

# Population Health Needs Analysis – UK Asylum Seekers and Refugees

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## **Abstract**

This article will explore the healthcare needs of UK asylum seekers and refugees, seeking to identify not only the size and location of these populations, but the range of their healthcare needs alongside the barriers to healthcare experienced by them. Significant focus will be on the mental and physical health needs of these populations, as well as the future for these populations within the UK, relating to their access to healthcare.

## **Keywords**

Refugee, Asylum Seeker, Healthcare, UK,

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## Introduction

Recent migration into the UK has meant that healthcare professionals such as paramedics are dealing with an diverse mix of patients, from a variety of different backgrounds and cultures, with ever-changing healthcare needs (Robertshaw, Dhesi and Jones 2017). This article will explore the population health needs of the growing asylum seeker and refugee communities in the UK; a population worthy of an in-depth analysis due to its significant coverage in national and international news and of growing prevalence within our communities. From a moral perspective alone, society's valueless attitude towards these populations as demonstrated in the media (Banks 2011) justify this report. According to Roberts, Murphy and McKee (2016) asylum seekers face humiliation at European borders and even upon reaching comparative safety they still lack access to basic primary healthcare.

Furthermore, from a political standpoint, Kirkwood (2017) highlights the narrative of UK politicians, who can often portray host nations as having limited means and space and therefore a place unable to provide refuge. Kirkwood (2017, p.116) also argues that politicians construct their arguments about these populations in a way that "avoids labelling the speaker as racist, and instead functions to portray speakers as being moral... while arguing against their (the asylum seekers' and refugees') presence."

This article sets out to understand precisely how these populations are defined, as each case is different. Amongst varying definitions of "refugee," the 1951 United Nations Convention Relating to the Status of Refugees defines a refugee as; "Someone who has

been forced to flee his or her country because of persecution, war, or violence, and have a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group” (UNHCR 1951).

It is also important to note that “Refugee Status” according to the Refugee Council (2017a) is only awarded to an asylum seeker that the Home Office recognizes as a refugee after his or her successful application. It is only then that these individuals are permitted to remain in the UK for up to 5 years, with the choice to apply to remain indefinitely. According to Migration Watch UK (2017, p.1) an individual “will remain an asylum seeker for so long as his application or appeal against refusal of his application is pending... while the position of unsuccessful asylum seekers is similar to that of those who enter on short-term visas and overstay.”

Since we often see coverage in the news and media regarding these populations, one can quickly become overwhelmed by the terminology used regarding asylum seekers, refugees and immigrants in general, making it essential to understand what these terms mean. According to Donkoh (2007) in a memorandum by the UNHCR regarding the treatment of asylum seekers and refugees in the UK media, confusion remains between the various terms such as “asylum seekers” and “economic migrant,” thus making it also important to differentiate between them.

Asylum seekers and refugees are by no means a new population within the UK. According to Refugee Week (2015), refugees and those who seek asylum have made a “massive

cultural social and economic contribution to life in the UK in the past 450 years,” (Refugee Week, n.d. p.3) ranging from the first Dutch protestants who fled religious persecution in 1665, to those that reside within the UK today. It is important to note that asylum seekers and refugees have a positive influence on the countries they inhabit, however refugees are more likely to be unemployed than the indigenous populations of those countries in which they reside (Fasani, Frattini and Minale, 2018). However, in a study of Australian refugees the Economist (2016a) suggests refugees pay less in tax than in benefits during the first 20-25 years of residency in a host country. This does not only raise questions about their economic benefit across other nations but negates the added value asylum seekers and refugees may bring such as culture and diversity, as well as the length of time it takes these populations to become settled. It is important to highlight that not only are the aforementioned issues limited only to the economic factors of asylum seekers and refugees but they do not take any account of the moral and ethical responsibilities of “First World” nations and their healthcare systems.

