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Health ASERT Programme Wales

Enhancing the health promotion evidence base on
Minority Ethnic Groups, Refugees/Asylum seekers,
and Gypsy Travellers

4.A Review of the Literature on the Health Beliefs, Health Status, Health Needs, and Use of Services in the Refugee and Asylum Seeker Population and of appropriate Health and Social Care Interventions

Foreword for series

As Minister for Health and Social Services, I am pleased to present the Health ASERT Programme Wales report series to you. This report series details the findings and the recommendations arising from this important research programme examining health promotion issues for minority ethnic groups, refugees/asylum seekers and Gypsy Travellers living in Wales.

This research programme demonstrates the commitment shown by the Welsh Assembly Government to promoting equality of opportunity in all aspects of Welsh life and reducing inequalities in health faced by ethnic minority and marginalised groups. In order for us to meet this commitment and develop appropriate policies and practices, it is imperative that we have access to a solid evidence base, drawn from the available literature and the views of those directly affected by our policies. The research reported here involved community members as well as key stakeholders at the national and local levels. This input, combined with the extensive review of the literature on the health beliefs and health status of these groups and their use of services and on appropriate health care interventions has culminated in a comprehensive piece of work.

One of the key conclusions of the research is that promoting good health is the responsibility of individuals, communities and Government. I wholeheartedly endorse this sentiment, which forms the approach behind Health Challenge Wales, a call to all people and organisations in Wales to work together for a healthier nation.

I trust that you will find this report series both enlightening and thought provoking, as indeed the Deputy Minister and I have. Furthermore we hope that you will use the report series as a source of reference material for your work.



Brian Gibbons AM
Minister for Health and Social Services



John Griffiths AM
Deputy Minister with responsibility for older people

Health ASERT Programme Wales Report Series

Health ASERT Programme Wales. Enhancing the Health Promotion evidence base on Minority Ethnic Groups, Asylum Seekers/Refugees and Gypsy Travellers.

1. Main Findings and Recommendations
2. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Gypsy Traveller Population, and of appropriate Health Care Interventions
3. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Minority Ethnic Group Population, and of appropriate Health Care Interventions
4. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Refugee and Asylum Seeker Populations, and of appropriate Health Care Interventions
5. A Review of Databases and Other Statistical Sources Reporting Ethnic Group and their Potential to Enhance the Evidence Base on Health Promotion (to be published 2006)
6. Summary Primary Research Report (to be published 2006)
7. Full Length Primary Research Report (to be published 2006)

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The views expressed in this report are those of the author and not necessarily those of the Welsh Assembly Government

Contents

| | |
|---|-----------|
| Executive Summary | 9 |
| I. Health Status, Behaviour, Wider Determinants of Health, and Use of Services | 15 |
| 1. Background and policy | 15 |
| 1.1 Background | 15 |
| 1.2 The national policy context | 15 |
| 1.3 The policy context in Wales | 17 |
| 2. Women’s health | 20 |
| 2.1 Antenatal care and pregnancy outcomes | 20 |
| 2.2 Maternal mortality | 22 |
| 2.3 Cervical screening | 22 |
| 2.4 Breast examinations and screening | 22 |
| 2.5 Female genital mutilation | 23 |
| 2.6 Domestic violence | 23 |
| 3. Children and young person’s health | 24 |
| 3.1 Post Traumatic Stress Disorder (PTSD) | 25 |
| 3.2 Emotional and behavioural difficulties | 29 |
| 3.3 Young people | 29 |
| 4. Mental health | 32 |
| 5. Chronic conditions | 34 |
| 6. Disability | 35 |
| 7. Communicable disease, gastrointestinal disease and infections | 36 |
| 7.1 Communicable disease | 36 |
| 7.2 Gastrointestinal disease | 37 |
| 7.3 Tuberculosis (TB) | 37 |
| 7.4 Immunisation | 38 |
| 8. Injury and Torture | 40 |
| 9. Sexual health | 41 |
| 9.1 Sexual health | 41 |
| 9.2 Family planning | 41 |
| 9.3 HIV/AIDS | 41 |
| 10. Oral health care | 43 |
| 11. Lifestyle factors | 44 |
| 11.1 Smoking | 44 |
| 11.2 Alcohol use | 44 |
| 11.3 Illicit drug use | 44 |
| 11.4 Diet and Nutrition | 45 |

