

Health Needs Assessment Refugees and Asylum Seekers in Calderdale

Katie Comer

September 2016

Summary

Introduction

Refugees and Asylum seekers are amongst the most vulnerable groups in society. They represent a wide range of different cultures, languages and backgrounds. By definition an asylum seeker or refugee are fleeing persecution and are seeking protection, however they will each have individual experience, some may be fleeing war or torture/sexual violence and have a wide range of physical and psychological health needs.

This health needs assessment will aim to provide a clear insight into the health needs of the asylum seeker and refugee population in Calderdale. It will do so by taking an epidemiological and corporate approach. The epidemiological approach will look the quantitative data available such as demographic data as well as available services. The corporate approach involves a structured collection of knowledge and views of stakeholders. It is based on the demands, wishes and perspectives of interested parties - professional, political and user/public views and therefore recognises the importance of knowledge available from those who have been involved in local services.

Calderdale Statistics

Published Home Office figures show that at the start of March 2016, 278 people were being supported in Calderdale while awaiting a decision on their claim. All of these were being accommodated. Those then granted protection by the Home Office may stay in the area as refugees. In addition to this Calderdale Local Authority has agreed to accommodate a further 50 Syrian refugees direct from refugee camps. These refugees will be vulnerable families and couples. The government has committed to also accepting unaccompanied minors but this process and details have not been currently finalised.

Data is sensitive and difficult to obtain but anecdotal evidence suggests that countries where Calderdale sees many of its asylum seekers coming from are Eritrea, Sudan, Iran, Afghanistan and Pakistan and increasingly from Syria. It is expected that because areas of instability remain, more applications will come from individuals from these countries.

Key Health Needs

Physical Health

- The types of concerns varied from specific chronic conditions that have been present from being in their previous country, throughout their journey and now such as diabetes and previous heart problems to chronic pain conditions which people believed were exacerbated by their journeys and experiences on their way to the UK.
- In terms of maternal health, several of the women had given birth in this country and had experienced minimal problems. The Wharf midwives provide a good link to St Augustine's Centre and try to link with other antenatal care if this has been provided out of area.
- The main problems identified in children, were general childhood illnesses that did not cause overall concern to the women but a few pointed out some respiratory difficulties that they thought was due to damp housing and also some difficulty in access. There did seem to be good catch up immunisation programmes
- Dental problems are a common complaint amongst refugees and asylum seekers. This may be due to poor nutrition for a prolonged period of time and lack of access to dental treatment. Dental care may also be required due to injury and torture.
- Although not discussed at length within the focus groups, the literature searching identified that sexual health and FGM are a key concern within the asylum seeking population from certain areas and this should be considered.

Emotional Health and Wellbeing

- Although mental health concerns were expressed by each of the focus groups, they were articulated in different ways with some explicitly referring to their mental health whereas others referring to stress and other emotional sequelae without wanting to directly refer to their emotional or mental health.
- Concerns were expressed amongst the groups about stigma of mental health conditions and whether this will affect their asylum claim

Screening

- Screening has been identified as a key health priority for the groups of asylum seekers and refugees interviewed. This is particularly true for those who have travelled across the Mediterranean
- Screening for long term conditions as part of NHS programmes such as cancers were not seen as a priority and many expressed an interest in testing for TB and HIV.
- There was also a particular interest in receiving the influenza vaccination on arrival.

Access to services

- Access to all types of healthcare was a prime concern for all groups and was mentioned first in every focus group reflecting the evidence in the literature review that this is a particular difficulty for the refugee and asylum seeking population.
- In terms of services providing dental care there was noted to be a particular problem. People report a particular difficulty in registering and seeing dentists within the area including with children. Several reported being told to use friends and relatives as interpreters and without bringing a person to translate they wouldn't be registered or see a dentist even in an emergency and it is reported that language line is not used or known about.

Recommendations

Improved Access to all services

- After speaking to the different services involved, it is recommended that there is better liaison with GPs in the area to arrange a certain time for asylum seekers to register.
- It is recommended that we liaise with all services to ensure that they are aware of what other services are available for refugees and asylum seekers and can be distributed if and when it is needed. This may result in leaflets or a publication being produced. This should include specific NHS registration guidance for GP practices

outlining key points including that inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient.

Gym Access

- On several occasions during the focus groups, it was suggested that although St Augustine's Centre provided many activities, access to the gym, it was felt could be a means of improving both physical and mental health amongst refugees and asylum seekers. This is currently being discussed with North Bridge Leisure Centre

Mental Health

- Services need to address trauma through culturally sympathetic approaches rather than expect asylum seekers to adapt to the methods of the services
- This health needs assessment should be presented to the various emotional health and wellbeing groups that public health are involved in. This will hopefully increase the awareness of the health need of this population and perhaps provide solutions to the problems encountered.

Staff at St Augustine's Centre

- Staff working at St Augustine's Centre work tirelessly in their efforts for the refugees and asylum seekers of Calderdale. This at times can be a very stressful and has the possibility of impacting upon the health of the volunteers and employees. Workforce development will be contacted to look at if it is possible to provide a form of external debriefing system if St Augustine's Centre wants it.

Housing

- Several members of the focus groups felt that damp in their housing, overcrowding and a lack of facilities had a negative impact on their health. It is appreciated that this is a difficult problem to overcome but it will be discussed with G4S who provide the results to inform them that this was mentioned in the focus groups.

Screening

- Screening for the refugee and asylum seeker population is currently being discussed with NHS England. They have provided various screening services to different populations throughout Yorkshire and it is currently being discussed how this may work for Calderdale. It is currently felt that in order for this to work; the system of registering asylum seekers with a GP needs to be more robust.
- It has also been discussed that if the proforma for the new patient health check could be provided in advance and translated into several different languages, it may help both the GP surgery in providing timely medical information and also allows the asylum seekers to pre prepare any questions and concerns they may have.