### **UK Asylum Seeker and Refugee Population Size and Location**

This population is relevant due to its prominence in today's society, news and media, with crises such as the Syrian Civil War and the war in Yemen increasing the number of asylum seekers and refugees across the EU and more widely (Kingsley 2015). According to UNHCR (2015a) there are around 1.5 million refugees in Europe and 149,765 refugees known to be living in the UK. According to Blinder (2016), the majority of the UK's asylum applicants come from Eritrea, Iran, Pakistan, Sudan and Syria. However, it is important to note that these countries are not reflective of the nationalities of the world's largest

refugee populations which consist of applicants from countries such as Syria, Afghanistan, Somalia, Sudan and South Sudan (British Red Cross 2017). When we compare the nationalities of UK asylum seekers to those of the world's largest refugee populations it appears that asylum seekers coming to the UK predominantly arrive from relatively politically stable countries such as Eritrea or Iran (Blinder 2016) rather than politically unstable countries such as Syria (British Red Cross 2017), suggesting that many of the UK's asylum seekers and refugees could be economic migrants.

With regard to the management of UK asylum seeker and refugee populations, Liebling et al. (2014) highlight a “culture of disbelief” that exists amongst UK politicians regarding the movement of asylum seekers and refugees into the UK. Liebling et al (2014) found that UK politicians often focus on returning as many asylum seekers and refugees to their home countries as possible, rather than returning them based upon their individual needs. Within this hostile environment it would not be surprising if many asylum seekers and refugees do not wish to present themselves to the Home Office, not only leading to inaccurate government asylum seeker and refugee population statistics, but also causing decreases in the number of applications for asylum within the UK, such as that which occurred from 2015 to 2016 (Refugee Council 2017b).

According to Aiyar et al. (2016) figures suggest that the number of UK refugees is significantly lower than it was thirty years ago. This decrease could be related to the rise of the UK Independence Party in the 2015 election, who according to Ibrahim (2017) encouraged significant negative media coverage towards asylum seekers and refugees

during their election campaigns.

Blinder (2016) finds that asylum seeker applications in the UK have increased since the 1980's and highlighted that there are significant evidence gaps and limitations in information about asylum seekers and refugees in general, going on to state that estimates of asylum seekers' role in net migration are uncertain, reinforcing the notion that asylum seeker and refugee statistics are highly inaccurate.

Nevertheless, whilst reports by Blinder, Ruhs and Vargas-Silva (2011) highlight how public attitudes towards asylum seekers and refugees hope to see numbers of these populations reduced, media reports such as that of Cockburn (2015) highlight the ethically justifiable cause for their entry; linking it to violence in the Middle East and North Africa - including nine civil wars now going on in Islamic countries between Pakistan and Nigeria. The validity of this claim is reinforced by the UNHCR (2015b) who emphasize how war in Syria has caused severe displacement of people and that conflict in Africa, the Middle East, and Asia (in order of significance) has lead to increased asylum seeker and refugee numbers in recent times.

According to the National Audit Office (NAO) (2017) 10% of asylum seekers make their asylum claim at the UK port where they arrive, while the remaining seekers make their application for asylum in Croydon. Following this, they are dispersed across areas outside of London unless they have "exceptional" medical circumstances. Home Office (2017a) figures found that by the end of 2016, 92% of asylum seekers in the UK were placed

outside of London. Furthermore, reports from the Economist (2016b) found that asylum seekers were often sent to the most impoverished communities of the UK.

## **Healthcare Needs and Barriers to Healthcare**

Public Health England (PHE) (2017) highlights that the majority of asylum seekers and refugees in the UK are healthy; however, broader reading suggests otherwise. Health problems can develop for many reasons including: difficulty in accessing healthcare services, lack of awareness of entitlement, problems in registering with primary and community healthcare services and language barriers (Robertshaw, Dhesi and Jones 2017). PHE (2017) suggests health needs for this group range from mental health and physical consequences of torture and imprisonment to loss of family and friends, hostility and housing difficulties upon arrival in the UK.

Unfortunately, there appear to be no uniform benchmarks to identify successful resettlement for asylum seekers and refugees in the UK, and in fact studies by Morris et al. (2009) found that the health status of refugees in the USA declined upon migration. Yako and Biswas (2014) found that language barriers and social isolation were inevitably stressful, contributing to declines in the general health of these populations on arrival in a new country.

UK support for newly resettled asylum seekers and refugees comes from charities such as United Nations International Children's Emergency Fund (UNICEF), Amnesty International, Refugee Action, The Refugee Council, Oxfam and British Red Cross. While

government based campaigns such as The Syrian Resettlement Programme (which focuses specifically on the UK government allocation of 20,000 Syrian Refugees) offer support arrangements for “high cost” cases such as families, offers general support for unaccompanied children and also support with housing costs, thus aiding initial resettlement issues (Home Office, 2017b).