| | |
|--|-----------|
| 12. Access to and use of services | 47 |
| 12.1 Rates of GP registration and use | 47 |
| 12.2 Barriers to access | 48 |
| 13. Wider Determinants of health | 52 |
| 13.1 Environmental factors: housing | 52 |
| 13.2 Socio-economic factors: employment, income and poverty | 52 |
| 13.3 Educational factors | 53 |
| 13.4 Social support and social inclusion | 54 |
| II. Health and Social Care Interventions | 55 |
| 1. Enrolment of asylum seeking children in school | 55 |
| 2. Support projects for young separated refugees/asylum seekers | 55 |
| 3. Care of unaccompanied asylum seeking children by statutory services and transition from care arrangements | 56 |
| 4. Training of refugee doctors | 56 |
| 5. Patient-held records | 57 |
| 6. Hand-held cards (childhood immunisation) | 58 |
| 7. Dedicated GP practices | 58 |
| 8. Dedicated GP for high mobility populations | 59 |
| 9. Health support teams to improve access and ease burden on GPs | 59 |
| 10. Other changes in primary care practice | 59 |
| 11. Specialist expertise in refugee and asylum seeker issues | 60 |
| 12. Specialist mental health services | 60 |
| 13. Specialist services for survivors of torture and organised violence | 60 |
| 14. Provision of translation, interpreting, and advocacy services | 61 |
| 15. Models of service delivery for health promotion | 61 |
| 16. Improved initial health assessments at point of arrival | 62 |
| 17. Tuberculosis (TB) screening of new arrival asylum seekers and refugees | 63 |
| 18. Personal Medical Services (PMS) Pilot Projects, Local Development Schemes, and the new GP contract: specialist provision for refugees and asylum seekers | 64 |
| 19. Culturally appropriate interventions for HIV/AIDS | 65 |
| 20. Maternity services | 66 |
| Culturally competent components of good practice in health promotion, preventive care, and treatment interventions | 67 |
| III. Recommendations | 68 |
| Appendix 1: Glossary of terms | 69 |
| Appendix 2: Literature search strategies | 71 |
| Appendix 3: Evidence grading of interventions | 73 |
| References | 75 |

Preface

The Health ASERT Programme Wales is a research programme commissioned by the Office of the Chief Medical Officer, Welsh Assembly Government to investigate health promotion issues among Minority Ethnic Groups, Refugees/Asylum seekers, and Gypsy/Travellers. The acronym ASERT stands for **A**sylum **S**eekers, **E**thnic minorities, **R**efugees and **T**ravellers. Research was undertaken by the Research Centre for Transcultural Studies in Health, Middlesex University and the Centre for Health Services Studies, University of Kent at Canterbury between February 2003 and March 2004. The study aimed to enhance the evidence base on health promotion issues related to minority ethnic groups, refugees/asylum seekers and Gypsy Travellers in Wales in order to inform policy and programme development in the Welsh Assembly Government's Health Promotion Division (now known as Public Health Improvement Division) and elsewhere in the Office of the Chief Medical Officer. The study objectives were to: identify gaps in the existing evidence base of health needs and health promotion issues for the study groups; identify existing good practice of health services and promotion for the study groups; explore ways of delivering health promotion policy/programmes targeting these groups in a culturally and socially sensitive manner; identify issues for further research.

Acknowledgements

I am grateful to Ms. Kaori Onoda and Ms. Launa Anderson of the Research and Evaluation Branch, Public Health Improvement Division, and other members of the Health ASERT Programme Wales Steering Group, and Welsh Assembly Government for their helpful and informative comments on an earlier draft of this report.

