

Health Needs Assessment:

The health needs of asylum seekers
living in communal accommodation
in NHS Grampian.

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Executive Summary

This health needs assessment sought to establish:

- A mechanisms for understanding and disseminating information relating to the composition of the population of asylum seekers living in communal accommodation in NHS Grampian.
- The needs of the population of asylum seekers living in communal accommodation in NHS Grampian.

The assessment has reached its conclusions through the evaluation of published data about the health needs of asylum seekers and migrant populations in the UK and other high income countries, examining other primary and grey literature, reviewing the findings of local qualitative research, and cross-referencing data from health care records in NHS Grampian to establish patterns of service use.

The assessment makes recommendations based upon data sharing and health care needs. These include:

- The need to establish data sharing mechanisms between Mears Group, local authorities, health and social care partnerships, and health intelligence.
- The assistance asylum seekers need to navigate health care systems and understand health care information.
- The provision of preventative and long-term health care interventions.
- The need for health protection interventions that improve the health of individual asylum seekers whilst also protecting the entire NHS Grampian population.
- The necessity to learn lessons about asylum seekers and apply them to other vulnerable or marginalised groups with complex health care needs.

The assessment highlights the gaps in current service provision compared with the needs of the population, and points to risks (to individuals, to the NHS Grampian population, and to the health board) should mitigating actions not be taken.

Introduction

Background

This health needs assessment was undertaken on behalf of NHS Grampian's Directorate of Public Health to examine the evidence regarding the health of the asylum seeker population living in the Grampian region, and inform decision-making regarding service provision to meet the needs of this population.

For the purpose of this health needs assessment, the term 'asylum seeker' refers only to those people who:

- Have claimed asylum in the UK;
- Are waiting for a decision on their asylum claim to be made by the UK Home Office;
- Are living in communal accommodation (e.g. houses in multiple occupancy or hotels) provided to them by the UK Home Office via its private contractors (Mears Group in Scotland) whilst this process is being undertaken.

Not included in this definition are people who are waiting for their asylum claims to be processed whilst being housed in other types of accommodation (families in single family homes), or people with other legal status (e.g. people with refugee status, people arriving in the UK under the Ukrainian Family or Ukrainian Sponsorship Schemes, people arriving in the UK under the Syrian Vulnerable Person Resettlement Programme).

In the year ending June 2024, 75,658 asylum applications were made in the UK [1]. The UK Home Office operates a policy of dispersal for asylum seekers, which incentivises accommodation providers to house asylum seekers in parts of the UK with lower costs of living [2]. Therefore, owing its relatively low cost of living [3], Aberdeen and the surrounding areas are attractive areas for Mears Group to accommodate asylum seekers, and an assumption is made that the number of asylum seekers housed in the Grampian region is likely to increase. In Scotland, UK Home Office accommodation for asylum seekers is provided by Mears Group [4].

Determining the size of the asylum seeker population in the NHS Grampian area is complicated. At the start of this assessment process, local authorities, health and social care partnerships, and the

territorial health board did not maintain a uniform method of collecting and sharing data about the asylum seeker population in Grampian. There was no mechanism for health and social care services to access data about the population, to allow for planning of health care delivery.

This report focuses on the needs of the asylum seeker population. However, aspects of the needs of this population are likely to have similarities to that of other groups. These groups might include other newly arrived people (regardless of visa scheme or status on arrival) or other vulnerable groups that have complex needs. The lessons learned through assessment may also be applicable to these other groups.

Aims and objectives

The aim of this assessment was to understand the health needs of the asylum seeker population in Grampian. This will support a whole system response to improving health, reducing inequalities and delivering sustainable health and care.

The objectives were to:

- Describe the composition of the asylum seeking population in Grampian.
- Synthesise the evidence base about the health needs of the asylum seeking population.
- Identify how local service provision aligns with published evidence on needs.
- Identify where local service provision is not aligned with published evidence on needs.
- Highlight risks from gaps in local service provision that is not aligned with evidence.
- Make recommendations regarding any unmet need.

Methods

Governance

Guidance and oversight of this health needs assessment was the responsibility of the NHS Grampian Public Health Asylum Seeker Short Life Working Group. This group has:

- Assisted with defining the scope of the assessment.

- Heard summaries of some of the quoted evidence, and had opportunities to ask questions of the research.
- Participated (alongside other stakeholders) in a workshop to discuss evidence, service provision, gaps in service provision, and potential risks.
- Reviewed the recommendations made in this assessment.

Population composition

A system to collate and present data describing the composition of the asylum seeking population in Grampian was designed by a Data Flow Short Life Working Group. This comprised:

- A representative from the health care navigator teams in Aberdeen City, Aberdeenshire and Moray;
- A consultant in public health;
- A registrar in public health;
- Analysts from the NHS Grampian health intelligence team;
- A representative of the information governance team.

The working group met regularly to establish a uniform data collection process, a process for collation of this data by the health intelligence team, and its presentation in the form of a dashboard.

Prior to the establishment of a dashboard, the size of the asylum seeker population was estimated using two methods:

- Method 1 (HCN Data): Using lists of asylum seekers held by the health care navigator teams in each of the three health and social care partnership areas.
- Method 2 (Trak Data): Colleagues from the NHS Grampian health intelligence created a list of CHI numbers for asylum seekers. This list was created by cross-referencing postcode data for hotels accommodating asylum seekers, date ranges for periods when these hotels accommodated asylum seekers, and identifying people who were registered with GP at these addresses during these periods.

A third method, extracting asylum seeker read codes from GP registration data, was explored but deemed to be unworkable.

Published evidence

A systematic review aimed to provide a comprehensive and up-to-date summary of current evidence related to the needs and experiences of asylum seekers accessing care services in high-income countries. Conference abstracts, case studies, grey literature, and research protocols were excluded [5]. A detailed search strategy is included in Appendix 1.

A rapid evidence review was undertaken to summarise evidence from scientific studies and grey literature not included in the systematic review, assessing health needs and barriers to healthcare provision to adult asylum seekers [6]. A detailed search strategy is included in the full report, which is available in Appendix 3.

Local evidence

Qualitative research was undertaken to better understand the health and care needs of asylum seekers living in hotels in Grampian [7]. Semi-structured interviews were conducted in January-February 2024 with staff who worked with asylum seekers. Information was gathered on:

- The health-related needs of current asylum seeker population.
- The experience of asylum seekers and staff navigating the health care system.
- The barriers/facilitators to addressing needs.

Transcripts were analysed for emerging themes. The full report is available in Appendix 4.

To determine how asylum seekers were utilising services across NHS Grampian, three processes were used:

- Meetings were held with stakeholders from a variety of services across the health care system, with representatives from health care navigator teams, public health teams, and teams responsible for service delivery.
- The list of asylum seekers established using method 2 (detailed earlier) was cross referenced to emergency department attendances at both the Aberdeen Royal Infirmary and Dr Gray's

Hospital, to examine how asylum seekers were using emergency departments. The resulting list of emergency department attendances was interrogated by a public health registrar and attendances categorised.

- Health care navigator data on referrals to services (e.g. dentistry, sexual health, vaccination) were examined to demonstrate numbers of asylum seekers using services across Grampian.

Population composition

The asylum seeker population is dynamic. Asylum seekers are accommodated by the UK Home Office and moved between regions and accommodation providers at UK Home Office discretion. This results in a population that changes frequently, with arrivals from UK Home Office reception centres, and asylum seekers moved to other accommodation (either within Grampian, to other locations in Scotland, or to other locations in the UK). These arrivals and departures to Grampian hotel accommodation are often at short notice. These movements, combined with a number of asylum seekers absconding from hotel accommodation, result in a population whose size and composition changes frequently.

Estimates of population size

At the end of June 2024, the size of the asylum seeker population (total since first arrivals in November 2021) in Grampian was estimated by method 1 and 2 (detailed earlier). These estimates are shown in Table 1.

Table 1: Estimates cumulative total asylum seekers

HSCP	Method 1	Method 2
Aberdeen City	752	495
Aberdeenshire	412	351
Moray	64	38
Total	1,228	884

Table 1 demonstrates that, in each health and social care partnership, there is a discrepancy between the number of asylum seekers who are known to health care navigators (method 1) and those who

have a CHI number and are therefore registered with a GP (method 2). There are multiple potential reasons for this:

- A lack of clarity in whose responsibility it is (health care navigators or staff from Mears Group) to register asylum seekers with GPs. This lack of clarity could be based in relationships between the parties, or be a lack of clarity in Mears Group's contractual obligations.
- A delay in registrations related to large numbers of arrivals and a lack of processing capacity; some asylum seekers may have left Grampian before registration was complete.
- Asylum seekers not engaging with health care navigator staff.
- Asylum seekers absconding before being registered with a GP.
- A lack of capacity at GP practices local to asylum seeker accommodation.

Data sharing and dashboard generation

A Data Flow Short Life Working Group brought together available population data from each health and social care partnership and produced a dashboard. This dashboard (as shown in Figure 1) allows users to access data regarding the number of asylum seekers present in Grampian, numbers in each age group, sex breakdown, and numbers of speakers of each language. This data is available for those asylum seekers currently resident in Grampian as well as cumulative totals since hotels began accommodating asylum seekers in November 2021. This dashboard is updated fortnightly based on information provided by the health care navigator teams in each of the health and social care partnerships.

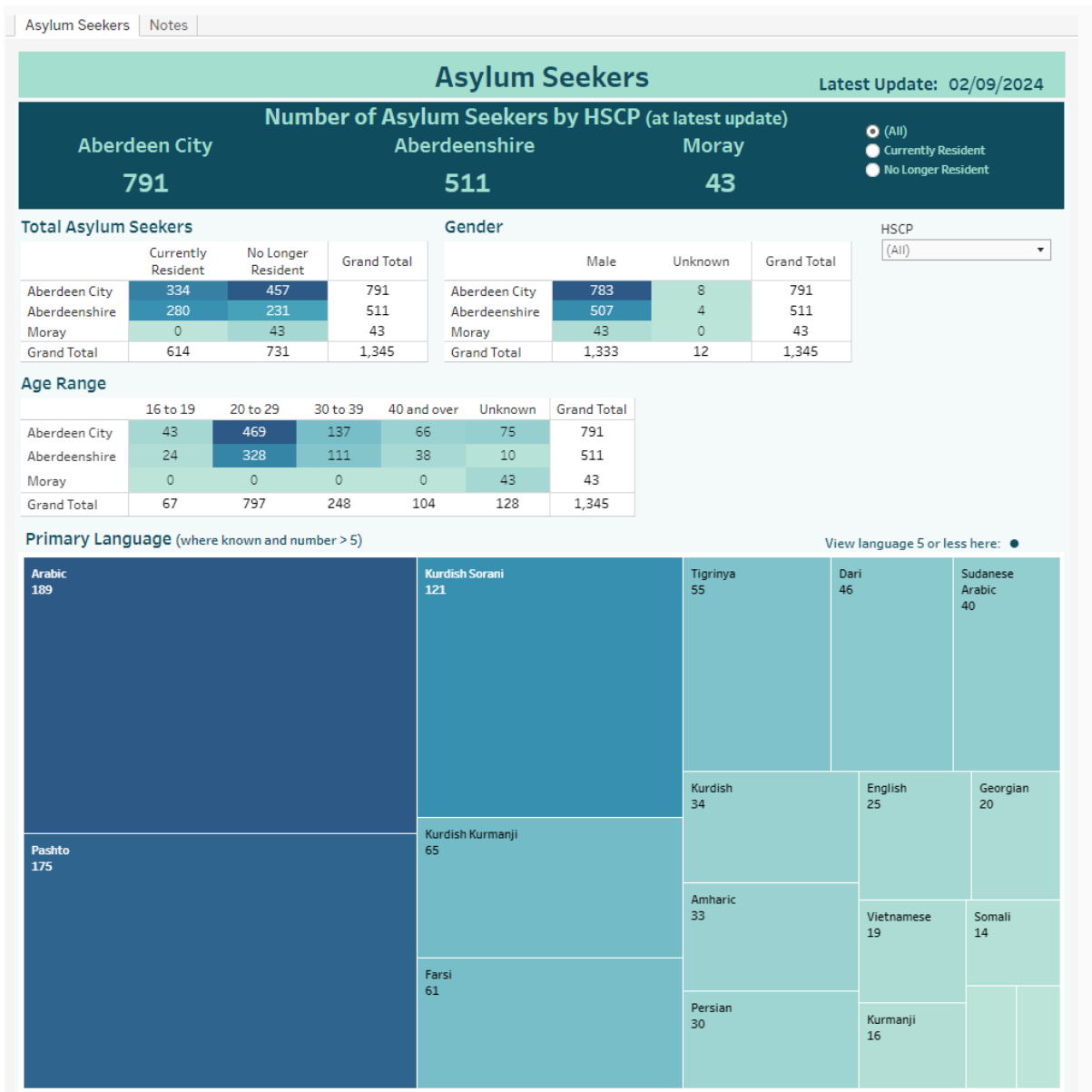


Figure 1: Dashboard showing asylum seeker population composition

Published evidence

Care needs of asylum seekers: A summary of current evidence from systematic reviews

This overview of systematic reviews was completed by the NIHR funded Health Determinants Research Collaboration Aberdeen and provides a comprehensive summary of the healthcare needs and experiences of asylum seekers in high-income countries. The full review has been submitted for publication. Details of the search strategy and a presentation delivered to NHS Grampian’s Public

Health Asylum Seekers Working Group on 2nd July 2024 are reported for completeness in Appendices 1 and 2 respectively.

Communication Challenges

Language barriers emerged as a key issue across all studies, significantly affecting informed consent. The shortage of professionally trained interpreters, especially those with culturally appropriate training, forced many asylum seekers to rely on non-verbal cues or untrained interpreters such as friends and family members. This led to misunderstandings and limited access to adequate care.

Healthcare Workers as State Actors

Asylum seekers often described healthcare workers as hostile, dismissive, and unsupportive. Fear of deportation or detention made asylum seekers hesitant to disclose personal information, as they lacked trust in the healthcare system. Even medical interpreters were not fully trusted due to concerns about their commitment to confidentiality.

Isolation and Mental Health Issues

Many asylum seekers reported severe mental health issues, worsened by traumatic experiences such as domestic violence, rape, torture, human trafficking, and war. Conditions like depression, anxiety, and post-traumatic stress disorder were common. Some asylum seekers reported that their mental health problems were significantly worsened by being processed through reception centres or held in detention camps.

Barriers to Healthcare Access

Asylum seekers faced numerous obstacles in accessing healthcare, including a poor understanding of how the health system worked and of the role of healthcare professionals. Many reported a lack of information on which services were available, while the cost of transportation to medical appointments was perceived to pose additional challenges. However, social workers and support groups were viewed as helpful in navigating the healthcare system and accessing care.

Housing and Relocation Challenges

In the UK, the policy of mandatory dispersal disrupted ongoing healthcare, negatively affecting asylum seekers' mental health. Relocation of asylum seekers to areas outside major cities, where services tailored to immigrant populations were scarce, further complicated their access to necessary care.

Synthesis of primary and grey literature

A rapid evidence review asked the questions:

- What are the health needs of asylum seekers?
- What are the barriers to asylum seekers' accessing health care and the provision of effective health services?

This review sought to examine literature that had not been captured by the systematic review. A full version of this rapid evidence review is included in Appendix 3.

Mental health

Mental health problems in the asylum seeker population are exacerbated by difficulty navigating a bureaucratic health care system. Rates of post-traumatic stress disorder and associated complex post-traumatic stress disorder are higher in asylum seekers than host populations. The stressors associated with these disorders include war, exploitation, torture, violence, and sexual violence. Stressors in the host country increase asylum seekers' susceptibility to suicidal ideation; the asylum seeker population has higher rates of suicide than the host population.

Maternity care and women's health

Care provision for female asylum seekers who have suffered female genital mutilation/cutting is inadequate. Pregnant asylum seekers in London had fewer antenatal appointments and ultrasound examinations compared with age and ethnicity matched controls; their neonates stayed in hospital longer than controls. Pregnant asylum seekers have more risk factors for developing perinatal depression.

Communicable disease

Communicable disease needs can be categorised as:

- The need to be screened and treated for communicable disease; and
- The need to establish vaccination history.

Asylum seekers may not engage with screening for (for example) blood borne viruses, owing to stigma. Asylum seekers are more likely to be infected with tuberculosis than the host population, and many are suffering from parasitic infections. Asylum seekers have been identified as being under-immunised and therefore at risk of vaccine-preventable disease.

Chronic conditions

Owing to long periods without access to regular health care, asylum seekers may have untreated chronic conditions such as diabetes or hypertension. The migratory journey has been identified as an independent risk factor for the development of cardiovascular disease.