City of Sanctuary

- City of Sanctuary is a movement committed to building a culture of hospitality and welcome, especially for refugees seeking sanctuary from war and persecution. Most cities and towns in West Yorkshire have signed up to this movement to 'build a culture of welcome across every sphere of society.' Halifax is not currently named as a town of sanctuary and it is an aim that we could become one. This movement is launching on 30th September 2016 and it is hoped that Halifax can become a Valley of Sanctuary and improve health through one of its streams.

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Health Needs Assessment - Refugees and Asylum Seekers Calderdale

Introduction

Refugees and Asylum seekers are amongst the most vulnerable groups in society. They represent a wide range of different cultures, languages and backgrounds. By definition an asylum seeker or refugee are fleeing persecution and are seeking protection, however they will each have individual experience, some may be fleeing war or torture/sexual violence and have a wide range of physical and psychological health needs. The 1951 Geneva Convention is an international treaty which sets out the definitions and rights of refugees along with the responsibilities of the nations that host the refugees. The United Kingdom is a signatory to the treaty along with 145 other countries. One of the main responsibilities of the host nation outlined by the treaty is that of non refoulement. This is a refugee's right to be protected against forcible return.

The 1951 Geneva Convention builds upon the Universal Declaration of Human Rights (1948). Article 25 states that *'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control¹.'*

The definitions related to refugees and asylum seekers are important as the health needs may differ between these two distinct groups. Fig 1 below illustrates several definitions that may be discussed within this needs assessment

Definitions

Fig 1

Term	Definition
Refugee	<i>"A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."²</i>
Asylum Seeker	'A person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded ³ .'
Refused Asylum Seeker	A person whose asylum application has been unsuccessful and who has no other claim for protection awaiting a decision. Some refused asylum seekers voluntarily return home, others are forcibly returned and for some it is not safe or practical for them to return until conditions in their country change ² .
Economic Migrant	Someone who has moved to another country to work. Refugees are not economic migrants ³ .
Humanitarian Assistance	A person who the Home Office identifies has strong reasons not to return to their country of origin, but cannot demonstrate a claim for asylum. They may then be granted Humanitarian Protection on a temporary basis. If protection is no longer required, the individual will be expected to leave the UK. Those who remain in the UK for more than 5 years, may be able to apply for Indefinite Leave to Remain
Indefinite leave to	Someone given permanent residence in the UK. These individuals are

remain	eligible for family reunion, with full access to state benefits and the right to work.
Discretionary leave to remain	A person who receives leave to remain in the UK as a refugee, granted if the person does not meet the strict criteria of the UN convention, but for reasons including family or medical cases.
Exceptional leave to remain	A person receiving leave to remain as a refugee granted if the person does not meet the strict criteria of the UN convention. This was replaced by Humanitarian protection and discretionary leave. Although this is a specific definition, in practice it is never seen.
Voluntary Assisted Return and Reintegration Programme (VARRP)	A programme open to all asylum applicants including those whose application has been refused, which may provide help to return to the country of origin, providing a package of support to help establish a new life there. This may include help setting up a business, education or training for a particular job
Destitution	Where an asylum seeker and dependants do not have adequate accommodation or means of obtaining it; or when adequate accommodation is available but they are unable to meet essential living needs

Background

Global and National picture

The United Nations High Commission for Refugees (UNHCR) was initially set up following World War II to help an estimated 1 million displaced people return home. The most recent global trends publication from the United Nations Refugee Agency estimates that number of people of concern to in 2015 reached an estimated 16.1 million. This is the highest level seen in 20 years and they are spread throughout the world living in varying conditions. On average, about 1 million people seek asylum on an individual basis every year. Globally, by end-2015, about 3.2 million people were waiting for a decision on their application for asylum in⁴. For each individual country, their national asylum systems are there to decide which asylum-seekers actually qualify for international protection. These numbers equate to globally, one in every 122 humans now being either a refugee, internally displaced, or seeking asylum⁴. Unfortunately given the current global situation with many countries deemed unstable by internal conflict and the war escalating in Syria both the numbers of people seeking asylum and therefore also refugees are likely to rise⁴. The vast majority of refugees stay in their region of displacement, and consequently are hosted by developing countries. Turkey now hosts the highest number of refugees with 1.84 million, followed by Pakistan with 1.5 million. Half of the top-ten refugee-hosting countries in the world are located in Sub-Saharan Africa⁵.

Most recent UNHCR figures show that at mid-2015 there were 117,234 refugees, 37,829 pending asylum cases and 16 stateless persons in the UK**Error! Bookmark not defined.** In 2015, the largest number of applications for asylum to the UK, including dependants, came from nationals of Eritrea (3,756; +465), followed by Iran (3,694; +1,195), Pakistan (3,254; - 722), Sudan (3,014; +1,399) and Syria (2,846; +493)⁶.

Grant rates for asylum, humanitarian protection, discretionary leave or other grants of stay vary considerably between nationalities. For example, 86% of the total initial decisions made for those giving Syrian as their nationality were grants of asylum or another form of protection, compared with 20% for Pakistani nationals.⁵ It should be noted that the rejection rate for all asylum claims in the UK for 2015 was 63%.⁷