Executive Summary

I. Health Status, Behaviour, Wider Determinants of Health, and Use of Services

I. Background and policy

Applications for asylum in the UK have increased markedly in recent years. However, there is a lack of statistical information on the numbers of refugees and asylum seekers in specific areas, other than numbers supported by National Asylum and Support Service (NASS). In December 2002 there were around 1,770 asylum seekers in Wales supported by NASS, although the settled refugee population in Wales is substantially larger, and estimated to be over 6,000 in Cardiff.

The most important recent change of national policy, brought about by the Immigration and Asylum Act 1999, is the national dispersal policy for asylum seekers. Policy issues raised in Wales include the lack of evidence with which to judge the impact of the national programme, the impact on local authority budgets of the programme, core funding for refugee community organisations, and detention of asylum seekers.

Refugees and asylum seekers experience a complex range of health problems of both a physical and psychological nature, with surveys reporting a wide spectrum on self-reported general health status measures. However, there is a lack of data on assessed generic health using standard instruments.

2. Women's health

Several studies report poor antenatal care and pregnancy outcomes amongst refugees and asylum seekers. Studies of Somali women suggest unequal access to maternity services because of inadequate interpreting services, stereotyping and racism from health service staff, and a lack of understanding amongst staff of cultural differences. A low uptake of cervical screening (around 25 per cent) is reported in two studies and even lower rates for breast screening. Other concerns specific to women that are reported in the literature include female genital mutilation and domestic violence, although there is a lack of prevalence data.

3. Children and young person's health

UK government statistics show a rapid rise in the number of unaccompanied children arriving in the UK to seek asylum. Overall, asylum seeking children represent 6 per cent of all children served by councils with social services responsibility. Information on the prevalence in the UK of Post Traumatic Stress Disorder (PTSD) amongst refugee/asylum seeker children from war zones and areas that have experienced 'ethnic cleansing' is very limited. Evidence from other countries shows that the prevalence of PTSD is considerably higher than that reported for the population as a whole, with rates of recovery (especially from PTSD) depending on experience of earlier war trauma and resettlement stress, gender, psychological resilience, and the treatment options available.

There is evidence that unaccompanied asylum seeker children do not receive the same standard of care routinely afforded to indigenous children under the Children Act 1989, for example, with respect to needs assessment, care plans, and placements. A broad spectrum of unmet needs has been identified in young (including separated) asylum seekers in relation to their housing circumstances, bullying at school and problems related to language barriers.

4. Mental health

Mental health is one of the most frequently reported health problems amongst both dispersed asylum seekers and those in areas of traditional settlement, including anxiety, depression, phobias and PTSD. Rates are up to 5 times higher in some samples. A recent study of over 800 Kosovan Albanian refugees settled in the UK yielded estimates of a diagnosis of PTSD in just under a half and a major depressive disorder in around one fifth. Both pre-migration experiences of violence and post-migration social difficulties appear to determine the severity of PTSD and depression.

5. Chronic conditions

There is a paucity of information in the literature on the prevalence of chronic conditions, although high rates of diabetes, hypertension, and coronary heart disease are reported in refugees/asylum seekers from eastern Europe. One UK study of dispersed asylum seekers found self-reported rates of asthma, diabetes, hypertension, and heart disease in the range 2.3 to 3.8 per cent and 6.3 per cent for arthritic disease.

6. Disability

There is only limited evidence on the prevalence of disability amongst refugees and asylum seekers in Britain, with estimates varying from 3-10 per cent across different samples. A recent postal survey found little or no commissioning of services for refugees and asylum seekers.

7. Communicable disease, gastrointestinal disease and infections

A wide range of communicable diseases has been found amongst refugees and asylum seekers, including malaria, tuberculosis (TB), and chronic hepatitis B. A Liverpool study found 5.7 per cent of a Somali population were carriers of the surface antigen and 8.7 per cent of children had evidence of exposure to hepatitis B. There is growing concern about the increase in incidence of TB in those recently arrived in the UK, especially the spread of multi-resistant TB. However, practice with respect to TB screening is reported to be variable. Studies suggest that the port of arrival scheme has a poor yield, with as few as a half of dispersed asylum seekers getting TB screening. Alternative settings include GP practices. Low rates of vaccination for children and poor provision are reported in a number of studies in dispersal areas, although higher rates have been reported in London.