Barriers to access

Barriers to accessing health care have been identified in multiple areas:

- Language: poor language skills, issues relating to interpreters (lack of funding, cultural competence).
- Hostile political and asylum environment: discrimination, fear of health care access influencing legal status, poor housing provision, little financial assistance.
- Health care professionals' cultural competence: lack of understanding of asylum seekers' rights, inexperience in dealing with relevant issues (e.g. female genital mutilation, complex post-traumatic stress disorder).
- Personal factors relating to asylum seekers: poor health literacy, vaccine hesitancy, fear of health care, lack of trust in host country institutions.
- Inadequate health care provision: lack of initial vaccination assessment and relevant screening.

Key literature from broader immigrant population

A systematic review has demonstrated that in Europe, migrant populations are more likely to utilise emergency department services, out of regular hours, for low acuity problems [8]. The review did not directly correlate this finding to asylum seeker population. The King's Fund estimates costs of care per episode to be:

- £56 for an average 10-minute face to face consultant with a GP.
- £91 for attendance at an urgent care centre, with the lowest level of investigation and treatment.
- Between £137 and £445 for attendance at a major emergency department with more complex investigation and treatment [9].

Therefore, inappropriate use of the emergency department is likely to an unnecessary cost to the health care system.

A review of studies examining the role of community navigators found that where immigrant (but not specifically asylum seeker) communities were able to utilise the services of a navigator to help them access health care, there was a significant improvement in health outcomes [10].

An analysis of European tuberculosis (TB) screening programmes suggests that the migratory journey may be a more significant risk factor for TB than TB prevalence in a person's country of origin [11].

A study regarding the epidemiology and management of hepatitis C infections in immigrant populations recommends that "Healthcare Authorities should support dedicated screening programs for immigrants" with respect to viral hepatitis [12]. Though this study does not explicitly reference asylum seekers, it does reference a German study, which found 32% of all new hepatitis B virus infections were amongst asylum seeker populations [13].

Local evidence

Qualitative analysis of health and wellbeing needs

Qualitative research undertaken by public health in NHS Grampian used semi-structured interviews to better understand the health and care needs of asylum seekers living in hotels. A full version of this research report is included in Appendix 4.

Health and wellbeing needs

The mental health needs of the asylum seeker population relate to their living circumstances and their feelings of isolation (linked to difficulties with transport from their accommodation to other places). There was a sense that there was nothing for them in the locations they were accommodated. The transience of their time in the Grampian area (owing to the UK asylum process) was also a contributing factor to mental health needs.

Mental health support was found from a variety of sources:

- A mental health practitioner who supported asylum seekers in Aberdeen City.
- A pilot mental health and wellbeing improvement service in Aberdeenshire.
- Local mental health and well-being practitioners working with asylum seekers in Moray.
- General practitioners
- The Royal Cornhill Hospital (though there were problems with waiting lists/delays and asylum status).
- Signposting asylum seekers to activities or other support.

The need for dental care was met by emergency dental appointments, arranged with support from the DIAL service.

Challenges to accessing support

Asylum seekers experienced a variety of challenges in accessing health care. There were issues of language, including the complexity of the language used, and both awareness of and practicalities

in using the language line service. There was some difficulty in registering with GP services; this included finding practices with capacity to take asylum seekers, inaccuracies in registration, and assumptions about asylum seeker entitlement. Asylum seekers had difficulties understanding the health care system, including waiting times for care, not attending appointments, and using services that were inappropriate for their needs. The transience of the population was at times a factor in asylum seekers have difficulty accessing health care.

Enablers to accessing support

There were factors that served as enablers to care. In particular, the health care navigator team enabled care by undertaking health assessments, making referrals to appropriate care, offering direct support which enables access to services (such as accompanying asylum seekers to appointments), co-ordinating transport help such as bus passes, and advocating on behalf of the asylum seeker population.

The Role of the Navigator Teams

Each of the three health and social care partnerships in the Grampian area host to a team of health care navigator staff, who work with asylum seekers, refugees, and other new arrivals in to Scotland.

On arrival, health care navigators undertake a health needs assessment for each asylum seeker. This process seeks to identify symptoms of communicable disease, opportunities for health promotion and improvement, and refer onwards to appropriate services. It is understood that there is no contractual requirement for Mears Group to conduct such a health needs assessment, only to assist in registering asylum seekers with a local GP. Health care navigators in Aberdeen City report that they have had difficulty identifying GP practices at which to register asylum seekers.

The team of health care navigators who support asylum seekers and refugees in Aberdeen City was disbanded in September 2024. This poses both short and long term risks.

The health care navigator team had a good working relationship with a number of GP practices and attempted to ensure all asylum seekers in Aberdeen City are registered prior to being disbanded. The disbanding of the team and shifting of this responsibility back to Mears Group staff will result in

this working relationship being lost. As there is no requirement for Mears Group to conduct health assessments, there is potential that asylum seekers with symptoms of communicable disease (TB, for example, for which the migratory journey is a risk factor) will be registered with GPs but not assessed, identified, and referred to treatment. This poses risks to the asylum seeker themselves, the people they share their accommodation with, the staff working in their accommodation, and the population of Aberdeen City at large.

Having established a working relationship with the asylum seeker population, the health care navigators are able to signpost to appropriate health care services. This includes referring for dental care, signposting for treatment via the Pharmacy First scheme, and providing asylum seekers with information about services such as sexual health. Without the health care navigator team in place, there is potential for asylum seekers to seek health care at GPs (should they be registered) and the emergency department more frequently.

The Data Flow Short Life Working Group have harmonised the data that is collected by health care navigator teams in the three Grampian health and social care partnerships, with a view to using data about resident asylum seekers to better understand their needs and provide them with health care services appropriate to these needs. Currently Mears Group provide the health care navigator team with a list of asylum seekers and the hotels in which they are accommodated. The health care navigator teams build on this dataset during the health needs assessment, identifying chronic health conditions, languages spoken, country of birth, and other relevant information. This information, when attempts to harmonise its collection and undertake analysis are complete, will enable public health to identify previously undiscovered health needs which will benefit the asylum seeker and (for example, in the case of vaccination) health to protect the population of Aberdeen City at large.

Local services

Local services are attempting to meet the needs of the asylum seeker population. An exploration of how services are operating to meet these needs has taken the forms of stakeholder discussions and analysis of service use. A summary of findings from stakeholder discussions is included in Table 2.

Table 2: Stakeholder discussions Provision of care by local services

Service	Stakeholder	Evidence
Sexual Health	Health care navigators	Health care navigator teams are responding to queries about sexual health services, and signposting asylum seekers appropriately.
	GUM consultant	Sexual health services are seeing asylum seekers present to their services.
	Public health practitioner	Some asylum seekers will have a history of risk factors that make them eligible for hepatitis B vaccination. How are these asylum seekers being identified and are they being offered vaccination? There is some anecdotal experience that asylum seekers are in need of contraception (especially condoms), suggesting that there are sexually active people within the population.
Vaccination	Health care navigators	Widespread refusal amongst the asylum seeker population to receive vaccination, with many citing a fear of needles as their reason for not wishing to be referred.
	Lead nurse for immunisation	Asylum seekers who have been vaccinated are likely to have been referred to the service by services other than the health care navigator team (likely GP, or secondary care).
	Clinical lead nurse for vaccination	SOP for referral of asylum seekers states that appointments will be sent to health care navigator team, who will inform asylum seeker.
Dentistry	Public health service manager	Liaised with health care navigator teams to ensure timely awareness of arrival of asylum seekers into Grampian and thus allow planning of resources; preferentially allocated afternoon appointments to ensure asylum seekers had time to plan transport and arrive at appointments.
Mental health	Health care navigators	Navigators referred to mental health and wellbeing service which offered 6 x1 hour sessions with a mental health support worker. This service has now stopped receiving referrals.
Health Protection	Health protection nurse specialist	Frequent contact from health care navigator team for advice about managing outbreaks of scabies in asylum seeker hotels.
	TB nurse specialist	When an asylum seeker is diagnosed with active TB, opportunistic screening of contacts is undertaken.

The list of asylum seekers established using method 2 (detailed earlier) was cross-referenced to emergency department attendances, to show how asylum seekers are using the emergency department. The resulting list of emergency department attendances was interrogated by a public health registrar and attendances categorised. Assessment of emergency department attendances across Grampian by asylum seekers as of 24 June 2024 showed 105 attendances. Reasons for attendance are shown in Table 3.

Table 3: Number of emergency department presentations by presenting complaint

Presenting Complaint	Number of attendances
Abdominal pain	16
Assault	<5
Chest pain	18
Dental problem	<5
Infection	5
Injury (non-assault)	24
Mental health and/or deliberate self-harm	14
Other medical problem	23

As of the end of June 2024, data from health care navigator teams in each health and social care partnership demonstrated which services asylum seekers were accessing or being referred to (with the support of the health care navigator teams). This data is shown in Table 4.

Table 4: Local services used by asylum seekers

Service	Aberdeen City (n=752)	Aberdeenshire (n=412)	Moray (n=64)
Seen by GP	No data available	No data available	32
999 or ED attendance	<5	11	8
Admitted to hospital	No data available	No data available	5
Pharmacy First	135	157	19
Dentistry	195	77	23
Smoking cessation	<5	30	9
Sexual health	<5	<5	No data available
TB screening	205		
Vaccination*	0 / 30	0 / 39	17 / 16
*First figure from health care navigator records, second figure from vaccination team records.			

Priorities for care

Table 5 shows a summary of themes from both published and local evidence, indicating priorities for care of asylum seekers.

Table 5: Summary of needs from published and local evidence

Mental health	Health protection	Chronic and other conditions	Communication challenges	System navigation
PTSD	TB	Diabetes	Interpreter availability	GP registration
Deliberate self-harm	Blood borne viruses	Hypertension	Longer appointments	Emergency department use
Suicidality	Routine vaccination	Smoking cessation	Assumptions of literacy	Health care staff attitudes
Depression	Parasitic infection	Sexual health	Culturally appropriate	Health care navigator teams
Anxiety	HBV vaccination	Dermatology	Access to mobile phones	Transport: costs, logistics

Alignment of needs and current service provision

The evidenced health care needs of asylum seekers is consistent, whether those health care needs are assessed locally (using qualitative methods or by interrogating health care records), nationally (by examining UK-based published evidence), or internationally (through systematic review of published evidence in high-income countries).

The evidence that emerges through these different methods can be broadly categorised as:

- Enabling access
- Preventative health care and long-term conditions
- Care for communicable and vaccine-preventable diseases

In Scotland, asylum seekers are entitled to health care provided by the NHS [14] [15]. Services offered to asylum seekers should not be limited or restricted on the basis of their asylum seeker

status, and if asylum seekers require support to access health care this should be provided (as it would for people with permanent residence in Scotland who require, for example, translation services).

The evidenced needs of asylum seekers represent the minimum level of service that should be provided to asylum seekers.

Enabling access

Asylum seekers in Aberdeen City face barriers to accessing services, in particular general practice services. At the end of June 2024, 29.92% of asylum seekers who had been resident in Aberdeen City had not been registered with a GP (figures provided by Aberdeen City health care navigator team). This could be due to:

- A lack of clarity in the contractual obligation of Mears Group regarding responsibility for registering asylum seekers with local GPs.
- A lack of capacity in local GP practices to take on large numbers of new patients.
- A lack of understanding of entitlement to care [16].

This inequitable access may impact patient outcomes and experiences [17].

Asylum seekers may not be proficient in the reading, writing, speaking and understanding spoken English. There is a need to ascertain what languages asylum seekers are proficient in, and ensure that this is recorded appropriately so that all health care services can access this information.

Owing to the need to use interpretation services, appointments in health care for asylum seekers may need to be longer than standard appointments.

Migrant populations, and other groups with no recourse to public funds, may default to using the emergency department [15] for low acuity problems, especially out of hours. Locally, there are some instances in the list of asylum seeker emergency department attendances that result in redirection due to inappropriate attendance, but there is insufficient data to determine an exact number of attendances where the use of other services would have been more appropriate. There is a need to provide asylum seekers with information about NHS services so that they may attend appropriate services to receive the correct care.

Assistance in navigating the health care system is evidenced to improve health outcomes for migrant populations. Therefore, there is a need to provide asylum seekers with support to navigate health care systems.

Health care services are sometimes not located conveniently for asylum seekers to access. There is a need to ensure that asylum seekers are supported to attend health care services when required, and this may extend to ensuring that they are provided with appropriate assistance (both logistical and financial) to attend health care.

Preventative health and long-term conditions

Not only will the migratory journey have interrupted care for long-term conditions, but the journey is itself evidenced to be a risk factor for cardiovascular disease. There is therefore a need to ensure that asylum seekers have the opportunity to discuss their past medical history and need for any regular prescriptions. Particular reference must be paid to the assessment of cardiovascular risk factors in the asylum seeker population.

There is local evidence to suggest that the asylum seeker population in the NHS Grampian area are sexually active, and therefore there is a need to ensure that they can access sexual health services if they need to.

The mental health needs of asylum seekers resident in hotels in the NHS Grampian area are likely to be aligned with the needs of asylum seeker populations in other high income countries. The variety of evidence sources available indicate that these needs are:

- Assessment, diagnosis and treatment of (sometimes complex) post-traumatic stress disorder.
- Assessment, diagnosis and treatment of depression.
- Assessment, diagnosis and treatment of anxiety.
- Assessment and treatment of the causes of deliberate self-harm.
- Assessment and treatment of the causes of suicidality.

Communicable and vaccine preventable disease

The migratory journey undertaken by asylum seekers may be an independent risk factor for the development of tuberculosis, and many asylum seekers come from countries where prevalence of tuberculosis is higher than in Scotland. There is therefore a need to ensure asylum seekers are screened for latent tuberculosis. As of the end of June 2024, 16.69% of asylum seekers in Grampian had been screening for latent or active TB.

Asylum seekers' vaccination history may not constitute being 'fully vaccinated' according to the UK vaccination schedule. This may be because asylum seekers'

- Country of origin may have vaccination programmes that are inconsistent with the UK vaccination regime.
- Country of origin has a vaccination regime that is broken down due to a collapse in national infrastructure.
- Are from societies where there may be scepticism about the vaccination process.
- Do not have documented evidence of their vaccination status.

There is therefore a need to ensure all asylum seekers are referred for assessment of vaccination status and subsequent vaccination if necessary. Using best available data, at the end of June 2024 the percentage of asylum seekers who have attended for at least one vaccination appointment was:

- Aberdeen City: 3.99%
- Aberdeenshire: 9.47%
- Moray: 26.56%

There is evidence that rates of new hepatitis B infection are higher in asylum seekers than the population as a whole in high-income countries. There is a need to ensure that asylum seekers are screened for blood borne viruses.

Members of the asylum seeker population may be eligible for vaccinations in addition to the vaccination schedule for individuals with uncertain or incomplete immunisation status [18], such as hepatitis B vaccination. Assessment of vaccination status should extend to vaccines which can be provided to specific groups within the asylum seeker population.

Changes to local practice

During the time taken to perform this assessment, there have been changes to practices in the partnership areas, which could serve as a basis for how care might be delivered across Grampian.

In Aberdeen City specific asylum seekers living in hotels have been identified by health care navigators as leaders within their communities. These asylum seekers have been offered vaccination and appointments set up. It is hoped that they will be able to spread the word amongst their communities within the hotels and increase the number of asylum seekers wanting to be vaccinated. The challenge is how to continue to facilitate this process without health care navigators in place.

Also in Aberdeen City screening for TB and blood born viruses has been undertaken. Printed materials have been provided in specific languages, and any asylum seekers literate in those languages have been offered TB screening. At the point at which Mantoux tests are read, all asylum seekers with a positive test have a blood borne virus screen. Those asylum seekers with a negative Mantoux are offered optional blood borne virus screening, with a high degree of uptake. The challenge is how to maintain this system without health care navigators providing input on the changing composition of the asylum seeker population in Aberdeen City.

In Aberdeenshire a clinical room has been set up at the hotel accommodating asylum seekers. There is a plan for the local medical practice to provide one half-day GP session and one half-day advanced nurse practitioner session per week to see asylum seekers for non-urgent primary care issues. Furthermore, the vaccination team in Aberdeenshire will use this facility to run vaccination clinics from the hotel, with a number of asylum seekers receiving their first dose of relevant vaccines at the first clinic session.

Across Grampian, the public health dental service have worked with the health care navigator teams to develop a triage document for navigators to use when asylum seekers report dental problems. This allows navigators to identify urgent problems and refer to emergency dentistry, whilst arranging non-urgent appointment for other problems. How this system can be maintained with health care navigators in some areas remains to be seen.

Risks of unmet need

Given the evidence of local service utilisation in NHS Grampian, there is a gap in the services being provided and the evidenced needs of the asylum seeking population. Without a change in working practices to meet the needs of asylum seekers, there are risks across the system.

A failure to continue data sharing after cessation of health care navigator services in Aberdeen City will result in the composition of the asylum seeker population being unknown. It will not be possible to understand the basic demographic information about the population, or plan for appropriate health care services, without an ongoing data sharing mechanism. Details of an options appraisal relating to this risk are in Appendix 5.

A lack of support to navigate the health care system will potentially increase inappropriate use of services and place further demand on GP and emergency departments.