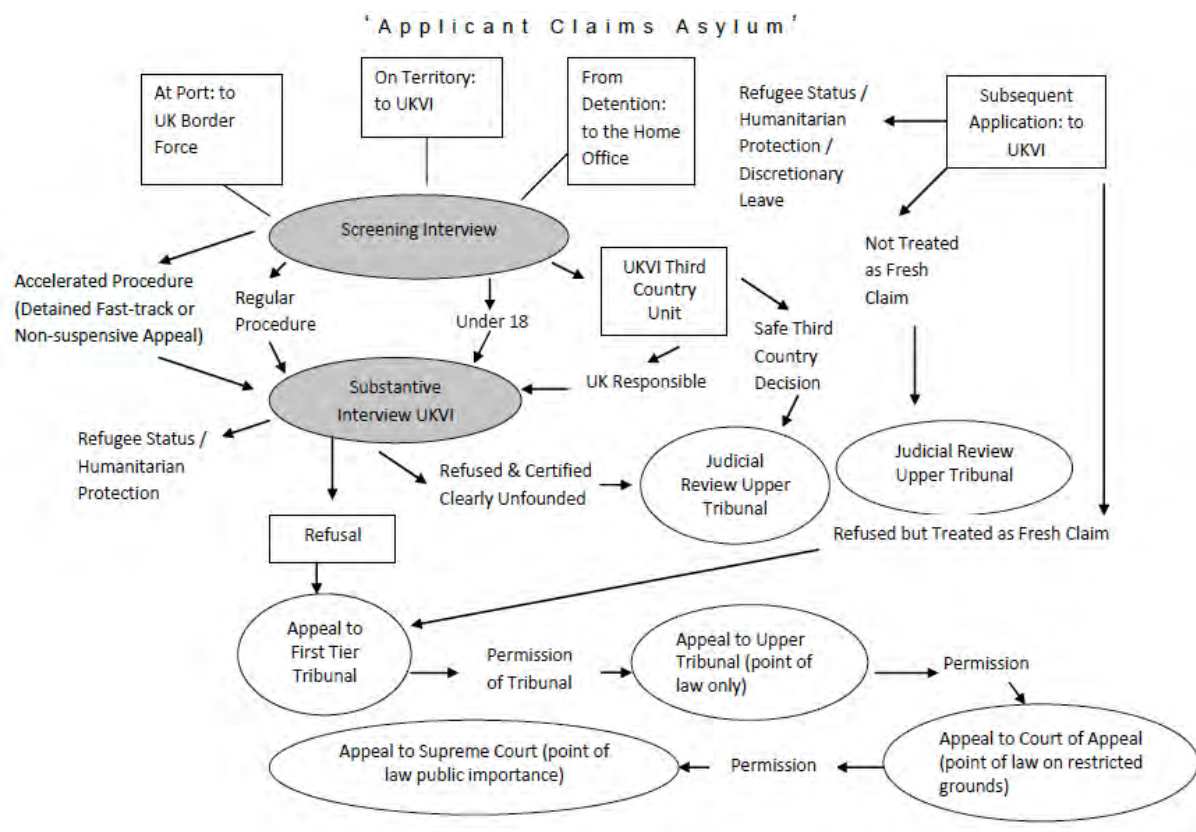
In addition, a total of 1,864 people in need of protection, including dependants, were resettled in the UK in 2015. Of these, 1,194 were granted humanitarian protection under the Syrian Vulnerable Persons Resettlement Scheme (1,337 since the scheme began). On 7 September 2015 the Prime Minister announced an expansion to the existing Syrian Vulnerable Persons Relocation Scheme. It is expected that 20,000 Syrians in need of protection will be resettled in the UK by 2020.^{8,9}

The asylum process

The asylum process in the UK is a complicated one. The UK Home Office is responsible for overseeing all aspects of the asylum process and immigration.¹⁰

Fig.2 shows a flow diagram of the asylum process

Fig 2¹⁰



An asylum claim may be made upon entering the country at the border, at an asylum screening unit or at a detention centre. The initial application process involves being given identification papers whilst a claim is being processed. A screening interview precedes the asylum interview which occurs at a variety of centres throughout the UK. The asylum interview is a means amongst others of assessing an individual's claim. This will include details about individual circumstances to support the claim. This coupled with supporting information will lead to a decision being made about the status of the individual as a

refugee or not. An asylum seeker who has their application accepted is recognised as a refugee and is granted leave to remain in the UK. They are entitled to work, travel documents, access to healthcare, benefits and accommodation the same as a UK citizen. Individuals can be granted “exceptional leave to remain” or “humanitarian protection” where the applicant does not meet the requirements of the 1951 Geneva Convention but is allowed to stay in the UK for a limited time period (usually 3-4 years).

If an asylum seeker has not been granted their claim they do have the right to appeal on several occasions. If the refusal remains they may have to leave the UK. This may be as part of the Voluntary Assisted Return and Integration Programme or they may be removed and deported. If there is no safe passage to their country of origin they may await deportation in a detention centre¹¹.

On 12 May 2016, the Immigration Act 2016 came into force, making it officially UK law. It brings several changes to the immigration system and further consequences when the law is not followed.

Specific changes include the amendment that any migrant that has made a human rights or asylum claim can now be removed to their home country pending the outcome of their appeal against the decision to remove them. That is, unless such removal would cause them ‘serious, irreversible harm’. Another enforced change is that it will soon be a criminal offence for a landlord to knowingly rent premises to an illegal migrant. If found guilty, the landlord can face up to five years in prison¹². It is felt that these new laws if fully enforced could create greater vulnerability for all migrants including asylum seekers.

Entitlements

Housing, cash support and healthcare make up the entitlements given to an asylum seeker. Currently, an asylum seeker who can prove that they do not have means to support themselves will be given housing but this may be in shared accommodation. They will not however have a choice where to live and it is stated that it will be unlikely that they will get given a house in London or the South West¹³.

Cash Support

The base rate for each individual in a household is £36.95. A pregnant woman will only get £3 extra a week, a child under 1 will get an extra £5 a week and a child aged 1-3 will get an extra £3 a week. Other benefits may be available in conjunction such as healthy start vitamins, free school meals for children in schools and a one off maternity grant if applied for¹⁴

Some asylum seekers who have had their claims refused can apply for somewhere to live and £35.39 per person on a payment card which can be used at certain shops. The payment card will not be given if the offer of a place to live is not taken up and no cash will be given to a refused asylum seeker. This can only be given if the person is homeless, does not have any money to buy food and you can show that there's a reason why they are unable leave the UK straight away¹⁵. This is known as section 4 entitlement.