According to the Refugee Council (2017b), in an attempt to support these populations’ health there are other programmes such as the UK government’s Gateway Resettlement Programme which offers resettlement support to asylum seekers during their first 12 months in the UK by a team of project workers, community development workers, and volunteer coordinators, with services including orientation on arrival, housing and tenancy support employment support and access to health services amongst many others.

Another factor affecting the health of asylum seekers and refugees is the quality of healthcare services available in their home country, which is often poor and predominantly outside of the top 100 healthcare systems in the world (WHO 2000). Of the top 10 asylum applicant countries in the UK, the highest ranked healthcare system was Albania (ranked 55<sup>th</sup>) while the lowest was Nigeria (ranked 187<sup>th</sup>) (WHO 2000).

Cheng, Drillich and Schattner, (2015) find that asylum seekers’ and refugees’ cultural understanding of healthcare can be a barrier to their health. Cheng, Drillich and Schattner (2015) found that utilization of healthcare is thwarted by asylum seeker and refugee experiences of healthcare services within their country of origin, their unrealistic

expectations of western healthcare systems such as expectations to be healed straightaway, and a failure to understand why they were physically examined in particular ways.

According to Whyte, Whyte and Hires (2015), asylum seekers are often perceived to have lower socioeconomic status than the UK indigenous populations, and ultimately receive a lower level of treatment from UK healthcare institutions, largely due to complex factors such as prejudice, language barriers, lack of understanding and cultural issues. Furthermore they also found that failed asylum applications render individuals destitute and whilst they may receive necessary initial healthcare provision due to ethical responsibilities of healthcare providers, they are often subsequently deported. Religious beliefs can also act as a barrier to refugee and asylum seeker healthcare needs - particularly sexual health, obstetrics, gynaecology, and midwifery. According to Wilson, Sanders and Dumper (2007) religion can also play a significant role in sexual health disparities, while Kolak, Jensen, and Johansson, (2017) reinforce this within asylum seeker and refugee populations, stating that immigrants' religious beliefs affect the efficacy of any antenatal education they might receive.

### **Mental Health Needs**

Mental health issues amongst asylum seekers and refugees are also a significant healthcare need. Steel et al. (2009) found in a study of over 80,000 refugees that there was a 30% prevalence of post-traumatic stress disorder (PTSD) and major depression, often linked to torture experiences and exposure to trauma as a result of conflict in their

home countries. These mental health issues are often exacerbated by resettlement stressors such as unemployment, poor housing and social isolation due to language and cultural barriers and discrimination as seen in the press. Turrini et al. (2017) found that some people within asylum seeker and refugee populations may struggle with high rates of psychiatric illness. The UK government currently fails to screen asylum seekers and refugees for mental health issues, and such screening may help to reduce them, since studies by Polcher and Calloway (2016) found that early recognition of mental health issues can lead to early intervention and therefore reduce their impacts.

Nevertheless, it is evident that asylum seekers and refugees face many health challenges ranging from language barriers to mental health problems. Alongside the complex needs associated with being an asylum seeker or refugee, they also appear to have an increased risk of morbidity compared to indigenous populations (Mangrio and Sjögren Forss 2017). According to Taylor (2009) the health of asylum seekers is significantly worse than that of the indigenous UK population on almost all measures of health and wellbeing. Furthermore, Haroon et al. (2008) believe achieving refugee status can lead to loss of home and financial support which can cause exacerbation of pre-existing mental and physical health and wellbeing issues.

Mental health needs also impact children. The UN Convention on the Rights of the Child (United Nations 1990) recognizes that children often suffer disproportionately as a result of government policy, suggesting there is less support and recognition of mental health issues among child asylum seekers and refugees than adults within these populations.

Nevertheless, there are charity based initiatives such as Mind's Refugee and Asylum Seeker Mental Health Advocacy Project, which are backed by the NHS, open to all ages and seek to ascertain the mental health concerns of refugee organisations. Furthermore, they also deliver training courses for "advocates" within refugee community organisations to cascade what they have learned about mental health information.

Asylum seekers and refugees suffer significant cultural barriers to health; and according to Loewenthal et al. (2012) there is a general lack of understanding about the cultural diversity of Black, Asian and Minority Ethnic (BAME) communities within the UK, leading to poor uptake of psychological/talking therapies by these populations. Loewenthal et al. (2012) also found that asylum seekers and refugees from BAME communities are frequently accessing services at a more critical later stage than Caucasian service users. Studies reviewed by Bellamy et al. (2015) found that cultural differences can affect attitudes toward medical care as well as the ability to understand, manage and deal with the course of an illness.