Without resolving delays in GP registration some asylum seekers will be left without an access point to routine health care. Evidence suggests that the migratory journey undertaken by asylum seekers is an independent risk factor for the development of cardiovascular disease. A lack of GP registration, and a lack of capacity in primary care for patients who are registered, could result in other modifiable cardiovascular risk factors not being managed, with subsequent morbidity/mortality and demands on the health care system. Without improvements in access to health care services, individuals remain at risk of suffering from poor mental health, from being exposed to communicable and vaccine preventable diseases, from experiencing morbidity from poorly managed long-term conditions. This may increase future demand on services such as the emergency department, liaison psychiatry and general practice.

With vaccination rates for (for example, measles) at less than the levels required to give herd immunity, without improvements to health care for communicable and vaccine preventable diseases, there is a risk that a pathogen causing illness in the asylum seeker population may move into other populations within Grampian.

The cost of treating a large scale outbreak of communicable or vaccine preventable disease is likely to be greater than the cost of providing screening (plus associated treatment) and vaccination. There

are cost implications of asylum seekers not being appropriately screened, for example a case of active pulmonary TB in an asylum seeker arriving in Lothian from England, and having travelled whilst infectious [19].

A large scale outbreak of communicable or vaccine preventable disease is likely to have a resource impact by requiring parts of the health care system to reduce work on other priorities to help with management.

A large scale outbreak of communicable or vaccine preventable disease is likely to raise questions about NHS Grampian preparedness and resilience, and have a negative impact on our reputation. This may decrease trust in the services provided by the health board.

Details of the controls for these risks, and gaps in controls, are shown in the risk register (Table 6).

Table 6: Risk register

Risk Title	Risk	Risk Description	Context/Impact	Risk Category/Level	Controls	Gaps in Controls
Infrastructure – Information Governance	Data sharing	Accurate and up-to-date information about the composition of the asylum seeker population is required to effectively plan service delivery.	Mechanism for sharing and collating data about population composition ceased to operate when Aberdeen City health care navigator team was disbanded. Current mechanism cannot be maintained without data sharing agreement between Mears Group and Health Intelligence.	3E Intolerable	Ongoing discussions with Mears regarding local data sharing.	Revised data sharing mechanism not in place before City health care navigator team was disbanded.
					Working with PHS to inform Scotland-wide data sharing agreements.	
Demand and capacity	Primary care registration	Not all asylum seekers are registered with GP.	There have been delays in registering asylum seekers with GPs in Aberdeen City owing to practice capacity. Asylum seekers may be unable to understand or engage with the registration process without the support of health care navigators in Aberdeen City. In Aberdeenshire practices are concerned about their sustainability in the event of further large numbers of arriving asylum seekers. Asylum seekers may be unable to access services without being registered at a primary care practice.	2D Undesirable	Mears Group contractually obligated to provide all asylum seekers with information to allow them to register with GP and dentist.	Information may not be provided in an accessible format (i.e. appropriate language, and audible if asylum seeker is illiterate in their primary language).
					Majority of Aberdeen City asylum seekers were registered with GPs prior to disbanding of the health care navigator team.	<p>GPs may inappropriately refuse to register asylum seekers despite eligibility for health care.</p> <p>Rapid unexpected increase in asylum seekers may place pressure on GP practices.</p>
Demand and capacity	Health care navigation	Removal of health care navigator support in Aberdeen City may increase inappropriate use of health care services	Health care navigators direct asylum seekers to most appropriate care provider (e.g. dentistry, mental health, Pharmacy First, sexual health). After cessation of navigator support these pathways are likely to be disrupted. Attendances at and reliance upon other services such as the emergency department or general practice may subsequently increase.	2E Undesirable	Community appointment days or other community led approaches could bring together some services at convenient locations for asylum seekers to provide care and assist in navigation.	Public health pathways continue to reference health care navigator teams as the route to specific services (e.g. dental care, vaccination).
						Delays in diagnosis due to difficulty navigating health care systems increase the demand on the system overall.

Risk Title	Risk	Risk Description	Context/Impact	Risk Category/Level	Controls	Gaps in Controls
Protecting health	Outbreak of communicable disease	Outbreak of communicable disease with the asylum seeker population.	Asylum seekers may be more likely to contract communicable diseases owing to increased exposure (due to their migratory journey and over-crowded conditions), increased susceptibility (due to under-vaccination, poor nutrition, over-crowded conditions, the migratory journey, being from places of high prevalence of communicable diseases), and a potential lack of access to health care when they are in the UK (difficulty navigating health care systems leading to potential delayed diagnosis).	3D Undesirable	Screening for symptoms of communicable disease forms part of the health needs assessment undertaken by health care navigators.	A process for ensuring access to health care for screening for symptoms of communicable disease needs to be established in City, where the navigator role is being retired.
					Screening of some asylum seekers for TB and BBV taking place.	Current system is not able to plan for or respond to changes in asylum seeker population in Aberdeen City for screening purposes.
					Processes in place for referring asylum seekers for vaccination and other health protection interventions.	Vaccine coverage in the asylum seeker population is low, and the number of asylum seekers referred for vaccination through existing processes is <10% in City and Shire.
						No mechanism exists for recording the offer of vaccination and other health protection interventions to asylum seekers who do not wish to be vaccinated.
Where there is a notification of a communicable disease, procedures are already in place for the identification of, exclusion of, and provision of vaccination/chemoprophylaxis to contacts (as appropriate).	The potential for an outbreak, or the ability to reduce the size/impact of a potential outbreak, would be mitigated by closing the gaps in controls for risks above.					

Recommendations

These recommendations seek to ensure that asylum seekers receive the right care, at the right time, in the right place.

Information sharing

1. A process of data sharing to understand the composition of the asylum seeker population has been established. This process must be adapted to fit the changing landscape of support for asylum seekers, including the withdrawal of the Aberdeen City health care navigator team. We need to acknowledge that the recommendations following this one will not succeed unless this data sharing is continued.

Enabling access

2. Both in terms of language and systems, asylum seekers need assistance and support to navigate the health care system. This assistance would ideally take the form of consistent team, allowing asylum seekers to build trusting relationships with a single point of contact. The value of less tangible support (such as assistance with transport and route planning) provided by those who assist with navigation cannot be overestimated. Language support will require different parts of the health care system to provide information to asylum seekers in an accessible format. There needs to be recognition that an accessible format might require information to be provided in a language other than English, and may need to be verbal or recorded to avoid assumptions of literacy.

Health improvement

3. We need to recognise that asylum seekers are entitled to the same health care provided to UK citizens living in Scotland. As such, there is an impetus to identify and remove barriers to engagement in relevant screening programmes, and other services that manage long-term conditions and risk factors, including dental and mental health care.

Protecting health

4. In order to protect individual and population health, asylum seekers will need support to engage with care that protects health, including screening for relevant communicable diseases (TB,

blood borne viruses) and vaccination to prevent disease. We need to ensure we can demonstrate people in the asylum seeker population have been given the opportunity to consent to care that protects health, or that they have had the chance to make a truly informed choice and have refused to consent to such care. This might rely on the utilisation of existing, or development of new datasets and data collection procedures. Such datasets could be informed by a retrospective analysis of the asylum seeker population to establish which asylum seekers have already had TB screening, for example. Making this recommendation operational will require objectives to be specific, measurable, achievable, relevant and time-bound.

Learning lessons

5. The lessons learnt from working with the asylum seeker population may be applicable to other vulnerable groups with complex needs across the health care system. Learning could be disseminated across the system to improve the care offered to these groups and prevent duplication of efforts to reach vulnerable people with complex needs.

The fulfilment of these recommendations, and the mitigation of gaps in controls in the risk register (Table 6) require actions to be taken. These actions are detailed in Table 7. Action owners will meet monthly to discuss progress.

Communication Plan

This communication plan will facilitate the dissemination of the information contained within the health needs assessment. This dissemination of information should take place across the NHS Grampian system, wider to health and social care/local authority partners, and relevant third sector organisations, allowing teams to optimise pathways and processes for delivering care to this marginalised group in the light of changing numbers of asylum seekers in Grampian and changing support mechanisms in place.

1. The health needs assessment has been approved by the NHS Grampian Public Health Asylum Seeker Short Life Working Group.

2. The health needs assessment has been presented at the NHS Grampian Portfolio Executive Leads group on 19 Dec 2024..
3. The health needs assessment will be presented at the NHS Grampian Public Health Monitoring and Governance Group, which will hold oversight for the actions in Table 7.
4. It has been suggested that a Community Appointment Day might be a feasible way of delivery some aspects of care to the asylum seeker population. Therefore recommendations from the needs assessment have been discussed with colleagues working on the Putting People First agenda (Luan Grugeon, Paul Southworth, David Watkin) for consideration.
5. With the assistance of relevant consultants in public health (Marjorie Johnston, Phil Mackie, Elizabeth Robinson), the health needs assessment will be disseminated to the strategic and operational groups in each health and social care partnership area.

Table 7: Actions required to fulfil recommendations and mitigate gaps in risk register controls

Risk Description	Gaps in Controls	Required Actions	Owner
Accurate and up-to-date information about the composition of the asylum seeker population is required to effectively plan service delivery.	Revised data sharing mechanism not in place before City health care navigator team was disbanded.	Engagement with Aberdeen City Council and Mears Group to devise a new mechanism for data sharing.	Jillian Evans
		Revised data flow for Tableau dashboard after data sharing mechanism is established.	Jillian Evans
Not all asylum seekers are registered with GP.	Information may not be provided in an accessible format (i.e. appropriate language, and audible if asylum seeker is illiterate in their primary language).	Liaising with local authorities, health and social care partnerships, Mears Group, and PHS to ensure information is available in accessible formats.	Elaine McConnachie
	GPs may inappropriately refuse to register asylum seekers despite eligibility for health care.	Liaison with HSCP primary care managers or GP cluster leads (as appropriate) to seek assurance that practices are aware of asylum seeker health care eligibility.	Phil Mackie Marjorie Johnston Elizabeth Robinson
	Rapid unexpected increase in asylum seekers may place pressure on GP practices.	Enquiring with health and social care partnerships for assurance of the approach if an unanticipated large influx of people to an area and associated increased pressure on GP practices across Grampian.	Phil Mackie Marjorie Johnston Elizabeth Robinson
Removal of health care navigator support may increase inappropriate use of health care services.	Public health pathways continue to reference health care navigator teams as the route to specific services (e.g. dental care, vaccination).	Pathways in Aberdeen City which utilise health care navigators to facilitate care require revision.	Phil Mackie
	Delays in diagnosis due to difficulty navigating health care systems increase the demand on the system overall.	Support for asylum seekers (as an example of a subpopulation with unmet needs) to access health care systems must be established, taking learning from the different models that have been used as per recommendation 5.	Corri Black Elaine McConnachie Lynsey Martin
Outbreak of communicable disease with the asylum seeker population.	A process for ensuring access to health care for screening for symptoms of communicable disease needs to be established in City, where the navigator role has been retired.	Pathways for accessing care in Aberdeen City need to be updated to reflect the lack of health care navigators.	Phil Mackie
	Current system is not able to plan for or respond to changes in asylum seeker population in Aberdeen City for screening purposes.	Procedure for screening in response to changes in the population needs to be established.	Chris Littlejohn
	Vaccine coverage in the asylum seeker population is low, and the number of asylum seekers referred for vaccination through existing processes is <10% in City and Shire.	Barriers and facilitators to vaccination need to be identified, and barriers removed where possible.	Chris Littlejohn
	No mechanism exists for recording the offer of vaccination and other health protection interventions to asylum seekers who do not wish to be vaccinated.	A mechanism for recording a valid refusal of consent for vaccination and other health protection interventions needs to be established.	Chris Littlejohn
	The potential for an outbreak, or the ability to reduce the size/impact of a potential outbreak, would be mitigated by closing the gaps in controls for risks above.	A whole system approach is required to mitigate risk and reduce the impact of an outbreak of communicable disease.	Chris Littlejohn

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Appendix 1: Systematic review of asylum seeker health care needs- search strategy

Table 8: Search strategy for systematic review of asylum seeker health care needs

Ovid MEDLINE(R) ALL <1946 to January 16, 2024>		
	Search syntaxes	Results
1	refugees/	13551
2	"transients and migrants"/	14551
3	"emigrants and immigrants"/ or undocumented immigrants/	15927
4	human migration/ or "emigration and immigration"/	27997
5	*vulnerable populations/ and (psychology or prevention & control or therapy or rehabilitation).fs.	2384
6	Acculturation/	7086
7	asylum*.ti,ab,kf.	5448
8	refugee*.ti,ab,kf.	15389
9	(migrant? or immigrant? or emigrant?).ti,ab,kf.	55308
10	(force? adj2 (migrat* or immigrat* or emigrat*)).ti,ab,kf.	925
11	(displac* adj1 (internal* or forced or mass or person* or people* or population*)).ti,ab,kf.	3042
12	floating population.ti,ab,kf.	307
13	or/1-12	102509
14	review.pt.	3265035
15	(medline or medlars or embase or pubmed or cochrane).tw,sh.	365262
16	(scisearch or psychinfo or psycinfo).tw,sh.	62776
17	(psychlit or psyclit).tw,sh.	918
18	cinahl.tw,sh.	48014
19	((hand adj2 search\$) or (manual\$ adj2 search\$)).tw,sh.	17569
20	(electronic database\$ or bibliographic database\$ or computeri?ed database\$ or online database\$).tw,sh.	62105
21	(pooling or pooled or mantel haenszel).tw,sh.	154065
22	(peto or dersimonian or der simonian or fixed effect).tw,sh.	11259
23	(retraction of publication or retracted publication).pt.	41883
24	or/15-23	566185
25	14 and 24	237702
26	meta-analysis.pt.	193455
27	meta-analysis.sh.	193455
28	(meta-analys\$ or meta analys\$ or metaanalys\$).tw,sh.	322305
29	(systematic\$ adj5 review\$).tw,sh.	356416
30	(systematic\$ adj5 overview\$).tw,sh.	3914
31	(quantitativ\$ adj5 review\$).tw,sh.	11014
32	(quantitativ\$ adj5 overview\$).tw,sh.	442
33	(quantitativ\$ adj5 synthesis\$).tw,sh.	4850
34	(methodologic\$ adj5 review\$).tw,sh.	9058
35	(methodologic\$ adj5 overview\$).tw,sh.	602
36	(integrative research review\$ or research integration).tw.	176
37	or/26-36	517146
38	25 or 37	607186
39	13 and 38	2414
40	limit 39 to English language	2345
Embase <1974 to 2024 January 16>		
	Search syntaxes	Results
1	refugee camp/ or refugee/	17822
2	asylum seeker/	1622
3	migrant/ or emigrant/ or immigrant/	32624

4	*migration/ or *immigration/	24014
5	asylum*.ti,ab,kw.	5613
6	refugee*.ti,ab,kw.	16658
7	(migrant? or immigrant? or emigrant?).ti,ab,kw.	60075
8	(force? adj2 (migrat* or immigrat* or emigrat*)).ti,ab,kw.	936
9	(displac* adj1 (internal* or forced or mass or person* or people* or population*)).ti,ab,kw.	3208
10	floating population.ti,ab,kw.	302
11	or/1-10	99636
12	exp review/	3214562
13	(literature adj3 review\$).ti,ab.	465820
14	exp meta analysis/	304955
15	exp "Systematic Review"/	449116
16	or/12-15	3586738
17	(medline or medlars or embase or pubmed or cinahl or amed or psychlit or psyclit or psychinfo or psycinfo or scisearch or cochrane).ti,ab.	474887
18	RETRACTED ARTICLE/	15192
19	17 or 18	489604
20	16 and 19	383681
21	(systematic\$ adj2 (review\$ or overview)).ti,ab.	410292
22	(meta?anal\$ or meta anal\$ or meta-anal\$ or metaanal\$ or metanal\$).ti,ab.	372088
23	or/20-22	702537
24	11 and 23	2291
25	limit 24 to English language	2239
APA PsycInfo <1806 to January Week 2 2024>		
	Search syntaxes	Results
1	refugees/	8931
2	asylum seeking/ or political asylum/	1160
3	human migration/ or *immigration/	31173
4	acculturation/	11313
5	asylum*.ti,ab,id.	4838
6	refugee*.ti,ab,id.	11894
7	(migrant? or immigrant? or emigrant?).ti,ab,id.	43478
8	(force? adj2 (migrat* or immigrat* or emigrat*)).ti,ab,id.	673
9	(displac* adj1 (internal* or forced or mass or person* or people* or population*)).ti,ab,id.	1388
10	floating population.ti,ab,id.	29
11	or/1-10	67200
12	(meta analysis or "systematic review").md.	69460
13	meta analysis/	5420
14	((systematic or structured or evidence or trials or studies) and (review or overview or look or examination or update* or summary)).ti.	46558
15	(meta-analys* or meta analys* or metaanalys* or meta synth* or meta-synth* or metasynth*).ti,ab,id,hw.	52112
16	((systematic or meta) adj2 (analys* or review)).ti,id. or ((systematic* or quantitativ* or methodologic*) adj5 (review* or overview*)).ti,ab,id,sh. or (quantitativ* adj5 synthes*).ti,ab,id,hw.	84025
17	(integrative research review* or research integration).ti,ab,id. or scoping review?.ti,id. or (evidence adj3 review*).ti,ab,id.	25252
18	"literature review"/ and (medline or medlars or embase or pubmed or scisearch or psychinfo or psycinfo or psychlit or psyclit or cinahl or electronic database* or bibliographic database* or computeri#ed database* or online database* or pooling or pooled or mantel haenszel or peto or dersimonian or der simonian or fixed effect or ((hand adj2 search*) or (manual* adj2 search*))).ti,ab,id,hw.	22854
19	((systematic or structured or evidence or trials or studies) adj3 review*).ti,ab,id. and (evidence based practice or treatment outcomes or mental health program evaluation).sh.	4781
20	or/12-19	149206