Health care entitlements

Current legislation dictates that all asylum seekers awaiting a decision on their claim and recognised refugees should have access to all NHS care for free. During a high court battle it was discussed whether an asylum seeker who had their claim rejected would be entitled to free NHS care, after an appeal it was decided that only emergency and specialist care as dictated by the department of health (sexual health and maternity services) would be provided for free. Without insurance secondary care services would be charged at 150% of the NHS costs (5). This will obviously impact on the health of this population. This is essentially the same as being treated as an overseas visitor.

Aim

The aim of this health needs assessment is to provide a clear insight into the health needs of the asylum seeker and refugee population in Calderdale.

In order to this trends in the asylum seeker population of both the UK and Calderdale need to be established and a projection of how these numbers are likely to change.

The current health and social care service provision available to refugees and asylum seekers needs to be outlined along with what the health and social care needs are of this population. An assessment can then be done as to the unmet need of the refugees and asylum seekers in Calderdale.

This report will then identify key priorities for action planning to improve the health and wellbeing of the refugee and asylum seeking population in Calderdale.

Methods

There are several different approaches to a health needs assessment. This health needs assessment will aim to take on an epidemiological and corporate approach. The epidemiological approach will look the quantitative data available such as demographic data as well as available services.

We gathered some primary qualitative data in the form of facilitated focus group discussions with interpreters. We looked at the common languages spoken by asylum seekers in Calderdale and with the help of St Augustine's Centre we were able to have five group discussions. It was felt this was the best method whereby we can ascertain the felt needs of a sample of refugees and asylum seekers and use this to inform decision making. This will also make up part of the corporate approach.

The corporate approach involves a structured collection of knowledge and views of stakeholders. It is based on the demands, wishes and perspectives of interested parties - professional, political and user/public views and therefore recognises the importance of knowledge available from those who have been involved in local services.

In order for the assessment to be evidence based. A full literature search will be conducted to gain a better insight into the general health needs of the UK population of refugees and asylum seekers. It is anticipated that data specific to Calderdale may be difficult to obtain therefore evidence based literature on the population may be important to reference.

Literature review

There is a wealth of information pertaining to different health needs of asylum seekers and refugees. There is a big difference in what these health needs are depending on what point they are at in terms of their journey. For example the health needs of refugees in camps on the Syrian border will be different from those who have just claimed asylum in the UK and different still from a refugee who has lived in the UK for a number of years. Asylum seekers and refugees are not a homogenous group and their needs will be individual just like the rest of the population. There are however, several themes that appear in the literature and should be taken note of.

Physical Health

Chronic Diseases

Evidence would suggest that the level of chronic disease in the refugee and asylum population broadly mirrors that of the general UK population. It should be noted however that these diseases, such as diabetes and hypertension may not have been diagnosed in the person's home country and may have progressed since arriving in the UK. It is also important to understand the impact that the journey that an asylum seeker has made on their health. They most probably will not have prescriptions or medications with them and conditions may have caused further problems to develop such as back pain^{16, 17}.

Communicable Diseases

Studies have noted that asylum seekers arriving in the UK have limited records of immunisations and frequently have not had any at all. A health screening assessment occurs at centres or initial accommodation once an asylum claim has been made for conditions such as TB. True prevalence rates for conditions such as HIV and hepatitis in the asylum seeking population are difficult to ascertain. Some studies have attempted to research this but sampling problems have made the conclusions not generalisable¹⁸.

Maternal Health

Research has shown that asylum seeking, pregnant women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population¹⁹. This may be due to several factors. Antenatal care may be limited in the individual's country of origin and thus problems may not have been detected prior to delivery. The physical and emotional stress that an asylum seeker is placed under may also play a part^{20, 21, 22}. It should also be noted that with dispersal and redispersal of asylum seekers occurring frequently, continuity of care may be a problem. The Royal College of Midwives acknowledge that pregnant asylum-seekers have an increased need for midwifery care. They advise that all women should be given a letter of referral to take with them on dispersal in order to enhance continuity of care. The development of known and appropriate routes of access to healthcare professionals for asylum-seekers should be made known, and an interpreter service should be available²⁰.

Sexual Health

UK surveillance programmes of sexually transmitted diseases (except HIV) do not routinely collect data on country of origin. Some of this information is collected at the dispersal centre but no data is publically available. Evidence shows that there is

poor uptake of family planning, which may reflect some of the barriers to accessing these services by women²³

Dental Health

Dental problems are a common complaint amongst refugees and asylum seekers²⁴. This may be due to poor nutrition for a prolonged period of time and lack of access to dental treatment. Dental care may also be required due to injury and torture. It is therefore important that access to dental services for refugees and asylum seekers is optimal.

Consequences of Injury and Torture

It is important to be aware that a number of refugees and asylum seekers have faced imprisonment, torture or rape prior to migration, and will bear the physical and psychological consequences of this. Female genital mutilation has long been regarded as a human rights abuse against women and girls under international law, but it continues to be practised by some groups around the world²⁵. Female refugees are considered to be high risk but it is difficult to collect and substantive data.

Emotional Health and Wellbeing

The psychological and emotional needs of asylum seekers and refugees have been the subject of much discussion. By definition, an asylum seeker will be fleeing from a hostile and traumatic environment and this combined with the journey to the UK and the whole process of claiming asylum will cause immense stress and pressure which may impact upon an individual's emotional wellbeing. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and underdiagnosed especially in children²⁶. It is frequently reported that access to services is particularly difficult for refugees and

asylum seekers, reasons for this may be similar as the general problems accessing all services as discussed in the paragraph below or perhaps due to stigma.

Access to services

The right to medical care and a standard of living adequate for health and wellbeing is a key component of the human rights act that applies to everybody¹.

Increasing numbers of refugees and asylum seekers will inevitably cause an increase in demand for health services and pressures on the host nation's health system.

Evidence suggests that asylum seekers and refugees are at an increased risk of certain health conditions as outlined above and it is imperative that health services are able to provide these services. Research has outlined a variety of reasons that access to services may be limited for refugees and asylum seekers. In both developed and developing countries, health systems may not be in place to deal with any increase in demand, particularly for the specialist services that may be required.

