-seeking families.

References

Ager, A. and Strang, A. (2008) Understanding Integration: A Conceptual Framework. *Journal of Refugee Studies*, 21(2), pp.166-191.

Al-Fahoum, A. S., Diomidous, M., Mechili, A., Archangelidi, O., Theodoromanolakis, P., and Mantas, J. (2015) The provision of health services in Jordan to Syrian refugees. *Health Science Journal*, 9 (2) 2.

Al-Shdayfat, N., and Hatamleh, R. (2017) Syrian Refugee Women's Reasons for Not Reporting Violence: An Exploratory Study. *International Journal of Nursing Education,* 9(4), pp. 96-100.

Braun, V. and Clarke, V. (2013) *Successful Qualitative Research.* London: Sage Publications Ltd.

Baumeister, R. and Leary, M. (1995) The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117(3), pp. 497-529.

Cooperrider, D. L. and Whitney, D. (1999) *Appreciative Inquiry*. Collaborating for Change. CA: Berrett-Koehler Communications, Inc.

Cowley, S., Whittaker, K., Grigulis, A., Malone, M., Donetto, S., Wood, H., Morrow, E. and Maben, J. (2013) Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families. *Department of Health Policy Research Programme*. London: King's College, National Nursing Research Unit. Available: http://www.kcl.ac.uk/nursing/research/nnru/publications/index.aspx [Accessed: 15 August 20].

Department of Health Policy Research Programme. London: King's College, National Nursing Research Unit. Available: http://www.kcl.ac.uk/nursing/research/nnru/publications/index.aspx [Accessed: 15 August 20].

Drolet, J. and Moorthi, G. (2018) The Settlement Experiences of Syrian Newcomers in Alberta: Social Connections and Interactions. *Canadian Ethnic Studies*, 50(2), pp.101-120.

European Directive General Data Protection Regulations (2018) (GDPR). https://ico.org.uk/about-the-ico/who-we-are/scotland-office/ [Accessed 29.2.21]

Home Office (2017) *Syrian Vulnerable Persons Resettlement Scheme (VPRS) Guidance for Local Authorities and Partners*. London: Home Office. Available: www.gov.uk/government/publications [Accessed: 30 January 2020].

Hugman, R., Bartolomei, L. and Pittaway, E. (2011) Human Agency and the Meaning of Informed Consent: Reflections on Research with Refugees. *Journal of Refugee Studies*, 24(4), pp. 655-671.

Inhorn, M., C. and Kobeissi, L. (2006) The Public Health Costs of War in Iraq: Lessons from Post-War Lebanon. *Journal of Social Affairs,* 23(90), pp.13-43.

Killian, K. D. and Agathangelou, A. M. (2018) The Wake of War: Relationships Among Gender, Trauma, Resources, and Traumatic Stress in Refugee Families. *Journal of Feminist Family Therapy*, 30(3), 129–154.

Lawrence, D. (2014) Working with refugees and asylum seekers: The role of the health visitor. *Journal of Health Visiting*, 2(2), pp. 72-78.

Leaning, J. (2001) Ethics of research in refugee populations. *The Lancet*, 357, pp.1432-1433.

Malone, M., Whittaker, K. A., Cowley, S., Ezhova, I. and Maben, J. (2016) Health visitor education for today's Britain: Messages from a narrative review of the health visitor literature. *Nurse Education Today*, 44, pp.175-186.

Maršanic, V. B., Franic, T. and Curkovic, K, D. (2017). Mental Health Issues of refugee children: lessons from Croatia. *European Child & Adolescent Psychiatry*, 26, pp. 377–381

Meiqari, L., Hoetjes, M., Baxter, L. and Lenglet, A. (2018) Impact of war on child health in northern Syria: the experience of Médecins Sans Frontières. *European Journal of Pediatrics*, 177(3), pp. 371-380.

Modigell, I., Fernandes, C., Al Samman, S. and Yamin, A. (2020) Hidden Hunger in Syria. Save the Children. Available: file:///H:/Clin%20Doc/hidden_hunger_in_syria-cc-2020.pdf [Accessed: 13 November 2020].

Orcutt, M., Rayes, D., Tarakji, A., Katoub, M., Speigel, P., Rubenstein, L., Jabbour, S., Alkhalil, M., Alabbas, M. and Abbara, A. (2019) International failure in northwest Syria: humanitarian health catastrophe demands action. *The Lancet*, 394(10193), pp.100-103. Available: http://dx.doi.org/10.1016/ S0140-6736(19)31564-8 [Accessed: 6 September 2020].

Pound, R. (2013) Influences on relationship-based health visiting, part 2: Discovering the need for balance through a new epistemology. *Journal of Health Visiting*, 1(9), pp. 522-528.

Reed, J (2007) *Appreciative Inquiry*: Research for Change. London: Sage Publications. Inc.

Tsai, T-I. Luck, L. Jeffries, D. et al. (2018) Challenges in adapting a survey: ensuring cross-cultural equivalence. *Nurse Researcher*. Available: doi: 10.7748/nr.2018.e1581 [Accessed: 2 February 2021].

Webster, S., Lewis, J., Brown, A. (2014) Ethical Considerations in Qualitative Research. In: J. Richie, J. Lewis, C. McNaughton Nicholls and R. Ormston. eds. *Qualitative Research Practice*. 2nd ed. London: Sage Publications, pp. 77-107

Yasmine, R. and Moughalian, C. (2016) Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. *Reproductive Health Matters*, 24(47), 27-35.