21	11 and 20	1311
22	limit 21 to English language	1207
Cochrane Library – Reviews only		
	asylum* OR refugee* OR migrant* OR immigrant* OR emigrant* OR (force* NEAR/2 migrat*) OR (force* NEAR/2 immigrat*) OR (force* NEAR/2 emigrat*) or (displac* NEAR/2 internal) OR (displac* NEAR/2 forced) OR (displac* NEAR/2 mass) OR (displac* NEAR/2 person) OR (displac* NEAR/2 people) OR (displac* NEAR/2 population) OR "floating population" in Title Abstract	23
Keyword		
CINAHL – 17 January		
	Search syntaxes	Results
1	(MH "Refugees")	9,346
2	(MH "Transients and Migrants")	0
3	(MH "Undocumented Immigrants")	1,118
4	(MH "Emigration and Immigration")	7,538
5	(MH "Acculturation")	6,395
6	asylum*	2,651
7	refugee*	11,542
8	migrant* or immigrant* or emigrant*	32,358
9	force* N2 migrat* OR force* N2 immigrat* OR force* N2 emigrat*	295
10	displac* N1 internal* OR displac* N1 forced OR displac* N1 mass OR displac* N1 person* OR displac* N1 people* OR displac* N1 population*	1,191
11	"floating population"	36
12	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11	49,509
13	(ZT "review")	364,865
14	medline or medlars or embase or pubmed or cochrane or scisearch or psychinfo or psycinfo or psychlit or psyclit or cinahl	188,897
15	(hand N2 search*) OR (manual* N2 search*)	7,430
16	"electronic database*" OR "bibliographic database*" OR "computerized database*" OR "online database*"	25,229
17	pooling or pooled or "mantel haenszel"	44,620
18	peto or dersimonian or "der simonian" OR "fixed effect"	3,907
19	14 OR 15 OR 16 OR 17 OR 18	224,701
20	13 AND 19	16,010
21	(ZT "meta analysis") OR (ZT "meta synthesis") OR (ZT "systematic review")	170,570
22	"meta analys*" OR metaanalys*	126,131
23	(systematic N5 review*) OR (systematic N5 overview*)	209,241
24	(qualitative N5 review*) OR (qualitative N5 overview*) OR (qualitative N5 synthes*)	10,481
25	(methodologic* N5 review*) OR (methodologic* N5 overview*)	4,753
26	"integrative research review*" OR "research integration"	127
27	21 OR 22 OR 23 OR 24 OR 25 OR 26	270,205
28	20 OR 27	282,154
29	12 AND 28	1,770
30	12 AND 28	1,726
Applied Social Sciences Index & Abstracts (ASSIA)		
	((noft(asylum* OR refugee* OR migrant* OR immigrant* OR emigrant* OR (force* NEAR/2 migrat*) OR (force* NEAR/2 immigrat*) OR (force* NEAR/2 emigrat*)) OR noft((displac* NEAR/1 internal*) OR (displac* NEAR/1 forced) OR (displac* NEAR/1 mass) OR (displac* NEAR/1 person*) OR (displac* NEAR/1 people*) OR (displac* NEAR/1 population*)) OR noft("floating population")) AND ((noft(review*) AND noft((medline OR medlars OR embase OR pubmed OR cochrane OR scisearch OR psychinfo OR psycinfo OR psychlit OR psyclit OR cinahl OR assia OR (hand NEAR/2 search*) OR (manual* NEAR/2 search*) OR ("electronic database" OR "electronic databases") OR ("bibliographic database" OR "bibliographic databases") OR "computerized database*" OR ("online database" OR "online databases") OR pooling OR pooled OR "mantel haenszel" OR peto OR dersimonian OR "der simonian" OR "fixed effect")) OR noft(("meta analyses" OR "meta analysis") OR metaanalys* OR (systematic NEAR/5 review*) OR (systematic NEAR/5 overview*) OR (qualitative NEAR/5 review*) OR (qualitative NEAR/5 overview*) OR (qualitative NEAR/5 synthes*) OR (methodologic* NEAR/5 review*) OR (methodologic* NEAR/5 overview*) OR "integrative research review*" OR "research integration")))) AND la.exact("ENG"))	3010

SCOPUS		
	((TITLE-ABS-KEY (asylum* OR refugee* OR migrant* OR immigrant* OR emigrant*) OR TITLE-ABS-KEY ((force* W/2 migrat*) OR (force* W/2 immigrat*) OR (force* W/2 emigrat*) OR (displac* W/2 internal) OR (displac* W/2 forced) OR (displac* W/2 mass) OR (displac* W/2 person) OR (displac* W/2 people) OR (displac* W/2 population) OR "floating population"))) AND ((TITLE-ABS-KEY (review*)) AND (TITLE-ABS-KEY (medline OR medlars OR embase OR pubmed OR cochrane OR scisearch OR psychinfo OR psycinfo OR psychlit OR psyclit OR cinahl OR assia OR (hand AND near/2 AND search*) OR (manual* AND near/2 AND search*) OR "electronic database*" OR "bibliographic database*" OR "computerized database*" OR "online database*" OR pooling OR pooled OR "mantel haenszel" OR peto OR dersimonian OR "der simonian" OR "fixed effect"))) OR (TITLE-ABS-KEY ("meta analyses" OR "meta analysis") OR metaanalys* OR (systematic W/5 review*) OR (systematic W/5 overview*) OR (qualitative W/5 review*) OR (qualitative W/5 overview*) OR (qualitative W/5 synthes*) OR (methodologic* W/5 review*) OR (methodologic* W/5 overview*) OR "integrative research review*" OR "research integration"))) AND (LIMIT-TO (LANGUAGE , "English"))	3411
Social Science Citation Index		
	Search syntaxes	Results
1	TS=(asylum* OR refugee* OR migrant* OR immigrant* OR emigrant* OR (force* NEAR/2 migrat*) OR (force* NEAR/2 immigrat*) OR (force* NEAR/2 emigrat*) or (displac* NEAR/2 internal) OR (displac* NEAR/2 forced) OR (displac* NEAR/2 mass) OR (displac* NEAR/2 person) OR (displac* NEAR/2 people) OR (displac* NEAR/2 population) OR "floating population")	-
2	TS=(review*)	-
3	TS=(medline OR medlars OR embase OR pubmed OR cochrane OR scisearch OR psychinfo OR psycinfo OR psychlit OR psyclit OR cinahl OR assia OR (hand* NEAR/2 search*) OR (manual* NEAR/2 search*) OR "electronic database*" OR "bibliographic database*" OR "computerized database*" OR "online database*" OR pooling OR pooled OR "mantel haenszel" OR peto OR dersimonian OR "der simonian" OR "fixed effect")	-
4	#2 AND #3	-
5	TS=("meta analyses" OR "meta analysis" OR metaanalys* OR (systematic NEAR/5 review*) OR (systematic NEAR/5 overview*) OR (qualitative NEAR/5 review*) OR (qualitative NEAR/5 overview*) OR (qualitative NEAR/5 synthes*) OR (methodologic* NEAR/5 review*) OR (methodologic* NEAR/5 overview*) OR "integrative research review*" OR "research integration")	-
6	#4 OR #5	-
7	#6 AND #1	-
8	LA=(English)	-
9	#7 AND #8	2598

Appendix 2: Systematic review of asylum seeker health care needs- summary presentation

Needs of asylum seekers in high-income countries and their experiences of accessing care services: An overview of systematic reviews



Dr Leonard Ho
Research Fellow

NIHR Health Determinants Research Collaboration Aberdeen



Summary

- Overview of systematic reviews
- We synthesised systematic reviews on **adult** asylum seekers' care needs and their experiences of accessing care services in high-income countries
- We found 5 systematic reviews published between 2014–2020
 - 3 were mixed-methods and 2 were qualitative systematic reviews
 - Included 6 to 32 primary studies, with 90 to 20,951 asylum seekers
 - 4 included evidence from the UK
 - 2 focused specifically on pregnant women

Common themes across the reviews

Communication challenges

Access to healthcare

Health professionals' attitudes

Mental health issues and social isolation

Housing and relocation challenges

Communication challenges

- Language barrier is a major obstacle affecting both health and social aspects
- Lack of professional and culturally appropriate interpreters
 - Unable to understand informed consent documents and benefit entitlement
- Lack of housing and educational opportunities

Access to healthcare

- Asylum seekers' poor understanding of health systems
 - Unsure about the roles of health professionals
 - Unsure about the availability of services and eligibility
- Health professionals' poor understanding of care entitlement and eligibility

Health professionals' attitudes

- Health professionals' dismissive, negative, and hostile attitudes
- Asylum seekers' lack of trust of in health professionals
- Perception of interconnecting immigration and health systems

Mental health issues and social isolation

- Immigration status concerns, poor care experience, and distance from family and friends
 - Sense of powerless and loneliness
- Lack of psychological support
 - Suicide and self-harm associated with previous traumatic experiences (e.g., sexual violence)
- Feeling of disempowerment, humiliation, and shame due to immigration status and poor care experience in the host country

Suggestions for policy

- **Tackling discrimination**
- Reducing communication barriers
 - Culturally appropriate interpretation services
- Training of health professionals
 - Information on asylum process and entitlements
 - Trauma-sensitive and cross-cultural training

**Asylum seekers: health needs and
barriers to the provision of effective
health services**

**NHS
Grampian
Evidence
Synthesis
Service**

June 2024

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This evidence review is not a systematic review; it is limited to a preliminary assessment of selected literature and does not assess the quality of the identified studies.

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Background

An asylum seeker is a person who has fled their country and made an application in another country to be recognised as a refugee under the 1951 UN Convention Relating to the Status of Refugees but who has not yet been granted this status.

In 2023, there were 67,337 asylum applications in the United Kingdom, relating to 84,425 individuals (Sturge 2024). This marked another year of a sharp increase in the upward trend in asylum applications since 2020, when around 30,000 applications were made. Asylum seekers and refugees account for 16% of immigration to the United Kingdom, and their presence has been subjected to a contentious political debate, including the passing of the Safety of Rwanda (Asylum and Immigration) Bill in April 2024 to relocate them to Rwanda for processing, asylum and resettlement.

The average time for an initial asylum decision to be made is 20 months according to the Migration Observatory (Cuibus, Walsh and Sumption 2024). During that time, asylum seekers in receipt of government support under the Immigration and Asylum Act 1999 are provided with accommodation, including contingency accommodation. They also receive a weekly support allowance on a pre-paid card; those living in catered accommodation, such as hotels, get £8.86 (as of January 2024).

In 2019, the Home Office signed government contracts with three companies, Clearsprings Ready Homes, Mears Limited, and Serco Limited, to procure and provide asylum accommodation. These private-sector companies are required to ensure the health and safety of properties used to house asylum seekers. While local authorities have no direct responsibility for asylum accommodation, private companies liaise with them to understand local community challenges.

While the Home Office policy has been to disperse asylum seekers across the country, in designated regions mainly in England and Glasgow, the widening of dispersal in November 2021 included the Grampian region, with two prominent sites being established in hotels in Westhill, Aberdeenshire, and Elgin, Moray, among others.

During the application period, asylum seekers are at risk of a number of health problems. Many have complex psychological needs. Extended periods of stress and uncertainty can also lead to further declines in mental health, including among those who arrived in the UK in good mental health or who had no previous history of mental health problems. Pre-existing chronic conditions might not be adequately managed, and the prevalence of communicable diseases, as well as lack of immunisation, is high among this population. But while asylum seekers are fully entitled to free NHS care, their health needs are not well understood and there still are many barriers to the effective provision of health services to them.

Aims

This rapid evidence review summarises selected evidence from scientific studies and grey literature about health needs and barriers to healthcare provision to adult asylum seekers in the UK.

The research questions are as follows:

1. What are the health needs of asylum seekers?
2. What are the barriers to asylum seekers' accessing health care and the provision of effective health services?

Methods

A systematic literature search was carried out in April 2024. Appendix 1 presents a full description of the methods used and the search strategy adopted.

Results – Research Question 1

General health needs

Asylum seekers tend to have complex health needs. These needs are affected by asylum seekers' experiences prior to leaving their home country, during transit, and after arrival in the UK. The scientific literature, and various professional bodies such as the British Medical Association (BMA), broadly recognise four common areas of health needs among asylum seekers (Figure 1). Studies tend to consider all needs or focus on specific areas recognising the interconnections between them and therefore highlighting the need for a holistic approach to healthcare provision. The BMA provides a brief refugee and asylum seeker patient health toolkit addressed to all UK doctors.

In this review, we follow the BMA nomenclature and discuss the general and specific health needs of asylum seekers, but we treat issues that are sometimes framed as 'needs', such as language and interpretation services, as 'barriers' and discuss them separately when addressing our second research question.



Figure 1. Common health challenges of refugees and asylum seekers (source: British Medical Association 2019)

There are no official statistics of medical conditions and diseases in the UK asylum seeker population and there are few studies looking at the prevalence of general health needs in this group. However, an evaluation of electronic medical records of a nurse-led 'Vulnerable Migrant Service' in a UK city with a population of 150 asylum seekers in Home Office accommodation can provide a partial insight into the general health needs. Clark et al. (2022) found and reviewed records of 86 asylum seeker patients. Table 1 summarises referrals at initial health check, and most common issues in the domains of physical, mental, and women's health. The study concludes that the health needs of asylum seekers are higher than that of the general population. Their findings on mental health, for example, correlate well with national research which suggests that asylum seekers are five times more likely to have mental health needs than the general population.

Table 1. Summary of data extracted from patient records' case notes (from Clark et al. 2022)

Adult asylum seeker patients in June 2018 (N = 86)	n (%)
Referrals at initial health check*	-
Dentist	59 (74%)
Optician	31 (39%)
Genitourinary medicine (GUM) clinic	5 (6%)
Tuberculosis (TB) screening	44 (55%)
Missing data	6
Physical health*	-
Any long-term physical health problem	40 (59%)
No known physical health problem	27 (41%)
Musculoskeletal (e.g. chronic back pain)	12 (18%)
Chronic dental problems	3 (4%)

Gastroenterological	4 (6%)
Gynaecological	4 (5%)
Ischaemic Heart Disease (IHD)	6 (9%)
Endocrine (e.g. hypothyroid, diabetes)	7 (10%)
Missing data	19
Other (e.g. chronic migraine)	11 (16%)
Infectious diseases*	-
Any infectious disease	17 (22%)
Latent TB	13 (16%)
Other (e.g. hepatitis)	4 (6%)
Missing data	7
Women's health (N = 34)	
Pregnant at initial health check	2 (5.8%)
Female Genital Mutilation (FGM)	4 (11.7%)
Missing data	6
Mental health	
Any mental health diagnosis	31 (51%)
Symptoms of mental distress and no diagnosis	17 (28%)
No mental health diagnosis	13 (21%)
Missing data	25
Depression	35 (57%)
Post-traumatic Stress Disorder (PTSD)	10 (16%)

*totals are not mutually exclusive

Mental health

It seems that the biggest health need of asylum seekers in the UK is mental health. This problem is further exacerbated beyond the pre-existing conditions by the uncertainty and status of a person seeking asylum and navigating the bureaucratic system and relatively hostile political climate. While the prevalence of mental health conditions, disorders and psychological distress, PTSD and CPTSD is higher in asylum seekers than in the general population (Mental Health Foundation 2024; Silva et al. 2021), rates only tell half the story. Asylum seekers have a high prevalence of head trauma (Saadi et al. 2023), are severely impacted by post-migration stressors (Murphy and Vieten 2022), are susceptible to suicidal ideation, behaviours and have higher suicide rates than the general population (Cogo et al 2022), and their mental health needs are often associated with complex traumatic experience such as war, exploitation, torture, violence and sexual violence (Baumgartner et al. 2023). The Mental Health Foundation (2024) has recently published a report into 'The Mental Health of Asylum Seekers and Refugees in the UK' that explores the broader context of the phenomenon. Table 2 summarises selected studies in the mental health domain.