8. Injury and torture

Estimates of the proportion of asylum seekers who have been tortured vary from 5 to 30 per cent, local studies reporting that injuries caused by persecution and torture are one of the most frequent issues raised amongst asylum seekers.

9. Sexual health, family planning and HIV/AIDS

Sexual health needs are prominent in assessment surveys undertaken in areas of dispersal, being the third most frequent issue raised in one survey. Studies in London also report a low uptake of family planning services, suggesting that there may be barriers to the ability of refugee and asylum seeker women to access these services. The prevalence of HIV/AIDS is raised in some migrant communities - especially those from the pandemic area of sub Saharan Africa - and is likely to reflect that in the country of origin, although refugees may have been placed at greater risk. Many studies report low take-up of HIV/AIDS treatment and care services, especially amongst the Black African community, and the dispersal programme may exacerbate this problem.

10. Oral health care

Dental problems are widely reported to be common amongst asylum seekers and refugees and access to dental services frequently experienced as difficult.

11. Lifestyle factors

There is a dearth of information on health related behaviours. A high prevalence of male smoking (47 per cent) has been reported in Vietnamese adults. Somewhat lower levels (43.6 per cent in males, 21.6 per cent in females) were found amongst dispersed asylum seekers in Sunderland and North Tyneside. The prevalence of alcohol consumption in this study was 45.4 per cent and 18.9 per cent, respectively. There is only limited evidence of illicit drug use amongst refugees and asylum seekers. However, concern has been expressed about the role of khat (qat)¹ in Somali communities where there is evidence of high and regular use. There is also some evidence that substance misuse is used as a coping strategy or as a self-medication.

Few studies have reported on diet and nutrition in refugee and asylum seeker communities, yet there is some evidence that poor nutrition may be going undetected in newly arrived asylum seekers. There would appear to be grounds for supporting both rapid assessments of the prevalence and causes of child hunger among this group in specific community settings and broader population-based assessments of food insecurity².

12. Access to and use of services

Varying levels of GP registration are reported in studies and some GPs offer only temporary registration, although data are frequently unavailable on this. There is, too, some evidence of higher use of Accident and Emergency (A&E) services amongst asylum seekers. Nearly all studies of asylum seekers and refugees identify barriers and problems in accessing health services and a very wide range of access issues are identified in both refugee and asylum seeker accounts and in those of providers and other health care professionals. The type and frequency of barriers varies across client groups and services. There is substantial evidence that communication (especially relating to language) is a major barrier in accessing primary care and other services, especially out of hours services.

¹ Khat (qat) is a green-leaved shrub that has been chewed for centuries by people who live in the Horn of Africa and Arabian Peninsula. It is a stimulant drug with effects similar to amphetamine.
http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11111\khat.html

² Food insecurity is a lack of access at all times, due to economic barriers, to enough food for an active and healthy lifestyle. (Quandt et al., 2004)

13. Wider determinants of health

The scale of housing required by NASS to support the dispersal programme is considerable and has required phased-in provision. Moreover, pressures on housing stock, especially in London, have forced Councils to house asylum seekers in unsuitable accommodation.

Recent research has demonstrated that asylum seekers and refugees experience significantly higher levels of unemployment than the population as a whole and many barriers to employment have been identified.

Standards of good practice with respect to access to education are not being met in a number of key areas and the barriers identified include the failure to offer language and other support. Once placed in schools, asylum seeker children may require a range of specialist education services to meet their needs. There are also national variations in the quality and quantity of ESOL (English for Speakers of Other Languages) provision.

The potential for social exclusion in the government's new dispersal arrangements has been recognised.

II. Health and Social Care Interventions

There is a dearth of robustly evaluated interventions that address the health and social care needs of asylum seekers.