A further cause of population healthcare needs are the refugee camps from which they originate in their home country. Of the 51 million people currently living as refugees 12 million of these reside in refugee camps (Byler, Gelaw and Koshnood 2017). They also suggest that these camps are overcrowded, and their rudimentary design has a negative impact on delivery of aid, disease levels and safety. Habib, Basma and Yeretzian (2006) found that 69.5% of refugee camp households reported a presence of illness amongst household members and of those that were ill, more than half reported at least two

conditions at the same time. Interestingly, Habib, Basma and Yeretian (2006) also found that over 50% of these illnesses were circulatory, musculoskeletal or respiratory.

Allsopp, Sigona and Phillimore (2014, p.29) found that upon arrival in the UK, asylum seekers and refugees were often placed in poor housing conditions. These include damp, lack of locks on bedroom doors, pest infestation, delays in repairs and lack of heating or hot water, leading to a rise in mental health problems and an increase in suicide risk (Cowburn 2017).

## **Travel**

For many of those seeking asylum the journey to the UK can be treacherous (Squire et al. 2017). Although information specifically related to travel methods is limited, Turner (2015) finds that many asylum seekers and refugees arriving in Europe are often transported across the Mediterranean by people smugglers, in boats that are not fit for the journey, overcrowded and dangerous.

## **Physical Health**

Although there appears to be limited research on the physical health of asylum seekers and refugees specific to the UK, there is evidence to provide an overall perspective of these populations' physical health needs. According to Webb, Ryan and O'Hare (2005) children may arrive without complete immunization schedules, unknown immunization history or with no prior immunizations or screening, while Levi et al. (2014) find that there is widespread uncertainty surrounding which vaccinations asylum seekers have received in their home countries.

According to the World Health Organization (WHO 2000), asylum seekers and refugees have a variety of non-specific health problems. Common health problems include; accidental injuries, hypothermia, burns, gastrointestinal illness, cardiovascular events, pregnancy and delivery-related complications, diabetes, and hypertension. The WHO (2000) also states that risks associated with population movements such as psychosocial disorders and reproductive health issues can increase the risk of non-communicable diseases. Furthermore, it states that these non-communicable diseases such as diabetes and hypertension have a prevalence as high as 25-35% in low or middle-income countries, those from which asylum seekers and refugees predominantly originate.

According to Olsen, Stauffeur, and Barnett (2017), asylum seekers and refugees may also suffer from nutritional deficiencies. Olsen, Stauffeur, and Barnett (2017) explain that nutritional deficiencies are particularly common in refugee populations, stating that 27-32% of Bhutanese and Nepali refugees arriving in the USA suffered from vitamin b12 deficiency due to malnutrition in their home countries.

Abidi et al. (2012) also find that refugee populations from war-afflicted countries are exposed to specific risk factors such as unprotected sex and intravenous drug use that predispose them to communicable diseases such as sexually transmitted diseases, blood-borne diseases and other infections. They also highlight how Afghan asylum seeker and refugee populations suffer from multiple disadvantages such as illiteracy, low socioeconomic conditions, high unemployment and limited life-sustaining resources such as running water and waste management systems, leading to exponential proliferation of

infectious disease.

According to Asif, Baugh and Jones (2015) pregnancy can cause additional healthcare complications for asylum seekers, and they state that it is difficult to ascertain the actual population of pregnant refugee and asylum seekers that reside within the UK. Interestingly, Feldman (2014) found that in 2011 there were 500 pregnant women seeking asylum and receiving support in the UK, in addition to 125 who were refused asylum. Both Asif, Baugh and Jones (2015) and Feldman (2014) agree that pregnant asylum seekers and refugees suffer a complexity of physical and mental health problems, as well as issues surrounding being dispersed to a different area later on in pregnancy causing interruptions and lack of continuity in maternity care. According to Bowyer (2008) the CEMACH (Confidential Enquiry into Maternal and Child Health) report found that black African women, including asylum seekers and refugees, have a mortality rate nearly six times higher than white women which may be linked to interruptions in maternity care.