The barriers that may arise in access to health services for asylum seekers may be due to a lack of understanding within the health services. For asylum seekers, a language barrier is often a key difficulty in access to health services as communication becomes difficult patients become disengaged and doctors struggle to refer to appropriate services²⁷.

Globally, cost can cause limitations in access and health inequalities. If healthcare is unaffordable it can prove to be catastrophic.

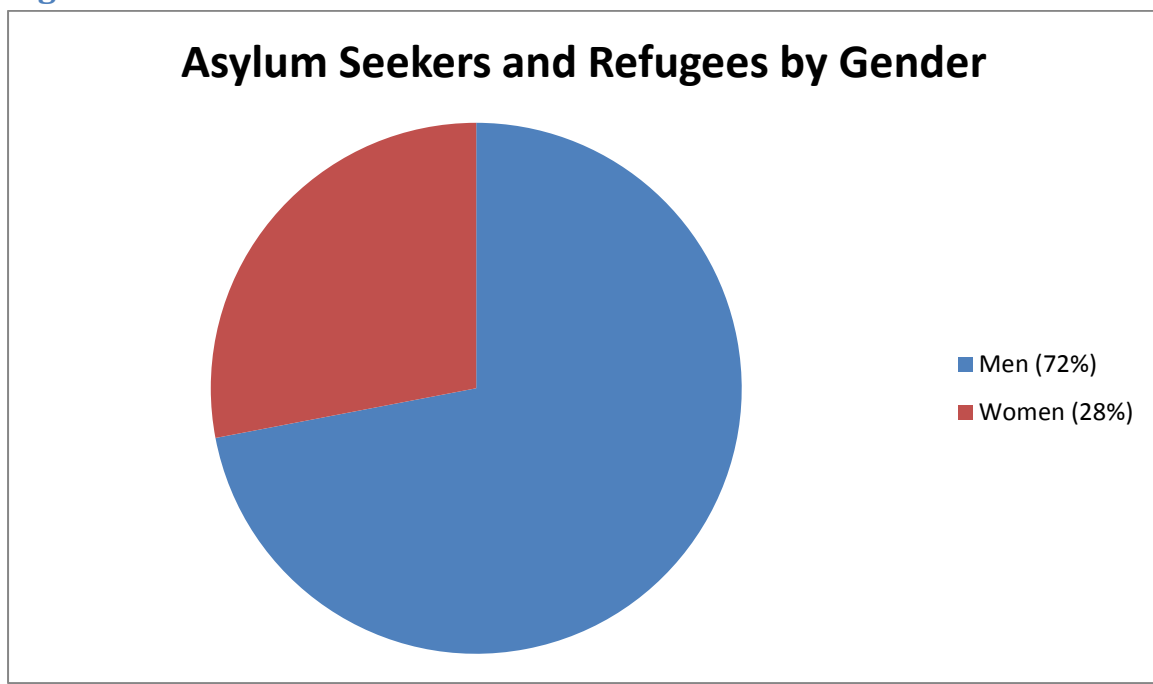
Data for Calderdale (epidemiological approach)

Published Home Office figures show that at the start of March 2016, 278 people were being supported in Calderdale while awaiting a decision on their claim²⁸. All of these were being accommodated. Those then granted protection by the Home Office may stay in the area as refugees. In addition to this Calderdale Local Authority has agreed to accommodate a further 50 Syrian refugees direct from refugee camps. These refugees will be vulnerable families and couples. The government has committed to also accepting unaccompanied minors but this process and details have not been currently finalised.

Once an asylum claim has been accepted and a person is given refugee status they are free to move around and live wherever they wish so it is difficult to estimate how many refugees currently reside in Calderdale. This information is not routinely collected as part of GP registration information.

It is unknown how many asylum seekers whose claim has been rejected currently reside in Calderdale. Demographic data is really difficult to obtain and is often restricted for public circulation. Quantitative data collected in this needs assessment was taken from records at St Augustine's Centre from 2015. These broadly match the demographics of the population of asylum seekers and refugees in Calderdale. Fig.3, 4 and 5 below display.

Fig 3²⁹



This gender divide amongst refugees and asylum seekers is seen throughout the country and the rest of Europe. The percentages become closer to an even 50:50 split amongst men and women when looking at refugee camps closer to an individual's country of origin. This is highlighted particularly in the data collected from refugee camps on the Syrian border³⁰. This divide has been the subject of much research, but it has been hypothesised that this is because the journeys embarked upon by the asylum seekers are so dangerous the men make the journey and hope that when they are given refugee status they are able to extend this to their first degree relatives.³¹

Data is sensitive and difficult to obtain but anecdotal evidence suggests that countries where Calderdale sees many of its asylum seekers coming from are Eritrea, Sudan, Iran, Afghanistan and Pakistan and increasingly from Syria. It is expected that because areas of instability remain, more applications will come from individuals from these countries.