With respect to children/young people, there are examples of good practice in the enrolment of asylum seeker children in school, support projects for young separated refugees/asylum seekers, and the care of unaccompanied asylum seeker children by statutory services and transition from care arrangements.

There are several examples of good practice with respect to the training of refugee doctors. Patient-held records for asylum seekers and refugees have been recommended by a number of sources but such records have only been formally tested in other populations, including maternity services. There is strong evidence from US studies of inner city and/or minority ethnic children to support the use of hand-held cards for childhood immunisation.

Dedicated GP practices or specialist centres for refugees and asylum seekers have been advocated and one such practice has opened in London, although they are likely only to be practical in areas with a high density of refugees and asylum seekers. Another approach has been to establish a dedicated resource for high mobility groups within a GP practice. While there are examples of this model, no evaluations have been reported. Some of the Primary Medical Services (PMS) Pilot Projects were set up to enable enhanced or separate primary care services to be developed for asylum seekers and other vulnerable sections of the population. However, none of the national evaluations of PMS pilots have evaluated those explicitly set up to address the needs of refugees and asylum seekers.

Similarly, there are examples of health support teams to improve access and ease burdens on GPs and, although no formal evaluations are available, initial feedback suggests that these arrangements are beneficial. Moreover, specialist expertise and service provision (e.g. specialist

health workers) is frequently cited as an example of good practice in surveys. A number of specialist mental health services and specialist services for the survivors of torture are cited as examples of good practice.

Several interventions have been documented that address language and other communication barriers, although none have been subject to comprehensive evaluation. The literature describes a range of models of service delivery for health promotion, including written information, videos and audio cassettes, telephone-based support services, and outreach teams but again, there is a paucity of formal evaluations.

There is evidence to recommend improved initial health assessments at port of arrival, such as questionnaire based assessments administered by interpreters. However, the evidence for the effectiveness of TB screening of new arrival asylum seekers and refugees appears to vary regionally, one study showing that such screening in primary care is feasible and could replace hospital screening of new arrivals.

Finally, the success has been reported of a number of culturally appropriate interventions for HIV/AIDS.

III. Recommendations

Based on this review of the literature on the health beliefs, health status, and use of services in the refugee and asylum seeker population, and of appropriate health care interventions, a number of recommendations for policy and practice are put forward.

1. Better information is needed on the size and location of the groups, although use could be made of the 2001 Census country of birth full tabulations.
2. Baseline health assessments, including co-ordination of those completed at entry (now being introduced by Government) are needed.
3. There is a lack of longitudinal data on the health experiences of refugees/asylum seekers that needs to be addressed.
4. There is a need for better information in administrative systems and ethnic monitoring.
5. There is a need for health needs based provision of services, the evidence base providing several examples of good instruments and research into practice models.
6. Projects focussing on this population require robust evaluation and outcome measurement, which is currently lacking.
7. Good practice examples should be built upon: support projects for the young, transition from care, training of refugee doctors, patient-held records, dedicated GPs/practices where justified by numbers, specialist services (e.g. effects of torture), culturally sensitive maternity services, etc.

I. Health Status, Behaviour, Wider Determinants of Health, and Use of Services

I. Background and Policy

I.1 Background

Applications for asylum in the UK are of a significant magnitude, despite falling in recent years. In 2002 there were almost 86,000 applications for asylum in the UK, 20 per cent more than in 2001. In 2003 this number was 49,405 and in 2004 it was 33,960. In 2004 the top applicant nationalities were Iran, Somalia, China, Zimbabwe, and Pakistan¹.

Prior to the establishment of National Asylum and Support Service (NASS), the Home Office did not publish statistics on the size of the refugee population in different local authority areas nor the number of new applications made by asylum seekers by local authority of residence. Now tables are published of the number of asylum seeker applicants (including dependants) in receipt of subsistence only support and those supported in NASS accommodation by local authority. In December 2002 there were a total of 180 asylum seeker applicants in Wales who were in receipt of subsistence only (0.48 per cent of the UK total) and 1,585 who were supported in NASS accommodation (2.93 per cent of the UK total). No other breakdown of these applicants is provided in the Home Office's Asylum Statistics. However, some Welsh cities and towns have large settled refugee populations, for example, Cardiff has a community of around 6,000.