Maternity care and women's health

Pregnancy and female genital mutilation are primary reasons for asylum seeking woman to engage with the healthcare system in the UK. A study looking at electronic births records to asylum seeking women at a London hospital over a period of one

year found that they w received fewer antenatal appointments and ultrasound examinations than age- and ethnicity-matched controls and their infants stayed longer in hospital than controls (Sturrock et al. 2022). It is also recognised that asylum seeking women have a higher number of risk factors for developing perinatal depression and are less likely to have their symptoms recognised by healthcare professionals (Firth et al. 2022). Female Genital Mutilation or Cutting (FGM/C) is prevalent in asylum-seeking women but care provision is inadequate due to lack of training and rarity of the phenomenon in the general UK population (Turner and Tancred 2023). Table 3 summarises selected studies in the women's health domain.

Communicable diseases

With respect to communicable and vaccine-preventable disease, the health needs of asylum seekers can be broadly categorised as the need to be screened and treated for communicable diseases (beyond tuberculosis and blood borne viruses) and the need to have a clinical review to establish vaccination history. Infectious diseases that are common in the countries where asylum seekers have spent time before coming to the UK should be considered. In some countries, screening programmes for infectious diseases, such as HIV and hepatitis, may not be easily accessible, or people may not seek testing due to fear of stigma or lack of treatment options. Asylum seekers are much more likely to suffer from various communicable diseases, for example, TB (Taha, Durham and Reid 2022). They also are also affected by high prevalence of parasitic infections (Stinchcombe et al. 2023). Both of these issues, among many others, highlight the importance of screening and immunisation, especially in this population group that has been found to be under-immunised (O'Boyle et al. 2023). Table 4 summarises selected studies in the communicable diseases health domain.

Chronic conditions

Refugees and asylum seekers may arrive in the UK with poorly controlled chronic conditions, such as diabetes and hypertension. This is usually the result of long periods without access to regular care, either in their home countries or during their journeys to the UK. Al-Rousan et al. (2022) have found that migratory experiences are an independent factor for cardiovascular diseases in asylum seekers. The same is the case for the prevalence of oral diseases Zinah and Allbrahim (2021). Asylum-seeking groups might whose health is managed using electronic health records (EHR) have better outcomes, especially for chronic conditions, highlighting the need for robust systems and data transfer mechanisms for these populations groups that tend to be moved often within their host countries whilst undergoing asylum application decisions. Table 5 summarises selected studies in the chronic conditions health domain.

Results – Research Question 2

Barriers to accessing health services and effective healthcare provision

Refugees and asylum seekers in the UK often have difficulty accessing healthcare and other public services. In many cases, they may be unfamiliar with the way these services are organised, but the majority of these barriers are structural problems in the healthcare and asylum systems in the UK. The list of barriers to accessing health services and effective healthcare provision is presented in Table 8, while further details from studies reviewed are summarised in Table 7.

Three important health resources for about asylum seekers have been identified and listed below (by BMA, RCGP, and the Equality and Human Rights Commission, respectively) to consult for how public messaging about asylum seekers' healthcare is realised and communicated.

<https://www.bma.org.uk/media/1838/bma-refugee-and-asylum-seeker-health-resource-june-19.pdf>

<https://www.rcgp.org.uk/policy/rcgp-policy-areas/asylum-seekers-and-vulnerable-migrants>

<https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/research-report-121-people-seeking-asylum-access-to-healthcare-evidence-review.pdf>

Additional literature sources are available for four areas concerning barriers to access: initial assessment, housing, registration, and healthcare workers' experiences. These can be additionally consulted to contextualise and expand on information presented here.

Table 8. List of barriers

Barriers to accessing health services and effective healthcare provision
Language barriers
<ul style="list-style-type: none">- Poor language skills,- Lack of interpreters / funding for interpreters / interpreters cultural competence lacking
Hostile political climate and asylum system
<ul style="list-style-type: none">- Racism and xenophobia from the local population- Discriminatory policies, racism and exclusion,- Asylum seekers not seeking healthcare access as they are afraid of consequences to their legal status,- Asylum seekers seeing themselves as a 'burden' and therefore avoiding accessing 'resources' such as healthcare,- Very poor housing conditions and frequent moves that disrupt healthcare continuity, provision, access and consistency of medical records,- Western health discourses that emphasise agency of patients don't 'work' for asylum seeker groups with very little agency and control over their lives,- Medicalisation of adverse life experiences as 'mental health',

<ul style="list-style-type: none"> - Little financial assistance to asylum seekers resulting in, for example, their inability to meet costs to travel to healthcare appointments, <p>Inadequate training / cultural competence of healthcare staff</p> <ul style="list-style-type: none"> - Profound lack of understanding of asylum-seekers' rights (resulting in refusal to register asylum seekers as patients, delaying healthcare), - Inexperience and lack of training when dealing with FGM/C, complex psychological issues related to war, violence and extreme poverty. - Lack of cultural knowledge and sensitivity to deal with asylum seekers that can unintentionally (or intentionally) create 'hostile' situations and environment. <p>Asylum seekers' personal factors</p> <ul style="list-style-type: none"> - Poor health and digital literacy, - Experience of stigma induced by asylum seeking status and hostile environment, - Culturally based fear of and hesitancy towards vaccines and/or institutional healthcare in general (e.g. preference for 'natural' medicine, dismissal of mental health issues), - General lack of trust in institutions in host countries, <p>Inadequate healthcare provision</p> <ul style="list-style-type: none"> - Poor screening and initial assessment for an under-immunised and vulnerable population of asylum seekers,

Initial assessment

Knights, F., et al. (2022). Initial Health Assessments for Newly Arrived Migrants, Refugees, and Asylum Seekers. *BMJ* 377, e068821. <https://doi.org/10.1136/bmj-2021-068821>

James, M.L., and Forrester-Jones, R. (2022). Human-Centred Design in UK Asylum Social Protection. *Social Science*, 11(9), p. 387. <https://doi.org/10.3390/socsci11090387>

Hollows, A. (2021). Working with Asylum Seekers and Refugees: What to do, what Not to do and how to Help Sarah Crowther. *British Journal of Social Work* 51(7), 2861-2862. <https://doi.org/10.1093/bjsw/bcaa048>

Housing

Neal, D. (2022). *An Inspection of the use of Hotels for Housing Unaccompanied Asylum-Seeking Children (UASC)*. England: Independent Chief Inspector of Borders and Immigration. [Online] [Accessed on 24 May 2024]. https://assets.publishing.service.gov.uk/media/634fa461d3bf7f618aaa30b9/An_inspection_of_the_use_of_hotels_for_housing_unaccompanied_asylum-seeking_children_UASC_March_to_May_2022.pdf

Mahase, E. (2022). Asylum Seekers' Health Suffers from "Unsafe" UK Accommodation, Report Claims. *BMJ (Clinical Research Ed.)*, 377, o1088. <https://doi.org/10.1136/bmj.o1088>

Migrant Voice (2023). No rest, no security: report into the experiences of asylum seekers in hotels. *Migrant Voice*. [Online] [Accessed on 24 May 2024]. <https://www.migrantvoice.org/img/upload/%E2%80%9CNo rest. No Security .%E2%80%9D Report into the experiences of asylum seekers in hotels - Migrant Voice .pdf>

Dobbin, J., Soares, C.A., Burns, F., Miall, N., Aspray, N., Mohammad, H., Bowles, M and Arnold, F. (2023). Medical Consequences of "contingency Accommodation" for People Seeking Asylum: Thematic Analysis of a Survey from Professionals Working in Contingency Accommodation. *The Lancet, Suppl. Supplement*, 1 402.
[https://doi.org/10.1016/S0140-6736\(23\)02093-7](https://doi.org/10.1016/S0140-6736(23)02093-7)

Crosby, L. (2023). The Housing Crisis Facing Asylum Seekers. *Inside Housing*, 39(12). [Online] [Accessed on 24 May 2024].
<https://www.insidehousing.co.uk/insight/the-housing-crisis-facing-asylum-seekers-79182#:~:text=%E2%80%9CA asylum%20seekers%20are%20victims%20of,forward%2C%E2%80%9D%20states%20Ms%20Goodall.>

Registration

Ciftci, Y. and Blane, D.N. (2022). Improving GP Registration and Access for Migrant Health. *British Journal of General Practice*, 72(715), pp. 56-57.
<https://doi.org/10.3399/bjgp22X718301>

Humphrey, A., Fagan, L., Carruthers, E., Yuan, J-M., Ogunlana, K., Alfred, J., Nagasivam, A., Stevenson, K., Aldridge R.W., Stevenson, F., Williams, S. and Burns, R. (2023). Perspectives on Registration to Primary Care from Inclusion Health Groups in England: A Mixed-Method Study. *The Lancet, Suppl. Supplement 1*, 402, S53.
[https://doi.org/10.1016/S0140-6736\(23\)02074-3](https://doi.org/10.1016/S0140-6736(23)02074-3)

Rowlands, S. (2023). Safe Prescribing for Refugees and Asylum Seekers. *Prescriber*, 34(5), pp. 15-19. <https://wchh.onlinelibrary.wiley.com/doi/full/10.1002/psb.2062>

NHS England. (2024) 'Guidance to Support HC2 Application for Asylum Seekers.' This guidance explains how professionals can support asylum seekers to access healthcare and prescriptions. It may also be useful for supporting access for other vulnerable migrants, such as refugees. [Online] [Accessed on 30th May 2024].
<https://www.england.nhs.uk/long-read/guidance-to-support-hc2-application-for-asylum-seekers/>

Healthcare workers' experiences

Partavian, A., and Kyriakopoulos, A. (2023). Therapist and Counsellors' Experiences of Working with Asylum Seekers in the Context of Asylum-Seeking Processes in the UK. *Counselling & Psychotherapy Research*, 23(2), pp. 323-333.
<https://doi.org/10.1002/capr.12501>

Tomkow L., Prager G., Drinkwater J., Morris R.L. and Farrington R. (2023a). 'That's how we Got Around it': A Qualitative Exploration of Healthcare Professionals' Experiences of Care Provision for Asylum Applicants' with Limited English Proficiency in UK Contingency Accommodation. *BMJ Open*, 13(11).
<https://doi.org/10.1136/bmjopen-2023-074824>

Tomkow L., Prager G., Worthing K. and Farrington R. (2023b). In Critique of Moral Resilience: UK Healthcare Professionals' Experiences Working with Asylum Applicants Housed in Contingency Accommodation during the COVID-19 Pandemic. *Journal of Medical Ethics*, 50(1), pp. 33-38.
<https://doi.org/10.1136/jme-2022-108632>

Paaras A., von Werthern, M., Katona, C., Brady, F. and Woo, Y. (2021). The Texture of Narrative Dilemmas: Qualitative Study in Front-Line Professionals Working with Asylum Seekers in the UK. *BJPsych Bulletin*, 45(1).
<https://doi.org/10.1192/bjb.2020.33>

Hines, Z., and Leishman, E. (2023). No Knowledge of 'Public Funds'? an Investigation into Social Work Practitioners' Confidence and Knowledge when Working with Adults with 'no Recourse to Public Funds'. *British Journal of Social Work*, 53(1), pp. 40-59.
<https://doi.org/10.1093/bjsw/bcac108>

Table 2. Mental health needs of asylum seekers

Reference, title, publication type, country	Summary	Method and participants	Needs identified (including barriers, if reported)
Saadi et al. (2023) Head Trauma in Refugees and Asylum Seekers: A Systematic Review (Neurology) Systematic review – international studies including the UK.	Refugees and asylum seekers are at risk of head trauma. They endure blows to the head due to exigent circumstances necessitating resettlement (e.g., torture, war, interpersonal violence) and during their dangerous journeys to refuge. Our objective was to assess the global prevalence of head trauma in refugees and asylum seekers and describe its clinical characteristics in this population.	Systematic review.	<ul style="list-style-type: none"> - Refugees and asylum seekers are vulnerable to head trauma and require care consideration to take this into account.
De Silva et al. (2021) Prevalence of Complex Post-Traumatic Stress Disorder in Refugees and Asylum Seekers: Systematic Review (BJPsych Open) Systematic review –	This systematic review aimed to summarise the available literature reporting the prevalence in refugees and asylum seekers of three operationalised definitions of CPTSD.	Systematic review.	<ul style="list-style-type: none"> - CPTSD prevalence in treatment-seeking samples was between 16 and 38%. Prevalence in population samples ranged from 2.2 to 9.3% in four studies, with the fifth reporting a much higher estimate (50.9%). - Asylum seekers are a 'highly traumatised' population.

international studies including the UK.			
Murphy and Vieten (2022) Asylum Seekers and Refugees in Northern Ireland: The Impact of Post-Migration Stressors on Mental Health. (Irish Journal of Psychological Medicine) Mixed methods study based in Northern Ireland.	This mixed method study on the everyday life experience of asylum seekers and refugees in Northern Ireland was conducted with view to understanding how service delivery and notions of integration/inclusion impact post-migration stressors.	Mixed method study including a survey and in-depth semi-structured interviews with service providers, refugees and asylum seekers.	<ul style="list-style-type: none"> - The asylum system in the UK (as a form of post-migration stressor) further exacerbates and contributes to poor mental health and well-being for many asylum seekers and refugees.
Jannesari et al. (2022) What Affects the Mental Health of People Seeking Asylum in the UK? A Narrative Analysis of Migration Stories (Qualitative Research in Psychology)	This paper aims to understand how people seeking asylum make sense of their migration experience and the factors impacting the mental health of people seeking asylum in the UK how this influences mental health and well-being.	Three extended unstructured interviews with asylum seekers.	<ul style="list-style-type: none"> - Dehumanisation of asylum seekers is prevalent due to the asylum process and public discourse. - Narrative analysis demonstrates how experiences of torture and lack of control in countries of origin continued in UK. Moreover, the asylum process inhibited people reconciling their pre-migration trauma and stopped interviewees planning for their future, leading to a loss of identity.

Qualitative study based in the UK.			
Cogo et al. (2022) Suicide Rates and Suicidal Behaviour in Displaced People: A Systematic Review (PLoS ONE) Systematic review – International studies including the UK.	Refugees, and other forcibly displaced people, face mental distress and may be disproportionately affected by risk factors for suicide. Little is known about suicidal behaviour in these highly mobile populations because collecting timely, relevant, and reliable data is challenging.	Systematic review.	<ul style="list-style-type: none"> - Suicide rates ranged considerably from 4.0 to 290 per 100,000 person-years across the 11 studies in general samples. - Prevalence of suicide attempts ranged from 0.14% to 15.1% across the studies in general samples. - Prevalence of suicidal ideation ranged from 0.17% to 70.6% across the studies in general samples. - Despite the sparsity of studies, there is evidence of a high risk of suicide and suicidal behaviour among refugees in camps and asylum seekers, which suggests that these groups require additional support and monitoring.
Baumgartner et al. (2023) Impairments in Psychological Functioning in Refugees and Asylum Seekers (Frontiers in Psychology) Quantitative study of survey data from Europe and UK.	Refugees are at increased risk for developing psychological impairments due to stressors in the pre-, peri- and post-migration periods. There is limited knowledge on how everyday functioning is affected by migration experience. In a secondary analysis of a study in a sample of refugees and asylum seekers, it was examined how aspects of psychological functioning were differentially affected.	Quantitative study (secondary analysis) of survey data of 1101 refugees and asylum seekers.	<ul style="list-style-type: none"> - This study underlines the need for the consideration of sub-clinical forms of war and trauma-associated disabilities, as patterns of functional impairment are even present in RAS without a clinical diagnosis of a mental health disorder. - E.g. Post-migration living difficulties was associated with worse functioning in 'cognition' ($p = 0.003$). Traumatic life events seemed to have heterogeneous effects on psychological functioning. While 'violence and abuse' (HTQ I factor 2) was significantly associated with impairment in 'participation' ($p = 0.007$).

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Table 3. Maternity care and women's health needs of asylum seekers

Reference, title, publication type, country	Summary	Method and participants	Needs identified (including barriers, if reported)
Firth et al. (2022) Perinatal Depression: Factors Affecting Help-Seeking Behaviours in Asylum Seeking and Refugee Women. A Systematic Review (Journal of Migration and Health) Systematic review of international studies including the UK.	Perinatal depression is one of the most commonly diagnosed mental health conditions in the general maternity population but whilst the prevalence is thought to be much higher in asylum seeking and refugee (AS&R) women, it is less frequently identified and diagnosed by health care professionals.	Systematic review.	<ul style="list-style-type: none"> - Frequently, women did not recognise Western symptoms of depression and were more likely to describe their feelings as boredom, tiredness or somatically as aches and pains which was a barrier to help-seeking. - Cultural influences on migrant women's mental health are not fully recognised by clinicians, who have a tendency to trivialise, dismiss or pathologise traditional and cultural practices
Sturrock et al. (2021) Antenatal Care and Perinatal Outcomes of Asylum Seeking Women and their Infants (Journal of Perinatal Medicine)	Asylum seekers have been highlighted as a particularly vulnerable group of expectant mothers due to complex medical and psychosocial needs, as well as the difficulties they may face in accessing care. Our aim was to examine if there were differences in the antenatal care and perinatal outcomes for	Quantitative analysis of electronic patients records of 34 asylum-seeking women were identified who had term born	<ul style="list-style-type: none"> - The increased postnatal length of stay in the infants of asylum seeking mothers may reflect their mother's reduced antenatal care and hence insufficient discharge planning for mothers and infants with increased social needs. - The median number of antenatal ultrasound examinations at the delivering hospital amongst asylum-seeking women was one (IQR 1–2), whereas the median number amongst the controls was three (IQR 3–4, $p < 0.0001$).