Fig 4²⁹

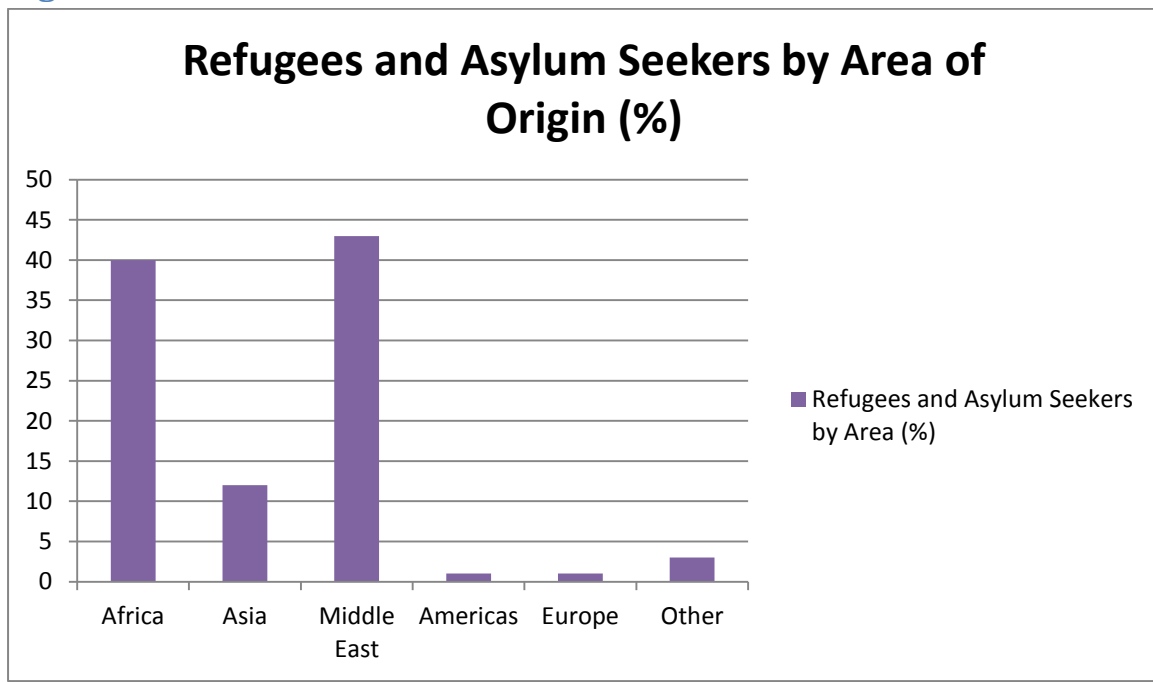
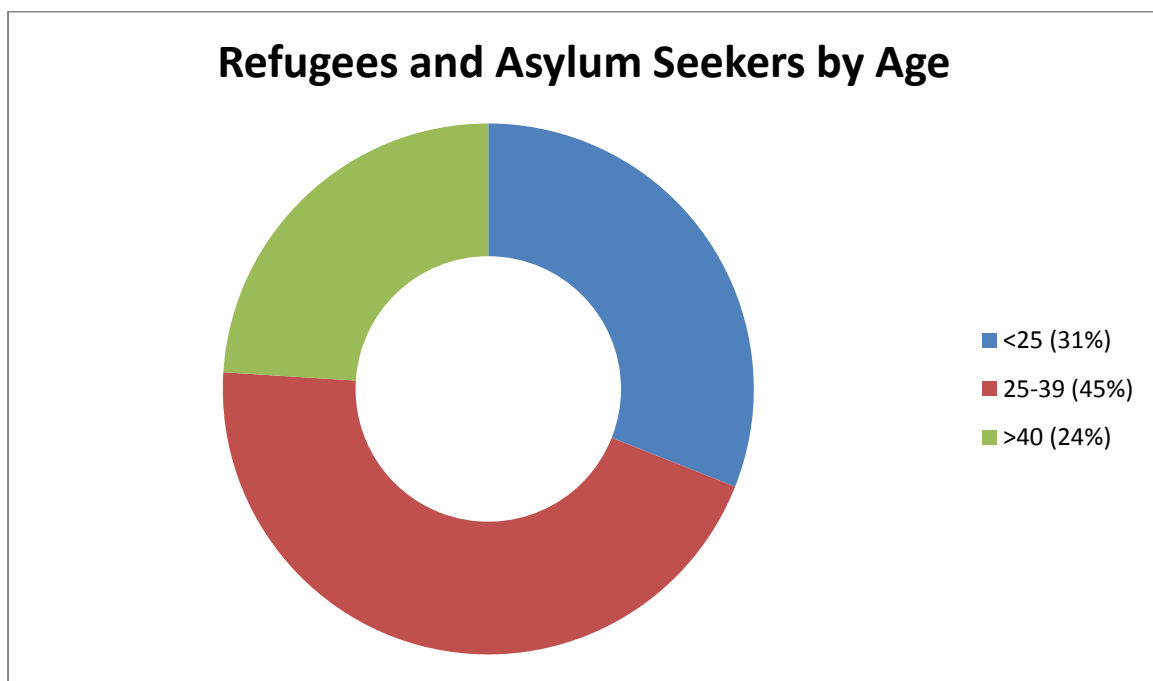


Fig 5²⁹

The age range of asylum seekers is fairly evenly spread but nationally the numbers tend to lie in the 25-40 age category. It is thought that this again relates to the journey and that those in this age group are the fittest and most able to undertake the journey.



Limitations to this data

It should be noted that there are limitations to this data. It has been collected from one source that is not centrally regulated. Data collected on this topic is highly sensitive and often marked not for distribution. Therefore the epidemiological data used here was the best data available. As noted, it was felt that as the information broadly matches the demographics and was pertinent to the health needs assessment and therefore was used.

Focus groups

Primary qualitative data was collected with the help of St Augustine's centre in Halifax. It was decided to conduct five different focus groups based upon the demographic data collected from the centre. The five groups were Arabic speaking refugees, Arabic speaking asylum seekers, Tigrinya speaking asylum seekers, African Women (speaking English) who were asylum seekers and Farsi speaking asylum seekers. There was a good mix of men and women in all groups except the group of African women. The groups were organised in this way for ease of the interpreters and also to gain a good cross section of male and female issues, refugees and asylum seekers and also across different cultures and people from different countries.

A full explanation was given by the interpreters in each group and each member of the focus groups signed consent forms. The consent forms and the broad questions asked and used to provide a template for discussion can be found in the appendix.

The results from the focus groups reflects the literature review outlined above in the issues that were highlighted with various concerns varying in strength between different groups but give clear indication of health needs of the population, some of which are not being met.

Key health needs identified from focus groups

The focus groups broadly identified areas of need mirroring those found in the literature review. Unsurprisingly, different groups felt certain needs were of more importance to them than others and were expressed in different ways but overall they all expressed need in certain areas.