Refugees and asylum seekers are widely reported to experience a complex range of health problems of both a physical and psychological kind, although there is a lack of generic health data on this population that is based on standard instruments like SF-36 or Euroqol 5D. Surveys have found a wide spectrum of general health status self-reported by asylum seekers on arrival. In a survey of asylum seekers in Haringey, 90 per cent of respondents reported that they were physically healthy on arrival and 83 per cent remained healthy after arrival (Haringey Council, 1997). Brent and Harrow Refugee Survey (1995), by contrast, found that the mental and physical health of the refugee population was significantly worse than that of the general population, with 53 per cent of refugees reporting having long-term illness. A study in Newham (Gammell *et al.*, 1993) suggested that the perceived health of refugees appeared to deteriorate over a period of time in the UK. There is the possibility that this may result from stress related to unemployment, temporary accommodation, poverty, and other factors.

I.2 The national policy context

The most important recent change in policy was brought about by the Immigration and Asylum Act 1999. In that year over 70,000 asylum applications were made, the backlog of claims awaiting a decision almost reached 100,000, and London housed over 85 per cent of asylum seekers and refugees. To ease pressure on London and Kent, the Act introduced a national dispersal policy for asylum seekers, the National Asylum and Support Service (NASS) being set up to manage the dispersal. Local authorities actively engaged in offering housing and support to asylum seekers were grouped into regional Consortia across the UK. By the end of 2002 almost 38,000 asylum seekers were in receipt of NASS subsistence only support and a further

¹ <http://www.homeoffice.gov.uk/rds/immigration1.html>

54,000 supported in NASS accommodation. The majority of asylum seekers in receipt of subsistence support only were in Greater London (75.5 per cent), but only 4.8 per cent of those supported in NASS accommodation.

The dispersal of asylum seekers was widely predicted to have deleterious consequences for the health of recipients who would be dispersed to areas of the country lacking the necessary infrastructure and support services (Connelly and Schweiger, 2000). A study of healthcare issues one year after the Home Office had begun to disperse asylum seekers (Johnson, 2003) reported the following findings:

- There were some health problems associated with travelling long distances during dispersal, especially amongst the elderly and pregnant women, which could have been identified through initial health screening.
- Healthcare professionals were concerned that asylum seekers were being moved from place to place by NASS and its accommodation providers, making it difficult to obtain registration with medical practitioners and healthcare programmes.
- High mobility meant that healthcare providers often had to treat asylum seekers before the arrival of their medical notes, although some practitioners were starting to issue hand-held patient records.
- Practitioners noted that the inclusion of some medical information on NASS accommodation would be useful.
- Most healthcare providers reported that their principal problems arose from the number, diversity and irregular flow of asylum seekers.
- Good practice guidelines for asylum seeker health should be promoted.
- There was a need for appropriate training and more support to help staff deal with the needs of asylum seekers and refugees sensitively, to work more effectively with interpreters, and help staff to deal with the emotional impacts of traumatic cases.

During 2003 there were further developments in national policy relating to the health of asylum seekers and refugees. The Department of Health established an Asylum Seekers Co-ordination Team (ASCT) (<http://www.dh.gov.uk/PolicyandGuidance/International/AsylumSeekersAndRefugees/fs/en>) with responsibility for co-ordinating policy relating to the healthcare of these groups. One of the functions of the team is to work with other government departments, especially the Home Office, to ensure that the health and social care needs of the diverse groups constituting the refugee/asylum seeker population are considered at all stages of the asylum process. The team's website contains a resource pack produced by the Department of Health and the Refugee Council (2003), which gives information on key policies and entitlements for use by all frontline health staff and service planners who come into contact with asylum seekers/refugees, a new patient-held record, and the team's newsletters.