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Quantitative study in a UK hospital setting.	asylum seeking women when compared to age- and ethnicity-matched controls delivering at the same hospital.	infants (and controls).	<ul style="list-style-type: none"> - Asylum-seeking women had fewer booking bloods taken at their delivering hospital (84.4%) compared to 98.4% of controls (p=0.002). - The median number of antenatal care episodes at the delivering hospital (including clinic and community midwifery contacts) was significantly fewer amongst asylum-seeking women compared to controls (3 vs. 9, p<0.0001). - Less than one in five asylum-seeking women (18.8%) met the WHO recommendation of eight antenatal visits (at the delivering hospital), compared to 70% of the controls. - Two-thirds of asylum-seeking women were identified as requiring an interpreter, but only 15% of these women had an interpreter used at their appointments. - The proportions who had pregnancy complications were similar in asylum seeking women and controls (p=0.245). - The median estimated cost of all antenatal care recorded was £1,566.68 for the asylum-seeking group, significantly lower than the median of £4,700.04 for the control group (p=0.002). - There was no significant difference in the median (IQR) estimated cost of delivery between the two groups.
Turner and Tancred (2023) Maternity Care Provision for Women Living with Female Genital Mutilation/Cutting: A Qualitative Study from a High Asylum-Seeking Dispersal Context in the		Qualitative, semi-structured interviews with 13 practicing midwives and an obstetrician/gynaecologist with experience of working with FGM/C.	<ul style="list-style-type: none"> - Participants indicated that there was inconsistent identification or disclosure of FGM/C, constraining appropriate follow-up and care prior to labour and childbirth. Traumatic experiences are a reality if FGM/C is not identified or disclosed before delivery. - Most participants were aware that a cultural barrier exists between themselves and women living with FGM/C, given the nature of the practice being potentially normalised in other communities or countries of origin, yet being illegal in the UK. This barrier was perceived to work both ways, with midwives sometimes being very uncomfortable with the topic, and patients being wary of discussing it.

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UK (International Journal of Health Planning & Management) Qualitative study conducted in the UK.			<ul style="list-style-type: none"> - The ability of asylum-seeking women to fully participate in the patient-provider relationship is made complex by the disruptive nature of the Home Office dispersal policy, whereby individuals and families are moved around the UK at various points in the asylum process. Reference was repeatedly made to the impact dispersal has for asylum-seeking women living with FGM/C in accessing care, and also on their continuity of care. - Participants recognised that training for FGM/C was often piecemeal or totally absent.
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Table 4. Health needs of asylum seekers – communicable diseases

Reference, title, publication type, country	Summary	Method and participants	Needs identified (including barriers, if reported)
Taha, Durham and Reid (2022) Communicable Disease Prevalence among Refugees and Asylum Seekers: Systematic Review and Meta-Analysis (Infectious Disease Reports) Systematic review and meta-analysis of international studies including England.	There is a need for broad screening campaigns amongst asylum seekers and refugees.	Systematic review and meta-analysis.	<ul style="list-style-type: none"> - Estimate: 72% of new TB cases in England are amongst asylum seekers and refugees. - TB is the most common communicable disease amongst asylum seekers and refugees, but could this be due to screening for TB? - The epidemiology of HIV is variable within the countries and regions of origin for asylum seekers and refugees. - Heterogeneity of data may be explained by variable prevalence of communicable disease in different countries of origin.

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<p>Stinchcombe et al. (2023)</p> <p>Communicable disease among migrant children and young people (CYP): results from a systematic review on health outcomes among migrant CYP (Archives of Disease in Childhood)</p> <p>Systematic review of international studies including the UK.</p>	<p>Results suggest a disproportionate burden of communicable diseases among migrant CYP, particularly those migrating from Africa.</p>	<p>Systematic review.</p>	<ul style="list-style-type: none"> - 47.6% of migrant CYP had one parasitic infection. - 20% of migrant CYP had multiple parasitic infections. - TB incidence is higher amongst CYP migrating from Africa than host populations.
<p>O'Boyle et al. (2023)</p> <p>National public health response to an outbreak of toxigenic <i>Corynebacterium diphtheriae</i> among asylum seekers in England, 2022: a descriptive epidemiological study (The Lancet Public Health)</p>	<p>Long-term disruption to vaccination programmes in origin countries along with barriers to accessing health care along migrant routes puts asylum seekers arriving by small boats at risk of disease.</p>	<p>Descriptive epidemiological study of an increase in diphtheria cases caused by toxigenic <i>C diphtheriae</i> among asylum seekers arriving by small boats to England.</p>	<ul style="list-style-type: none"> - Migrants are under-immunised, and therefore at high-risk of vaccine-preventable disease. This risk is particularly prominent along the migratory route, where there is limited access to healthcare. - It is important to clinically assess, then provide antibiotics and/or vaccination in a timely manner in high-volume migrant reception centres. This need is made more pressing by the reduced ability to undertake individual-level case management and contact tracing in migration centres. - There is a need for regional collaboration to reduce transmission along migrant routes in Europe.

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<p>Descriptive epidemiological study.</p> <p>Zenner et al. (2023)</p> <p>Drivers determining tuberculosis disease screening yield in four European screening programmes: a comparative analysis (European Respiratory Journal)</p> <p>Quantitative study.</p>	<p>TB risk among asylum seekers from high-incidence countries of origin was less dependent on the country of origin.</p>	<p>Individual-level data from four European TB screening programmes pooled in a multicountry database. Univariable and multivariable logistic regression analyses to determine the effect of individual-level (e.g. demographic) and programme-level exposure variables on TB yield.</p>	<ul style="list-style-type: none"> - Age, male sex, screening period and having been a contact to a TB case are important risk factors for TB, and demonstrated increasing TB risk with increasing incidence in the country of origin. - Country of origin-independent risk among asylum seekers is likely related to unknown or unmeasured cofactors and could relate to specific circumstances asylum seekers face during their journeys or on arrival, rather than a reflection of background TB incidence in their country of origin. - The TB risk enroute raises important considerations well beyond the central Mediterranean route.
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Table 5. Health needs of asylum seekers – chronic conditions

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Reference, title, publication type, country	Summary	Method and participants	Needs identified (including barriers, if reported)
Buford et al. (2022) Systematic review of electronic health records to manage chronic conditions among displaced populations (BMJ Open) Systematic review of international studies including the UK.	Well-designed and integrated electronic health records can be a powerful tool to improve healthcare systems and chronic disease outcomes in refugee settings.	Systematic review.	- Electronic Health Records (EHR) can improve chronic disease outcomes and enhance healthcare systems in refugee and asylum seeker settings
Al-Rousan et al. (2022) Epidemiology of cardiovascular disease and its risk factors among refugees and asylum seekers: Systematic review and meta-analysis (International Journal of Cardiology Cardiovascular Risk Prevention)	Results suggest that the migratory journey is an independent risk factor for cardiovascular disease amongst refugees and asylum seekers.	Systematic review.	- The results of a random-effects meta-analysis (heterogeneity I ² 97.8%) showed the RR of cardiovascular disease to be 1.71 (95% CI 1.03 - 2.83), where primary outcome was CVD incidence (including both fatal and non-fatal outcomes as a composite of difference CVD outcomes).

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Systematic review and meta-analysis of international studies including the UK.			
Zinah and Al-Ibrahim (2021) Oral Health Problems Facing Refugees in Europe: A Scoping Review (BMC Public Health) Scoping review of European studies including the UK.	Europe has been experiencing a flow of refugees and asylum seekers driven by conflicts or poverty. Their oral health is often neglected despite its clear impact on quality of life.	Scoping review.	- Limited access to oral health care services was shown with a higher prevalence of oral diseases compared to the native populations of the host countries.

Table 6. Barriers to accessing health services and effective healthcare provision (all health domains).

Reference, title, publication type, country	Summary	Method and participants	Barriers and facilitators
Khanom et al. (2021) Asylum seekers' and refugees' experiences of accessing health care: a qualitative study (BJGP Open)	Most ASRs understood the role of general practice in providing and coordinating care but were unaware of out-of-hours services. Some feared seeking support for mental health from their GP, and few were aware they had the right to move practice if they were unhappy.	Eight focus groups were undertaken with ASRs, support workers, and volunteers (n = 57); including 26	<ul style="list-style-type: none"> - Language difficulties, - Access to competent interpretation service, - Health literacy, - Unrecognised needs, - Cost of travel to appointments, but - Remote GP consulting may increase health inequality by reducing access to interpreters with the added barrier of digital poverty.

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Qualitative study conducted in Wales.		asylum seekers.	Recommendations: <ul style="list-style-type: none"> - Education about entitlements targeted at both ASRs and health providers at all levels, in particular the legal entitlement to interpretation services, - Offer access to interpreters in situations where mental health care is sought.
Scott, Forde and Wedderburn (2021) Refugee, Migrant and Asylum Seekers' Experience of Accessing and Receiving Primary Healthcare in a UK City of Sanctuary. (Journal of Immigrant and Minority Health) Quantitative and qualitative questionnaire study conducted in England.	This study highlights patchy experience of primary care, even in a region of the UK designated as a 'City of Sanctuary' (Bournemouth, Christchurch and Poole) for people seeking refuge.	A questionnaire study explored the views of asylum seekers and vulnerable migrants (AMRs) and third sector workers (TSWs) supporting them. 22 adult AMRs and 10 TSWs were recruited through The Red Cross and International Care Network (ICN).	<ul style="list-style-type: none"> - Third sector workers (70%) reported difficulties in registering clients with a GP. The reasons included surgeries asking for proof of ID/address when none was available (40%), language barriers (20%) and practices not being aware of entitlements to care (20%). - Lack of understanding the rights to care for asylum seekers among health workers. - Language barriers.
Paisi et al. (2022) Factors affecting oral health care for	This qualitative study investigated factors influencing oral health behaviours and access to dental services for	Twelve participants providing support to	<ul style="list-style-type: none"> - Asylum seekers' and refugees' oral health care barriers were: prioritising safety and survival; variations in cultural norms and practice; lack of knowledge about dental care; financial hardship and affordability of care; a

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asylum seekers and refugees in England: a qualitative study of key stakeholders' perspectives and experiences. (British Dental Journal) Qualitative study conducted in England.	asylum seekers and refugees (ASRs) and highlights equitable access to health services and appropriate language support for this population group.	asylum seekers and refugees in various capacities participated in semi-structured interviews.	<ul style="list-style-type: none"> - gulf of understanding of what dental care would be like and experiences of it; and structures of dental services that leave vulnerable groups behind - Opportunities for improving oral health care were: accessible oral health education; partnership working and creating supportive environments; translation; providing culturally sensitive and person-centred care; and incorporating ASRs' views into service design.
Nowak, Namer and Hornberg (2022) Health Care for Refugees in Europe: A Scoping Review. (International Journal of Environmental Research and Public Health) Scoping review of European studies including the UK.	Accessing and using health care in European countries pose major challenges for asylum seekers and refugees due to legal, linguistic, administrative, and knowledge barriers. In addition to removing legal, linguistic, formal, and organisation barriers, the living conditions of refugees should be given greater consideration in the provision of care. On the one hand, they influence the development of health and illness directly. On the other hand, an improvement in living conditions and liberation from dependencies ca	Scoping review.	<ul style="list-style-type: none"> - The qualitative results suggest that too little attention is paid to the living situations of refugees. This is especially true in access to care, and in the doctor-patient interaction. This can lead to a gap between needs and care. - Living conditions are a key determinant for accessing health care. - Language challenges. - Health care is not used because participants are afraid of consequences to their legal status - Societal conditions lead to experiences of hostility in health care through which refugees experience themselves as a "burden" for the system - Perceived excessive medicalisation detrimental because life experiences of asylum seekers are not sufficiently acknowledged in the health care system.
Isaacs et al. (2022)	This paper presents an analysis of the ways in which the UK asylum and immigration system	24 semi-structured interviews	<ul style="list-style-type: none"> - In high-income countries, the dominant health discourses assert that, to be healthy requires individuals to take an active role in their health. Asylum seekers, however, have

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<p>'I don't think there's anything I can do which can keep me healthy': how the UK immigration and asylum system shapes the health & wellbeing of refugees and asylum seekers in Scotland (Critical Public Health)</p> <p>Qualitative study conducted in Scotland.</p>	<p>places ASRs in spaces of risk for poor long-term health and chronic illness. The asylum system had a profound impact, both directly, and by compounding other structural influences to diminish agency at a psychological level (e.g., through placing individuals in limbo, casting them as the subject of suspicion), and also at a resource level (e.g., through enforced poverty). Even seemingly cost neutral health-promoting activities, such as walking, carry a burden of visibility which can lead to experiences of racism and discrimination.</p>	<p>were conducted with ASRs from Sub-Saharan Africa</p>	<p>no control over their futures. This leads to a tension between health promotion, which emphasises individual agency, and a legal status that diminishes that agency. The result is an existence where individuals have limited control of their personal circumstances, little idea of what may happen to them and when, severely constrained access to resources, and where they are the subject of suspicion and racial discrimination.</p>
<p>Asif and Kienzler (2022)</p> <p>Structural barriers to refugee, asylum seeker and undocumented migrant healthcare access. Perceptions of Doctors of the World caseworkers in the UK. (SSM – Mental Health)</p>	<p>This article contributes new insights into how refugees, asylum seekers and undocumented migrants experience access to healthcare in the UK from both the perspective of caseworker volunteers and the assessment of policy regulations that influence such experiences.</p>	<p>6 qualitative interviews conducted with Doctors of the World caseworkers and Freedom of Information documents from NHS trusts.</p>	<ul style="list-style-type: none"> - Barriers include changing regulations, the refusal to register patients at GP practices without proof of ID, language barriers and complications navigating the healthcare system, including discriminatory policies, racism and exclusion. - Facilitators include providing meaningful and culturally sensitive healthcare and social support

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<p>Qualitative study and document analysis conducted in England.</p>			
<p>Ginsberg et al. (2023)</p> <p>Self-reported priorities of asylum-seeking families around health services in the UK and perceived barriers to accessing these. (Archives of Disease in Childhood)</p> <p>Questionnaire study conducted in England.</p>	<p>This study aimed to explore the aspects of care most important to asylum seeker and refugee families, barriers that may prevent them from accessing these services and features of care which influence positive and negative experience.</p>	<p>Families attending Asylum Seeker-Refugee (AS-R) Family Clinic at University College London Hospital were invited to participate. 27 respondents. Of these, 16 (59.2%) were fathers and the rest mothers.</p>	<ul style="list-style-type: none"> - Dental services, general practice, and vaccination clinics were the most reported as 'very important' by 25 (92.5%), 25 (92.5%) and 24 (88.9%), respectively. - Mental health, growth and development services were also all perceived as 'very important' by 16 (59.2%) respondents. - The majority of parents agreed language barrier (18 (66.7%)) and temporary nature of accommodation (14 (53.8%)) were barriers to accessing services. - All 27 respondents (100%) reported willingness to access routine vaccinations, though two (14.8%) reported they didn't know how to access them. - Being unable to get GP appointments, register at dental practices, and lack of tailored advice for refugee families were also mentioned in free-text answers as barriers to accessing care. - Families reported the importance of approachability of staff as a facilitator to accessing health services.
<p>Clark et al. (2022)</p> <p>Quantifying the health needs of migrants in vulnerable circumstances registered with a nurse-led primary</p>	<p>Those seeking asylum face adversity before, during and after arrival in the UK, resulting in complex health and social needs. The study setting was a nurse-led asylum seeker service in a dispersal city, commissioned to provide an initial health assessment,</p>	<p>80 electronic records of asylum seekers were reviewed by seven auditors to analyse documentation of</p>	<p>Needs</p> <ul style="list-style-type: none"> - High prevalence of mental health conditions (five times the general population of the UK) and especially depression, anxiety and PTSD, and trauma - Long term physical health problems, mainly musculoskeletal problems, - Infectious diseases (mostly latent TB).