Physical Health

When asked, all groups immediately identified physical health concerns as important. The types of concerns varied from specific chronic conditions that have been present from being in their previous country, throughout their journey and now such as diabetes and previous heart problems to chronic pain conditions which people believed were exacerbated by their journeys and experiences on their way to the UK. The issues with musculoskeletal pain tended to come from groups who made the journey through North Africa and Europe whereas long term health conditions dating back further tended to be expressed by those speaking Farsi or originating from Iran.

The experiences between refugees and asylum seekers differed in the current health state in that overall the refugees reported better health than the asylum seekers. They believed that this was due to a number of factors:

- Overall they had been here longer and felt that they had had more opportunities to access better healthcare
- The psychological stress, although always present was less intense than when they were seeking asylum and therefore did not manifest itself as physical pain
- They were aware more of services and entitlements to healthcare and therefore used them.

Other health conditions such as communicable diseases and sexual health conditions were asked about but not discussed openly in the group discussion between all groups. The group comprised of women only who were from Africa were more open to discussing this

topic but did not give an overall indication of need. They were aware of local services and that the Brunswick offered HIV testing but no further discussion followed.

In terms of maternal health, several of the women had given birth in this country and had experienced minimal problems. The Wharf midwives provide a good link to St Augustine's centre and try to link with other antenatal care if this has been provided out of area. This was true of the participants of the focus groups however case studies that were given from St Augustine's did not all provide such a positive experience.

The health of children was discussed in the groups where attendees have children. This was mainly in the group of African women and also the Farsi speaking group. The main problems identified were general childhood illnesses that did not cause overall concern to the women but a few pointed out some respiratory difficulties that they thought was due to damp housing and also some difficulty in access. There did seem to be good catch up immunisation programmes but this was discussed only amongst the women and will have to be researched further with appropriate data if possible.

Emotional health and wellbeing

Evidence from the literature review shows that there are several mental health concerns amongst refugees and asylum seekers that should be considered when planning services that involve this population. Although mental health concerns were expressed by each of the focus groups, they were articulated in different ways with some explicitly referring to their mental health whereas others referring to stress and other emotional sequelae without wanting to directly refer to their emotional or mental health.

All groups expressed how being an asylum seeker was 'stressful' causing lack of sleep and 'emotional conflict.' This was particularly evident in the refugee group who were able to discuss the difference in impact on their health as a refugee and as an asylum seeker. They discussed that as an asylum seeker the uncertainty and fear causes great psychological distress affecting both their physical and mental health. They each made it clear that this distress lessens when asylum is granted, but it never really disappears and the fear of instability and 'being sent back' remain for a long time.

Concerns were expressed amongst the groups about stigma of mental health conditions and whether this will affect their asylum claim, this was particularly evident in the Tigrinya speaking group who were also the most recent to make an asylum claim.

Further anxieties were discussed by both the Arabic speaking refugees and the Farsi speaking asylum seekers about the treatment offered for mental health conditions. They felt that even when they had been to see a GP and had commenced on medication, no psychological therapies were offered as there was a difficulty with accessing language services. Instead they felt medication was increased and increased with no effect and would have benefitted more from access psychological therapies.

Screening

Screening and Immunisations were discussed in all groups but particular importance was given to this in the Tigrinya speaking group and the African Women when discussing their children. Other groups although said this area was important gave more emphasis to other health needs.

The Tigrinya speaking group focussed on the screening procedure on entering the UK and the health check following GP registration. They felt that this was insufficient given the circumstances that they arrived under and often did not occur at all. They did not discuss specific details but described a particularly arduous journey often across Libya, the Sahara, Europe and through Calais. They alluded to various different types of abuse and exploitation. They explained they were suffering anxiety that these journeys will have had serious impacts on their health. They all spoke of going to their GP if registered to 'check if they were ok' but found difficulty in explaining why they felt they needed a health check and struggled to understand why a comprehensive check was not done.

The African women discussed immunisations for themselves and their children. They felt that the care their children received was very good in terms of ensuring that the confusing schedule of vaccinations was given and in particular the children's centres were helpful with this. It was more complicated with children who were born outside of the UK and required 'catch up' immunisations but on the whole this was remedied once GP registration had

occurred.

Access to services

Access to all types of healthcare was a prime concern for all groups and was mentioned first in every focus group reflecting the evidence in the literature review that this is a particular difficulty for the refugee and asylum seeking population. They explained that there was difficulty along the whole process from registering with a GP to getting access to tertiary and other services.

They rely heavily on the staff at St Augustine's Centre not only to sign post but to take them to register at the local practice. For ease, the staff tends to direct people to the nearest practice with whom a relationship has formed but there are several other practices within the area where refugees and asylum seekers are registered or have attempted to register. On the whole, Park Community practice was felt to be the easiest place to register and get an appointment. Comments were made however about other practices being 'unfair' and 'not allowing them to register.' Several people across each of the focus groups felt that some practices treated them unfairly because they were asylum seekers feeling 'degraded'.

It was clear that there was confusion about the process and documentation that was required to register and also a language barrier issue.

There was also some confusion about the structure of services in the UK. Most were aware of GP surgeries and A&E but not about other services such as walk in centres.

In terms of services providing dental care there was noted to be a particular problem. People report a particular difficulty in registering and seeing dentists within the area including with children. Several reported being told to use friends and relatives as interpreters and without bringing a person to translate they wouldn't be registered or see a dentist even in an emergency and it is reported that language line is not used or known about. Dental problems featured frequently when asked about health needs and the focus groups felt that this may be because after leaving their home country they had so many other things to consider that dental health got neglected.

Areas to improve health

Each of the focus groups were asked about what areas the group members felt could be improved to improve all areas of their health with specific examples if possible. Half of the groups specifically mentioned that exercise might be something to improve both their physical and mental health. They discussed that having too much time to 'sit and think' was bad for their health and wished they could have access to the gym. They have set up their own football team which play in the park but this is not suitable for everyone and definitely not suitable year round.

They also asked about whom to address housing concerns to. A number of people within different groups commented on damp housing which is of a significant level that they feel negatively impacts on theirs and their children's health.