Nationally, new developments provided for in the Nationality, Immigration and Asylum Act 2002 (November) included induction centres, health assessment, and proposed accommodation centres. The government was aiming for an UK network of induction centres, where asylum seekers would stay for a short period before being dispersed, the first of these being established at Dover. Initially, health assessments were only given to a selection of the residents at east Kent as a 'pilot' but this has now been extended to all residents and

is making use of the new patient-held record. The asylum seeker takes the patient-held record with them on dispersal and a copy is at the relevant induction centre. Health assessment for all asylum seekers in induction comprises a health needs assessment, records a basic health history, addresses public health concerns, and includes screening for tuberculosis (TB). More recently, the government announced that it would not be proceeding with the proposed accommodation centres, due to falling numbers of asylum seekers and new measures proposed in a five year strategy for asylum and immigration (HM Government, 2005).

1.3 The policy context in Wales

Some of the evidence presented in this section is based on debates and expert testimony from the Welsh Assembly Government, Equality of Opportunity committee meetings. Where this is the case this is indicated. Access to the minutes and transcripts to these meetings are available on-line².

The Welsh Assembly Government has expressed a commitment to reducing inequalities in health, including those for ethnic minority and marginalised groups in Wales in a number of recent reports and policy statements. This was demonstrated in the consultation document *Well Being in Wales* (Welsh Assembly Government, 2002) which highlighted the specific needs of disadvantaged groups such as Travellers and black and minority ethnic communities and the need to improve the health of disadvantaged groups. This builds on the foundation set by the consultation document *Better Health Better Wales* (National Assembly for Wales, 2000) which gave a commitment to reduce health inequalities faced by minority ethnic groups in Wales. The NHS Plan for Wales recognised the need for health services to meet the needs of local people and for them to be delivered in culturally appropriate ways (National Assembly for Wales and NHS Wales, 2001). The Chief Medical Officer's Report for 2001/2002 *Health in Wales* (National Assembly for Wales, 2002) also emphasises the disproportionate impact of health inequalities on minority ethnic and marginalised groups.

The National Assembly for Wales' (2005) Race Equality Scheme for 2005-2008 sets out policies to date and future commitments, highlighting the need to meet the health and social care needs of people from minority ethnic groups. Local initiatives have been stimulated by various grant schemes. For example, the Assembly Government's Inequalities in Health Fund (IHF)³ has assisted disadvantaged communities, including support for action to improve access to health services for people from black and minority ethnic groups (Hutt, 2002). The Sustainable Health Action Research Programme (SHARP) is another Assembly Government programme which has funded seven projects across Wales for a period of five years (2000-2005), some of the projects having an ethnic minority focus⁴. Through the All Wales Selected Minority Group a number of initiatives are in place to meet the health needs of refugees and asylum seekers, including funds for Local Health Boards to meet the costs of assessing the health needs of asylum seekers. The Primary and Secondary Care Race and Health Projects, which began in August 2000, aimed to determine the primary and secondary care needs of black and ethnic minorities through a process of consultation and collaboration. Both of these were undertaken by the All Wales Ethnic Minority Association (AWEMA) and are now completed.

² <http://www.wales.gov.uk/keypubassemblerequalcomm.index.htm>
<http://www.wales.gov.uk/keypubassemblerequalcomm2/index-e.htm>

³ <http://www.cmo.wales.gov.uk/content/work/inequalities-in-health-fund/index-e.htm>

⁴ <http://www.cmo.wales.gov.uk/content/work/sharp/index-e.htm>

There is a wide range of agencies involved with refugee and asylum seeker issues in Wales. These include the Welsh Assembly Government, National Health Service, Welsh Local Government Association, Welsh Refugee Council, Oxfam Cymru, Commission for Racial Equality and Cardiff and District Asylum Seekers Network. Furthermore there are specific refugee support organisations e.g. Swansea Bay Asylum Seekers Support Group and the Somali centre, Cardiff. There are also bodies such as the National Asylum Support Service, as asylum is a non-devolved issue.