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care service (Journal of Research in Nursing) Health records review – quantitative and qualitative data – conducted in England.	immunisations and support to register with a general practitioner.	demographics , asylum status, service use, barriers to care, physical and mental health.	Barriers - Administrative issues (i.e. being refused access for not having proof of address or ID, lack of understanding of the healthcare system). - Language barriers.
Gordon, Crenstil and Mamluk (2023) Attitude and experiences of asylum seekers and refugees to the COVID-19 vaccination: a qualitative study (BJGP Open) Qualitative study conducted in Bristol, UK.	Fear, trauma, and isolation propagated by systemic issues are primary factors impacting healthcare decision making, and standard approaches to increasing vaccination uptake must be reconsidered in light of these issues.	Semi-structured interviews were conducted with 12 asylum seekers or refugees in Bristol attending one of three non-governmental organisations (NGOs) providing education, community support, or food.	- Factors increasing uptake of COVID-19 vaccination: sense of social responsibility in community, good/accessible information, desperation to escape lockdown, trusting relationship with GP, NGOs assisting with access to healthcare, sense of community, fear of COVID-19 greater than fear of vaccination. - Barriers to COVID-19 vaccination: systemic asylum system issues, misinformation, poor mental health, trauma and bereavement overseas, perceived poor access to care, social isolation, fear of vaccination greater than fear of COVID-19.
Abraham et al. (2023)	The aim of this pilot project is to assess and overcome potential barriers to implementation of BBV screening and linkage to	Pilot project to optimise test and treat pathways for	- Cases are identified by opportunistic screening amongst populations with high prevalence of BBV. Patients consented to screening if agreement was reached that every effort would be made to delay the transfer of

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Improving blood borne virus screening in immigration removal centres in the UK (Journal of Hepatology) Pilot project, London, UK.	care in immigration removal centres.	new immigration removal centre admissions.	residents if diagnosed, an issue that has previously been a barrier to screening		
Deal et al. (2023) Defining drivers of under-immunization and vaccine hesitancy in refugee and migrant populations (Journal of Travel Medicine) Rapid review of international studies including the UK.	A range of factors driving under-immunization and hesitancy in refugee and migrant groups, including unique awareness and access factors that need to be better considered in policy and service delivery. Acceptability of vaccination was often deeply rooted in social and historical context and influenced by personal risk perception.	Rapid review.	Drivers of under-immunisation and vaccine hesitancy:		Solutions and strategies:
			Personal factors	Fears of side effects, vaccine safety or low efficacy.	Research community-specific fears to tailor information campaigns.
				Lack of trust in vaccines, healthcare, or institutions.	Co-design of services and information campaigns with NGOs.
				Risk perception: preference for 'natural' options.	Education and outreach.
				Bad previous experience with vaccines or HCWs.	Training HCW on health needs and eligibility.
				Low awareness of vaccine preventable disease.	Education and outreach.
				Low digital or health literacy.	Information in multiple formats.
Physical	Actual and perceived eligibility to access.	Innovative access points.			
Direct and indirect costs.	Financial incentives. Outreach campaigns. Minimal data				

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			Access point: inconvenient, untrusted or non-existent. Lack of proactivity to reach migrant groups.	collection. Remove policies restricting access.	
			Social processes	Circulating misinformation.	
				Institutional racism and structural inequalities.	Research and counter misinformation. Remove policies restricting access.
				Views on vaccines or trust in institutions in home country.	Accessible information in relevant languages.
				HCW low knowledge of migrant health care needs.	Increased training for HCW.
Menezes et al. (2022) Country differences and determinants of yield in programmatic migrant TB screening in four European countries (The International Journal of Tuberculosis and Lung Disease) Quantitative study of European data including the UK.	Explored programme- and individual-level variations regarding TB screening yield in four important European migrant screening programmes.	Analysis of pooled individual TB screening data from multiple European nations.	- Significant variability of these programmes in location and time, leading to highly variable outcomes only partly explained by the demographics of the screened population.		

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Eisen, Williams and Cohen (2023) Infections in Asymptomatic Unaccompanied Asylum-seeking Children in London 2016-2022 (The Pediatric Infectious Disease Journal) Quantitative analysis of administrative and health data from London, UK.	The data supports recommendations for routine screening of asymptomatic unaccompanied asylum-seeking children.	Retrospective analysis of routinely collected data from all unaccompanied asylum-seeking children seen in 3 services in London, UK.	- Infections identified in unaccompanied children in London, UK identified cases of TB, schistosomiasis, hepatitis B, giardia, tapeworm, hookworm, and strongyloides.	
Palattiyil and Sidhva (2021) HIV, Human Rights and Migration: Narratives of HIV-Positive Asylum Seekers in Scotland (Journal of Human Rights and Social Work) Qualitative study in the UK (Glasgow, Scotland).	Barriers to HIV treatment for asylum seekers in Scotland include poverty, inequality, stigma and discrimination.	Open-ended in-depth interviews and two focus groups were held with 19 Black African asylum seekers living with HIV in Glasgow, Scotland.	- Asylum seekers are being moved to alternative accommodation without chance to collect their medication to take with them. - All asylum seekers living with HIV in this study had faced significant housing and financial difficulties, stigma and discrimination, with some assuming the role of a fugitive because they had no place to stay. - The narratives of HIV-positive asylum seekers in this study clearly portrayed a life that is "profoundly degrading and dehumanising".	

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<p>Cinardo et al. (2022)</p> <p>Screening for neglected tropical diseases and other infections in refugee and asylum-seeker populations in the United Kingdom (Therapeutic Advances in Infectious Disease)</p> <p>Systematic review of UK studies.</p>	<p>There is a heterogeneous approach to screening practices in the United Kingdom.</p>	<p>Systematic review.</p>	<ul style="list-style-type: none"> - There is some evidence for screening for schistosomiasis, strongyloidiasis and soil-transmitted helminths. - Chagas disease is therefore a good example of how a comprehensive screening programme for Latinx, improved education for healthcare providers as well as raised awareness in the community would be beneficial both for the individual and as a public health intervention.
<p>Deal et al. (2024)</p> <p>Understanding the views of adult migrants around catch-up vaccination for missed routine immunisations to define strategies to improve coverage: a UK in-depth study (Vaccine)</p> <p>Qualitative study conducted in the UK.</p>	<p>The major barrier to adult catch-up vaccination for missed routine immunisations and doses in migrant communities in the UK is the limited opportunities, recommendations or tailored vaccination information presented to migrants by health services.</p>	<p>In-depth semi-structured interview with migrants (this term includes asylum seekers). There was a focus on migrants from Congo and Angola. Results analysed using a thematic framework.</p>	<p>Multiple barriers to effective catch-up vaccination were identified:</p> <ul style="list-style-type: none"> - Uncertainty of vaccine history. - Vaccination being associated with fear or pain. - Nations of origin enforcing vaccination, casting them in a negative light. - Vaccination history not being asked, and not being offered vaccination, since arrival in the UK. - Language barriers. - Financial constraints. - Concerns about side effects or perceived risks. - A sense of "vaccine fatigue" post-COVID-19. - Lack of trust in healthcare professionals.

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Appendix 1: Methodology and grey literature

Criteria for considering studies for this review

Population: Adult asylum seekers in the UK.

Intervention: None.

Comparison: No intervention/other interventions.

Outcomes: health (physical, mental), healthcare access and barriers.

Study types: Policy documents, reports, systematic reviews, primary studies from the UK

Years: 2022 onwards.

2024-04 Asylum seekers – grey literature search

Grey literature search strategy:

Websites of bodies listed below (see also information on websites checked but not producing relevant results at the end of sections)

Google Advanced searches, keywords included:

- "asylum seekers", health
- Also tried limiting to PDFs to try to locate reports.
- And also tried combining keywords with string of Scottish Health Boards
- "NHS Ayrshire" OR NHSGGC OR "NHS Greater Glasgow" OR "NHS Grampian" OR "NHS Lothian" OR "NHS Dumfries and Galloway" OR "NHS Fife" OR "NHS Western Isles" OR "NHS Forth Valley" OR "NHS Highland" OR "NHS Orkney" OR "NHS Lanarkshire" OR "NHS Shetland" OR "NHS Tayside"

Other resources: Tripdatabase.com, Google Scholar (for working papers – "asylum seekers" and health and (Scotland OR UK)

Search terms

Search terms for the database search are included in Appendix 2.

Limits

Retrieval was limited to publications available in the English language.

Selection of articles

Searches, deduplication and initial screening was carried out by LM. Titles and abstracts were screened by LR. Full texts of potentially relevant articles were retrieved by LM and assessed for inclusion by LR.

Data extraction

One reviewer (LR) extracted data using a structured data extraction tool.

Appendix 2: Database search terms

2024-04 Asylum seekers – databases, search strategy

Databases searched:

Medline, Embase, PsycINFO, Amed, MIDIRS, Health Management Information Consortium (HMIC), Social Policy and Practice, CINAHL, Proquest Public Health, Proquest Sociology Collection

Limits – English language, 2021-, NICE validated filter for the UK used [lines 10-17 below]

Sample search - Medline (adapted for other databases):

1. (asylum adj4 seek*).mp.
2. (asylum adj4 sought).mp.
3. (asylum adj4 application*).mp.
4. (asylum adj4 applicant*).mp.
5. asylumseek*.mp.
6. 1 or 2 or 3 or 4 or 5
7. limit 6 to english language
8. limit 7 to yr="2021 -Current"
9. remove duplicates from 8
10. exp united kingdom/ or exp england/ or northern ireland/ or exp scotland/ or wales/
11. (national health service* or nhs*).ti,ab,in.
12. (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab.
13. (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in.
14. (bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worchester not

(massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in.

15. (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.

16. (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.

17. (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in.

18. bibby stockholm.mp.

19. or/10-18

20. 9 and 19

Appendix 4: Qualitative analysis of health and wellbeing needs

Synthesis of qualitative information on asylum seekers' health and wellbeing needs

Background

Understanding the health-related needs of asylum seekers and designing, delivering and improving services is key to a safe response. To support this, the Public Health Asylum Seeker Working Group is conducting a needs assessment to improve understanding of the health and care needs of asylum seekers living in hotels. So far this has comprised a systematic literature review, a rapid evidence review, analysis of system data and qualitative work with health and social care staff and primary care staff who work with asylum seekers.

This document reports on the qualitative work to identify themes around health needs, challenges and enablers to accessing care.

Aim: To better understand the health and care needs of asylum seekers living in hotels

Methods:

Semi-structured interviews were conducted in January-February 2024 with: 3 Health Assessment Team leads, 4 Care Navigators, 1 Resettlement Manager, 2 GPs, 2 Pharmacists and 1 DIAL coordinator.

Information was gathered on

- the health-related needs of current asylum seeker population
- the experience of asylum seekers and staff navigating the system
- the barriers/facilitators to addressing needs

Transcripts were analysed for emerging themes.

Results

The main themes identified are listed in Table 1 and explored in more detail in the Appendix.

Conclusion

The findings will be considered along with the other elements of the needs assessment by the Public Health Asylum Seekers Working Group and discussions will take place about how the public health directorate can enact solutions to meet the needs identified.

Table 1: Thematic analysis of interview responses

Areas of Interest	Main Themes	Sub-Themes
Health & Wellbeing Needs	Mental Health	Living circumstances Isolation Lack of transport 'Nothing for them here' Transience of population Asylum process Mental Health support
	Dental	Dental support
Challenges to Accessing Support	Language Barriers GP Registration	Capacity Funding Assumptions about asylum seekers Delays / Inaccurate personal details
	Understanding of System	Waiting times DNAs Inappropriate requests Cultural understanding
	Transience of population Lack of Funding	Mears understaffed Health assessment team Transport
	Communication	Communication between teams Understanding of service providers
Enablers to Accessing Support	Health Assessment Team	Health assessments Referral to appropriate care Direct support to access services Indirect support - life skills Advocacy Understanding-supporting-valuing
	Partnership Working Language Support Community Support	As above (MH support, Dental support, Other services, Communication)
Improvement Ideas	Dedicated asylum seeker clinic	

Appendix – Detailed findings¹

Health & Wellbeing Needs

MENTAL HEALTH

The strongest health and wellbeing need identified by participants was mental health, mostly (anxiety and depression) arising from recent experiences in the country they left, during their travels and since arrival in the UK. Many asylum seekers are escaping persecution and bad treatment and some have taken years to make the journey, including one who was caught in modern slavery and others who were sexually assaulted. Although they know that Scotland is relatively safe, it is taking them time to feel they are safe and to recover from these experiences.

Many aspects of their life in Scotland may contribute to poor mental health:

Living circumstances

Any existing tensions can be heightened by living in a small community and this is likely to intensify with the recent maximisation policy, meaning that residents may be forced to share rooms. Problems with the hotel infrastructure (e.g. poor WiFi, lack of hot water and heating) along with unfamiliar food can increase the sense of isolation and disconnection. Poor weather has also impacted on mobility and social activities.

Isolation

Most residents are separated from their communities, friends and family, even those who have family and friends in other parts of UK. There is also a sense of being separate from local communities and services, which is exacerbated by difficulty in getting mobile phones, for which they rely on charities. Even when they do have phones, often contact information along with possessions of sentimental value have been lost on the journey.

Lack of transport

There is no funding for travel to social and educational activities, and a return bus ticket from the Aberdeenshire hotel to the centre of Aberdeen costs nearly a resident's full weekly allowance of approximately £9. From April, residents were meant to have free bus passes but this change has not been implemented. They have access to bikes, but there have been accidents, and these are not suitable for all.

'Nothing for them here'

It has been a challenge for residents to fill their time, and even when Mears have organised indoor activities and games not everyone wants to be involved. There is no access to the fully-equipped gym in the Aberdeenshire hotel due to lack of staff, despite repeated requests from residents.

Transience of population

Particularly for the residents in Moray, they know they'll not be staying in the area long-term, and there are fears about unexpected relocation, creating a sense of instability.

Asylum process

The asylum system is a constant stressor and exacerbates existing problems. There is lack of control, lack of information and lack of consideration. Residents and staff alike feel powerless to improve the process and feel 'caught in a system that is designed to be cruel.' Unable to work, there is always uncertainty about the future.

¹ Note: for brevity direct quotes have been assimilated into the text

Mental Health support

Easily accessible community mental health services have been much appreciated by the hotel teams and well used by residents. In Aberdeenshire a pilot mental health and wellbeing improvement service would offer an initial assessment followed by 6 weekly sessions. In Aberdeen a mental health practitioner was supporting residents at the end of last year and took direct referrals from the Health Assessment Team. It is not known whether these services have continued or been replaced. In Moray local mental health and well-being practitioners are available for talking therapy and support. In each area, link workers and health and well-being practitioners are able to help with lifestyle advice to support mental health.

A few of the residents have been referred to Cornhill for assessment and treatment and a few have seen GPs about mental health issues. Some join the existing waiting lists for treatment, but this is unlikely to be provided until they are in more permanent accommodation. One participant noted that a mental health professional had indicated there was "no point in working with existing trauma until the residents have moved to their permanent residence because they're not ready to deal with it until they're settled." So day-to-day mental health support is all that is available to many, such as signposting to sports centres and other activities. "To enable them to cope with their lives by keeping busy."

In Moray specialist services are mainly limited to emergency care due to a lack of psychiatrists. Residents may be referred for e.g. specialised trauma counselling but will remain on the waiting list until problems become more significant.

One respondent suggested there may be a perception among residents that being on medication can be helpful for their asylum claims. Also, a perception was noted that a letter from a GP would mean a resident could avoid having to share a room under the maximisation policy (rarely accepted by Home Office).

DENTAL

Dental health was the second most-mentioned health issue with one care navigator estimating that over half of residents required attention. This is partly due to the lack of care that has been taken with teeth during long journeys, resulting in cavities and abscesses.

Dental support

For emergency treatment DIAL is able to refer residents and have developed a form for care navigators to complete that includes information on language support. DIAL operators contact the residents directly to assess and arrange treatment. (Recent figures: 30 interactions in January, 18 in February.)

For non-emergency/regular care and check-ups, access is more difficult. For example dentists near the Aberdeenshire hotel are closed for NHS registration, so residents need to travel to Aberdeen or Stonehaven.

OTHER

The current asylum seeker adult population are aged between 18 and mid-fifties and are generally in reasonable physical health. In addition to the usual ailments linked to ageing (diabetes, heart) and pain (head/ear, muscular), other health conditions mentioned included: skin conditions (fungal infection, eczema, psoriasis, stress reactions, vascular), foot and leg problems linked to travel, chronic pain from existing injuries, smoking cessation/patches which may be linked to inability to afford cigarettes and constipation possibly linked to diet.

Other services

Funding has been found for GPs, even though asylum seekers come with no health funding, practices are given an amount per patient contact in acknowledgement of the increased

workload. GPs will often provide double appointments as needed e.g. complex condition; lack of medical history. A dedicated asylum seeking clinic was operating out of Marywell Healthcare Centre in Aberdeen during 2023, but its future is uncertain.

Pharmacies, physios and opticians are also available as part of the primary care team. Residents do not often present to ED in Moray, which may be linked to the clinical advice available from the team there. The situation at ED in Aberdeen is still to be reviewed.

It is difficult to assess how well needs are being met once residents engage with services as these are confidential, although care navigators reported getting feedback if residents did not feel they got what they needed.