A key point that every person from every group without fail wanted to make clear was their appreciation for St Augustine's Centre. The centre provides a safe space for help when needed, discussion, learning and social cohesion. They all felt that St Augustine's Centre should be mentioned as a key factor in improving their physical and mental health and without it many people would struggle.

Current service provision

Once arriving in Calderdale, asylum seekers are often sign posted to St Augustine's Centre, a community centre for anyone who needs help, advice or support. Many of Calderdale's asylum seekers come here to access the 'welcome programme.' This includes support registering with a GP, dentist and other health services as well as asylum application help and legal representation, English lessons and many other community programmes. Upon discussion with the staff, they agree with the health needs outlined above from what they have seen and discussed with people at the centre. They have been also extremely helpful facilitating focus groups and helping with suggestions and ideas of how the health needs may be addressed.

The local schools and Children's Centres also assist with asylum seekers and refugee children who have come to settle in Calderdale. The Jubilee Children's centre has a dedicated key worker assigned to refugees and asylum seekers who does outreach work within the community and aids in many different issues.

Park Community Practice currently is identified as the GP practice that most asylum seekers attend. As part of the health needs assessment discussions have been set up to see how best registration can be facilitated. They work closely with G4S who facilitate the health assessment asylum seekers undergo once a request for asylum has been made. Queen's Road medical practice are also located close to where many asylum seekers are housed and are committed to improving the health of asylum seekers and refugees in the area.

The current Syrian Refugee Relocation programme has involvement from many key stakeholders within the community, local authority and Calderdale Clinical Commissioning Group (CCG). Monthly meetings occur and key discussions and plans are made prior to arrival of the refugee families. This is facilitated by the communities' team as part of Calderdale Council. They provide assistance and support to refugees and asylum seekers within Calderdale.

The Wharf Midwifery Team work in Calderdale and provide support to pregnant asylum seekers and refugees to ensure continuity of care throughout pregnancy. This is especially

important when women can arrive in the area late in pregnancy having received minimal antenatal care previously.

Healthy Minds have been working closely with St Augustine's Centre to hold a number of mental health workshops and support groups. They have found that mental health provision for asylum seekers does not address their highly specific needs assuming they can access it in the first place and therefore people disengage.

Recommendations

Improved access to all services

It has been discussed above both in our data collection from groups and also from recent literature searches that access to health services is a particular problem for some refugees and asylum seekers. This is relevant to both primary and secondary care encompassing GP services and specialist services such as mental health and dental care. There seems to be an emphasis on the voluntary sector providing services and it simply isn't enough.

After speaking to the different services involved, it is recommended that there is better liaison with GPs in the area to arrange a certain time for asylum seekers to register.

Because of language problems and complications with identification documentation, it is inevitable that the process will take longer than usual. This adds pressure on the reception staff and means that asylum seekers are less likely to register. In having a set time or day of the week away from 'peak' GP time to register asylum seekers, reception staff will have more time and privacy to contact language line and discuss documentation.

It became clear during the focus group sessions that both the refugees and asylum seekers interviewed were unaware of how the health system worked in the UK or what services were available to them. For example, although they may be aware of A&E they were not aware of walk in centres or the dental hospital or that some services will not be available at a weekend.

It is recommended therefore that we liaise with all services to ensure that they are aware of what is available and can be distributed if and when it is needed. This may result in leaflets or a publication being produced. This should include specific NHS registration guidance for GP practices outlining key points including that inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient³².

Gym access

As access to gym services was something that was specifically brought up by the focus groups we have contacted the sports services manager for the council who deals with Northbridge leisure centre. He has committed to helping to arrange some protected off peak time to enable asylum seekers to have access to football pitches etc. We are currently in the process of discussing access to gym equipment and swimming pools. This is a little more complicated as for health and safety reasons, gym inductions will need to occur and an interpreter possibly booked for this.

Mental health

This was a big health need identified across all refugees and asylum seekers. It is understood that Healthy Minds have been working in this area along with St Augustine's and this needs to be supported. They have found that there is a difficulty in engagement with mental health services and a lack of emotional trauma and torture survivor services. It is therefore recommended that services need to address trauma through culturally sympathetic approaches rather than expect asylum seekers to adapt to the methods of the services

This health needs assessment should be presented to the various emotional health and wellbeing groups that public health are involved in. This will hopefully increase the awareness of the health need of this population and perhaps provide solutions to the problems encountered.

Staff at St Augustine's

Staff working at St Augustine's Centre work tirelessly in their efforts for the refugees and asylum seekers of Calderdale. This at times can be a very stressful and has the possibility of impacting upon the health of the volunteers and employees. Workforce development will be contacted to look at if it is possible to provide a form of external debriefing system if St Augustine's centre wants it

Housing

Several members of the focus groups felt that damp in their housing, overcrowding and a lack of facilities had a negative impact on their health. It is appreciated that this is a difficult problem to overcome but it will be discussed with G4S who provide the results to inform them that this was mentioned in the focus groups.

Screening

Screening for the refugee and asylum seeker population is currently being discussed with NHS England. They have provided various screening services to different populations throughout Yorkshire and it is currently being discussed how this may work for Calderdale. It is currently felt that in order for this to work; the system of registering asylum seekers with a GP needs to be more robust.

It has also been discussed that if the proforma for the new patient health check could be provided in advance and translated into several different languages, it may help both the GP surgery in providing timely medical information and also allows the asylum seekers to prepare any questions and concerns they may have.

City of Sanctuary

City of Sanctuary is a movement committed to building a culture of hospitality and welcome, especially for refugees seeking sanctuary from war and persecution. Most cities and towns in West Yorkshire have signed up to this movement to 'build a culture of welcome across every sphere of society.' Halifax is not currently named as a town of sanctuary and it is an aim that we could become one. This movement is launching on 30th September 2016 and it is hoped that Halifax can become a Valley of Sanctuary and improve health through one of its streams.

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