Lewis (2007) also highlights other issues such as a reluctance to seek maternity care among these populations due to fears about immigration status or shame within their community, in addition to high levels of physical and sexual violence suffered by women asylum seekers and refugees. Additionally the WHO (2006) highlights how the health of asylum seekers and refugees who have undergone FGM (female genital mutilation) may also be at risk of difficulties during labour, including the need to have a caesarean section, dangerously heavy bleeding, and prolonged hospitalisation after birth.

Feldman (2014) finds that the majority of non-English speaking pregnant asylum seekers and refugees did not have access to translation services; a significant factor that may have affected communication of their healthcare needs. Nabb (2008) also finds that provision of maternity care to pregnant asylum seekers is inadequate and must be addressed so that appropriate services that overcome complex barriers to healthcare can be developed and delivered. Nabb (2008) states that these might range from specific midwifery support for women in emergency accommodation, to streamlining of interpreter services so that women can discuss their care in a known language. Nabb (2008) goes on to highlight how interpreter services are integral to providing effective healthcare, since, if this is not available, information can become lost and the standard of treatment ultimately suffers.

The physical and psychological healthcare needs of female asylum seekers may be worse than that of their male counterparts due to war. Canning (2011) states that rape has only recently been recognized as a weapon of war, and considers being female to be more dangerous than being a soldier. War is usually the primary reason behind asylum applications and it could be argued that the psychological and physical healthcare needs of female asylum seekers and refugees arriving from such countries will have greater demand for specialist services in contrast to their male counterparts. Canning (2011) also identifies that there is a lack of suitable support for female asylum seekers who are victims of sexual violence and FGM. Canning (2011) states that not only are a large number of talking therapists male and as a consequence highly unapproachable, but also from a cultural perspective, the notion of speaking to a stranger about such personal

issues may be a bizarre notion for many asylum seekers and refugees.

Diseases related specifically to asylum seekers and refugees can be challenging to identify, as according to Kärki et al. (2014) only just over half of countries where asylum seekers and refugees originate from had screening programmes in place for infectious diseases such as hepatitis B and tuberculosis. Moreover, Rechel et al. (2013) find that it is particularly challenging to ascertain information about specific infectious disease rates amongst asylum seekers and refugees, and that movement into the EU may be a contributing factor to increased rates of tuberculosis and hepatitis B .

### **Future of healthcare amongst asylum seekers and refugees within the UK**

There appears to be a significant lack of research and information surrounding what the future holds for the healthcare provision of asylum seekers and refugees. There does, however, appear to be a series of recommendations for provision improved healthcare amongst them. Taylor (2009) recommends practical solutions, such as mandatory health screening and dedicated healthcare advocates, as well as social solutions such as improved social integration, which Taylor (2009) believes can improve health outcomes for asylum seekers and refugees.

Charities like Mind (2017) suggest that healthcare providers need to build stronger relationships with asylum seeker and refugee communities to improve their mental health, as well as suggesting many strategies to benefit the mental health of these populations such as the development of accredited mental health advocacy qualifications specializing in refugee communities. Mind (2017) also recommends support for mental health

advocates from refugee communities to develop the skills to become Independent Mental Health Advocates and also highlights that there is a need for cultural competence training for NHS staff at all levels.

On a more pragmatic level, Arnold et al. (2015) outline work being undertaken by Public Health England (PHE), who are exploring ways to address the health needs of all UK asylum seekers, refugees and migrants. PHE (cited in Arnold et al. 2015) suggest a revision of guidance on pre-entry health assessments, as well as improved support for health professionals who deal with these groups. The paper identifies the importance of these initiatives to prepare healthcare services for asylum seeker and refugee populations in the future.

## **Conclusion**

Historically, asylum seeker and refugee populations have been overlooked by both politicians and the communities around them for many years. Whilst economic perceptions of asylum seekers and refugees are quick to highlight the financial burden these populations appear to place upon the UK; there is limited research to suggest how we deal with their healthcare issues to reduce this.

The information within this article suggests that not only are the healthcare services which serve these populations severely under-resourced, but also there are significant barriers to effective healthcare for asylum seekers and refugees as a result of cultural disparities between these service users and UK healthcare providers, which can only be resolved through substantial educational interventions amongst asylum seekers, refugees and

healthcare services. Without this education-focused approach, combatting the growing cultural, economic and health disparities between the indigenous population and the population of asylum seekers and refugees within the UK may be impossible.

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