Challenges to Accessing Support

The most frequently mentioned challenges to accessing support were language barriers, difficulties around GP registration, residents' limited understanding of the system and society, lack of funding to the teams directly working with asylum seekers and the transience of the asylum seeking population. Other factors included transport and communication with primary care providers.

LANGUAGE BARRIERS

Limitation in their understanding of English underlies many of the challenges to accessing support encountered by residents. It adds a layer of complexity to communication with service providers, the Health Assessment Team (HAT) and the general public. It also means their awareness of opportunities is reduced and it makes their world smaller.

There is potential for misunderstanding that can lead to difficulties and frustration on both sides. Because residents don't have family or friends, services need to recognise this and reconsider how they usually manage patients with limited English. With an interpreter double-time appointments are usually needed and most providers are open to this.

Although Language Line is available to all primary care providers, not all are aware of this and it may not always be practical to use, in, for example, a busy single-handed pharmacy. While Language Line generally works well, it is not always possible to access an interpreter in the required language and sometimes there isn't even a common language that can be used instead. There are instances of interpreters ending a call because they can't hear properly and providers having to start the process again as a result. Also there may be significant waiting times for an interpreter, particularly with less common languages.

Google Translate is being used in some circumstances, which isn't recommended for use by health services, but is a pragmatic choice. Locally in Aberdeenshire, there is no English tuition available to asylum seekers, while in Moray, the Resettlement team are engaging volunteers to teach residents.

GP REGISTRATION

Registration with a GP is the gateway to most health care services and has been a priority for the HAT. Although Mears are responsible for the registrations, in Aberdeenshire the health team stepped in and took on the task of registering residents when Mears staff were unable to complete the forms with sufficient speed and accuracy.

Capacity

In Aberdeen and Moray, many general practices are at full capacity and closed to new patients, but even some open practices initially refused to accept asylum seekers. The HAT had to resort to using temporary registration for those with immediate health concerns.

Funding

There has been no funding linked to asylum seekers' health available from the Government. Practices now receive funding to register asylum seekers from local sources and residents are allocated to practices. This in turn means that sometimes the health team try to reduce costs by waiting to register residents until there is a health need rather than automatically registering every one.

Assumptions about asylum seekers

When trying to book appointments the HAT often come across the idea that all residents will be time-consuming and complicated and found it difficult to overcome this assumption. Often they do need a double appointment and Language Line support and there have been instances of push-back and reluctance to make a booking. In such cases, meeting individuals face-to-face usually helps to soften attitudes along with evidence from the Marywell dedicated clinic of appointments averaging only 30 minutes.

Inaccurate personal details

Mears are responsible for GP registrations, and early on often supplied inaccurate personal details to practices resulting in the need to re-register which was frustrating for the practice, the health team, the residents and practitioner services who would need to reissue CHIs (Aberdeenshire). Eventually the GP practice refused to take any more residents unless there was a proof of ID, which could prove a challenge to provide and delay care.

UNDERSTANDING OF SYSTEM

Linked to language limitations are challenges arising from limitations in residents' understanding of the health and care system, and of the wider society in Scotland. It is difficult for residents to learn about how things work informally because they don't have the opportunity to watch other members of the local community and they don't have support from their own family. One respondent mentioned that they also may be vulnerable to trafficking and illegal work due to low remuneration and low education/literacy levels.

There have been challenges with residents not understanding how to access services, what services offer and how they differ e.g. what is available free from Pharmacy First; the requirement to get a GP prescription for medicines before collecting from the pharmacy.

Waiting times

Often residents' are used to an 'on-demand' system in their countries of origin; when they need to see a doctor then they go and have immediate access, so are not used to waiting a few days or weeks for an appointment. This unfamiliarity has proved quite problematic at times. Also attending late for appointments has been an issue.

DNAs

Residents failing to attend for health-related appointments has been a common problem, especially early in the day. This is particularly problematic for the practices and services when longer appointment slots have been given. Follow up of DNAs is a clinical decision and often no feedback has been given to HAT unless there are a large number occurring at one time.

Inappropriate requests

A few of the expectations mentioned: remedies for hair loss and sleeping tablets were common concerns seen by one pharmacist, also tooth whitening and toothpaste on the free Pharmacy First service. Teeth cleaning and cosmetic orthodontic work (DIAL) Medication may be seen to be helpful for asylum claims rather than lifestyle changes (above under MH).

Cultural understanding

One GP mentioned concerns about the approach of a couple of residents who wanted to see male staff in preference to female and for those staff to also be doctors rather than one of the

wider team. The encounter was upsetting for the staff involved and the practice spent some time explaining the staff roles and hope it has been resolved and the residents have a better understanding. This lack of understanding can sometimes lead to frustrations and tensions between residents and providers and within the hotel communities.

TRANSIENCE OF POPULATION [link to mental health theme]

This impacts on access to services when care is being planned and residents are moved to other areas. This introduces a delay at the very least, and knowledge about the health need may be lost to the system altogether.

Movement also it means that any funding provided is stretched, as it would be capped at the maximum number of beds available. Unexpected movement can make it difficult for the hotel teams to plan ahead.

In addition to official moves, sometimes residents abscond because they would prefer to be elsewhere, or don't want to live with the local conditions, including the threat of relocation.

LACK OF FUNDING

The Home Office has not supplied any additional funds for asylum seekers' health so the HAT are supported from the general resettlement fund. This means they do not have the capacity to cover more preventative health work.

There was a sense that Aberdeen is already generally less well staffed and funded than other parts of Scotland and having asylum seekers in any large number is relatively recent, so there is less relevant knowledge and support available. However looking at the wider picture, some questioned whether funding would make much difference to meeting health needs, given the general picture of a broken system with limited resources and long waiting times for everyone.

Mears understaffed

Mears welfare support officers are responsible for every aspect of residents' welfare including health and GP registration. The plan was that they would deal with the day-to-day concerns and the HAT would be more strategic and look at the longer term health needs e.g. assess the need for smoking cessation classes. However there are often not enough welfare support officers to cover all the hotels all the time. At one point before Christmas Mears were not available to residents in the Aberdeenshire hotel and residents missed appointments or referrals.

Another concern that was raised by HAT was that the Mears welfare support officers, whose positions are paid at entry-level, often lack the training and experience needed to support residents effectively. This puts additional work onto the Resettlement teams. Also Mears staff are not permitted to hand out medication, which also adds to the HAT workload e.g. medication needed prior to hospital procedure and pain relief.

Perhaps caused by understaffing, there has been an inflexibility noticed in Mears approach. Examples include leaving the gym in the Aberdeenshire hotel unstaffed and not supporting an initiative to get residents out-and-about in a community bus that had been sourced.

Health assessment team

HAT have had to find a balance between taking on extra work and pushing for Mears to fulfil its responsibilities. Understaffing by Mears led to concerns for residents with immediate health needs and the HAT have picked up some day-to-day / emergency work with residents e.g. GP registrations and making health appointments. This has meant that the health needs assessments have been delayed by weeks or months and that HAT are not able to focus on their intended, more strategic work - around general health and well-being and long term health outcomes, including screening and linking residents with public health services.

Transport

Residents are entitled to a taxi paid by Mears for medical appointments more than 2.5 miles away, but may be too far if feeling unwell and sometimes Mears have been perceived as reluctant to pay for taxis and have pushed for other means of transport with hospital appointments, particularly the Elgin to Aberdeen route. In Moray the health team have occasionally driven residents to GP appointments.

COMMUNICATION

Communication between hotel-based teams

Communications between HAT and Mears vary by location and change over time depending on staff. In Aberdeenshire, with a high turnover of Mears staff and location in different offices communication could be a challenge. Participants mentioned instances of Mears staff not acting with appropriate urgency over health conditions e.g. transport from GP practice to A&E or passing on appointment letters. Sometimes HAT only found out by chance that new groups of asylum seekers were expected in their hotels.

Communication with residents

The lack of phones previously mentioned can have an effect on access to services and sometimes care navigators or service providers have been unable to contact residents who are in the process of a referral.

Communication with service providers

Initially there was a period when some pharmacies weren't sure whether they could give free treatment or if they could advise someone who wasn't registered, but this has been dealt with now. Pharmacies were not always certain of referral pathways for residents e.g. scabies, smoking cessation. Also there have been occasions when pharmacies have tried to contact hotel staff about individuals and been unable to get through. Primary care providers also were not always aware of Language Line and some needed signposting by HAT.

A GP expressed a wish to be more involved with the resettlement team to improve everyone's understanding of the situation and how to work together.

Enablers to Accessing Support

HEALTH ASSESSMENT TEAM

Health assessments

Structured health needs assessments conducted one-to-one by the HAT with residents, are a key means by which health needs are identified and addressed. Assessments are shared with GPs and practices triage the information to prioritise those in most need of attention. The assessments also cover vaccinations, infections and other potential public health issues. The HAT are able to refer and signpost residents to a wide range of services.

Referral to appropriate care

When health needs are identified, following a health assessment or a query from a resident, the HAT are able to direct them to the appropriate service. Often this avoids unnecessary appointments with GPs and can get residents into the habit of turning to other primary care services e.g. pharmacy, physio, optician and mental health. This benefits residents and GP practices.

Direct support to access services

In addition to referrals and signposting, the teams have accompanied residents to appointments, particularly for a first visit, and set up appointment reminder systems, including

phone calls, knocking on doors and showing residents how to set alerts on their own phones. In some areas this has reduced the DNA rate.

Two of the HATs have tried to improve communication between residents and primary care services by completing 'health passports' for residents with limited English; these are forms with basic personal information and some details of health conditions. The participating pharmacists had seen one or two of these in use, said they were helpful and that it would be good to see them more widely used. HAT have also been in touch with providers to allay any uncertainty about residents using their services and informed them too about access to Language Line. In one area the HAT give presentations to GP practices

HAT have also supported travel where they can, applying for bus passes for those residents who are eligible and arranging for bike lessons in safety and maintenance. In Aberdeenshire, a Community Planning Officer has mapped out every organisation available within walking distance for the hotel.

Indirect support, life skills

By supporting residents to navigate the system teams improve their life skills, which will give them greater independence and be of benefit to them throughout their time in the UK. Other examples include sessions on cultural awareness and housing; helping them to think through their future plans; helping with college enrolment; impressing on them the importance of time-keeping; and taking them through useful information sources.

Advocates, holding others to account, getting services on board

One of HAT's roles is as an advocacy service to support residents to resolve any challenges and issues. They try to combat any negative stereotypes and any queries or concerns from services. Sometimes they take on the work of other teams, as when they registered residents with GPs.

Understanding-supporting-valuing

The HAT participants felt residents benefitted from their support in listening to them, building relationships and trying to understand and value them.

PARTNERSHIP WORKING

Content has been covered above under **Mental Health support, Dental support, Other services and Communication**. Partnership working was considered by participants as an important aspect of meeting residents' needs and required ongoing attention.

LANGUAGE SUPPORT

Language Line is the primary interpretation service used and was generally considered a good service by participants. There was sometimes a delay in connection, especially for unusual languages, and some times of day were found to be better than others.

One participant spoke about the importance of supporting interpreters by giving them information and treating them with respect, and also the need for the health professional to remain in control of the situation and understand everything that's being said.

Service providers have been finding their own ways to communicate with residents e.g. identifying their records by room number and using standard forms in different languages to convey medication details.

Many asylum seekers are keen to learn English and some have been attending college and conversation hubs organised by the local community (Aberdeenshire).

COMMUNITY SUPPORT

In Aberdeenshire the Westhill Partnership Group is a combination of church volunteers, community volunteers, ESOL teachers and local people. There is a post to support all the community groups in Aberdeenshire that run informal community cafes, including language cafes. Residents have been involved in the local men's shed and people have donated bikes, clothes and games. The community was also mentioned as supportive in Moray.

Improvement Ideas

Introducing a **dedicated nurse or clinic or hub** was the suggestion most mentioned by participants, preferably visiting the hotels to triage and ideally to treat residents. An alternative (secondary) suggestion was having teams assigned to cover asylum seekers as part of their role who would be familiar with the particular issues facing them.

Other ideas were related to improving team working:

- include wider primary care in team meetings to improve understanding (GP)
- clarity for providers on who to contact at the hotel with questions about residents (Pharmacist)
- increase size of HAT to ensure health assessments are done in a timely manner
- speed up the process of getting CHIs (Pharmacist)
- training on working with interpreters (GP)
- advance notice of new cohorts arriving (DIAL)
- better awareness of Pharmacy First and what it covers at the hotel (Pharmacist)

Improving facilities/services for residents

- find room for local Iman to visit the hotel (HAT)
- language cafés - sharing experiences, social contact and arranging activities (HAT)
- open the gym (Aberdeenshire hotel) – perhaps using volunteers or students (HAT)
- DIAL direct access on new website
- improving information given to residents, particularly explaining the system (various)

Other ideas:

- Promote Language Line in pharmacies
- Improve HAT connections with to pharmacies, opticians, dentists and GPs

Appendix 5: Options Appraisal for Data Sharing

The following options appraisal was presented to the NHS Grampian Public Health Asylum Seeker Short Life Working Group on 10 September 2024:

Situation The health needs assessment for asylum seekers in Grampian makes five recommendations. The first of these is the foundation on which the remaining four stand. The first recommendation states: *“A process of data sharing to understand the composition of the asylum seeker population has been established. This process must be adapted to fit the changing landscape of support for asylum seekers, including the withdrawal of the Aberdeen City health care navigator team. We need to acknowledge that the recommendations following this one will not succeed unless this data sharing is continued.”*

Background Each of the health and social care partnerships has a team of staff who work with asylum seekers, refugees, and people newly arrived in Scotland under specific schemes (the Ukrainian displaced persons programme, refugees from Syria). Referred to as health care navigators, these teams assist in GP registration, referral to services, signposting (e.g. to Pharmacy First or sexual health) and also offer practical assistance to asylum seekers such as helping to plan transport to appointments. The health care navigators from each partnership have worked with health intelligence to develop a data collection process that is uniform across the partnerships. This data is shared with health intelligence and presented as a dashboard showing the basic composition of the asylum seeker population (gender, age group, HSCP, primary language). It is envisaged that this dashboard can be shared with services who deliver care to asylum seekers, to enable them to understand the composition of the population and plan to deliver care appropriately.

Aberdeen City HSCP will redeploy their health care navigators to other roles before the end of September 2024; there will be no replacement for this team. Health intelligence have approached Mears Group to ask about the potential for data sharing. Mears Group have stipulated that:

“The information that MEARS receive is data that belongs to the Home Office and as we have no mandates in place with SU's we are, unfortunately, not in a position to share any information with you. I would suggest that GP surgeries may be in a position to share any info? All SU's are register with a GP.” [20]

However, this response neglects to discuss the problems with GP registration. Between November 2021 and June 2024, 29.92% of asylum seekers residing in Aberdeen City were not registered with a GP during their stay.

Therefore, a mechanism for data sharing after September 2024 is required.

Assessment

Option 1: Accept Mears Group’s refusal to share data, and that data sharing will not proceed. The asylum seeker population composition dashboard will become redundant.

Option 2: Attempt to access data from GP read codes. This is complicated in two ways:

- a) It is dependent upon asylum seekers actually being registered with GPs, which they may not be.
- b) Though read codes to identify asylum seekers exist in both EMIS and SystemOne, it is unknown if they have been used; there would be a need to survey practices to understand if codes had been used before data could be extracted. This is unlikely to be complete in the required timescale.

Option 3: Ask Health Intelligence to combine postcode and date data to establish lists of asylum seekers registered at hotels/HMOs in a given time frame. This is complicated in two ways:

- a) It is dependent upon asylum seekers actually being registered with GPs, which they may not be.
- b) It is dependent on us knowing the exact addresses of HMOs, which may not be provided to us by Mears Group.

Option 4: Request Mears Group revisit this conversation, referencing specific reasons:

- a) There is already a degree of data sharing in place with health care navigators in Aberdeen City: a room list with names is provided.
- b) There is already a degree of data sharing in place with health care navigators in Aberdeenshire: navigators are provided with a copy of GP registration documents.
- c) There are examples of data sharing in place in other local authorities: in Tayside the immunisation team were provided with a list of names, CHI numbers and GPs to facilitate a vaccination campaign.

NB: A query as to what other data sharing takes place across Scotland is being made to the PHS Migrant Health Meeting on Tues 10 Sep 2024.

- d) There are clauses in the contract between UK Home Office and Mears Group which indicate a requirement for data sharing; these could be explored with Mears Group.

Recommendation The NHS Grampian Public Health Asylum Seeker Working Group are being asked to select the preferred options from the four listed above.

After discussion, the NHS Grampian Public Health Asylum Seeker Short Life Working Group unanimously endorsed option 4, approving further discussions with Mears Group regarding data sharing.

Other organisations (Public Health Scotland, the Convention of Scottish Local Authorities, UK Home Office) are either known or thought to be in discussions with Mears Group about the need for data sharing, but given a lack of detail about these discussions, they were not included in this options appraisal.