The Welsh Refugee Council, the only national Welsh refugee agency, was set up in 1990 as a registered charity, currently employs around 30 persons, and has responsibility for reception and the one-stop shop. It has offices in Newport, Swansea, and Wrexham and its services include befriending projects, volunteering, adult education, and worker support.

The National Assembly for Wales Equality of Opportunity Committee stated that NASS proposes to disperse to Wales around 4,000 asylum seekers, 2,000 with the Welsh Local Authorities Consortium for Asylum Seekers (WLACRAS), 1,000 with Cardiff, and 1,000 with the private sector (with concern expressed about costs of infrastructure to support private sector contracts). However, there are no reliable figures on the overall size of the asylum seeker and refugee population in Wales. Using data from the 1991 Census, voluntary organisations working with refugees, and a survey of other organisations in contact with refugees, Robinson (1997) estimated that the refugee population in Wales then comprised approximately 1,016 households and 3,565 individuals. Amongst more recent estimates, a report by Cardiff City Council (2004) states that the city had a settled refugee population of over 6,000 and the Welsh Refugee Council estimates that there are around 10,000 refugees in Wales.

There is a dearth of up to date statistical data. The main source of such data that is in the public domain relates to asylum seekers supported by NASS (Table 1). Of those dispersed to Wales since April 2001, a substantial majority is in receipt of both accommodation and support. At the end of June 2005, 2,390 asylum seekers were receiving accommodation and/or subsistence from NASS in Wales, around 43% (1,025) of whom were based in Cardiff. These statistics are broadly consistent with figures (n=2,232) on dispersed asylum seekers in Wales given by WLACRAS in 2004: 231 single males, 56 single females, 872 people in families with a male as head, and 1,073 people in families with a female as head (again, 43.5% being based in Cardiff).

Only limited information is available on children as such data are not recorded by NASS. However, Cardiff City Council Asylum Team does report the ages of dependent children: 395 accompanied children from 37 countries were being accommodated by the city council in August 2004, 107 of whom were two years old and under and 287 ten years and older. Although reliable figures on unaccompanied asylum seeking children are unavailable, Save the Children Wales (Hewett *et al.*, 2005) estimated that 70 unaccompanied children were being looked after by local authorities in Wales (based on data supplied by WLACRAS). Further, the NASS statistics do not provide information on the numbers of residents in Wales who have received refugee status or other forms of temporary protection, such as Exceptional Leave to Remain, Humanitarian Protection, or Discretionary Leave.

There is also a dearth of data on the diversity of the asylum seeker/refugee population in Wales. With respect to those housed in NASS accommodation at the end of December 2004, asylum seekers came from 53 countries, the largest country of origin groupings being Somalia

(28% of the total), Pakistan (16%), Iraq (15%), and Iran (10%). Other research - undertaken by Save the Children (Middleton, 1994) and Hansen and Hempel-Jorgensen (2001) - points to a long established Somali community in Cardiff.

Table 1. Numbers of refugees and asylum seekers in Wales

| Unitary Authority | Number of Asylum Seekers | Asylum Seekers Supported in NASS Accommodation December 2002⁵ |
|------------------------------|---|---|
| Cardiff | A settled refugee population of over 6,000 people from more than 50 countries; over 1,000 asylum seekers, part of the Government's dispersal programme ^{3,4} | 1,025 asylum seekers, 980 in receipt of accommodation and subsistence and 45 subsistence support only from NASS (as at June 2005) |
| Wrexham | Refugees and asylum seekers number 85, including 14 children under 17 years of age. Their countries of origin are: Zimbabwe (29), Iraq (18), Turkey (13), Nigeria (5), Czech Republic (4), South Africa (3), Cameroon (3), Rwanda (2), Estonia (2), and Ivory Coast, Congo, Sudan, Sri Lanka, Eritrea, and Ethiopia (1 each) ² | 48 (41 with NASS accommodation and 7 with NASS subsistence support only) |
| Newport | Local asylum seeker teams support 15 single people, 5 families and 5 unaccompanied children ¹ | 195 (173 with NASS accommodation and 22 with NASS subsistence support only) |
| Monmouthshire | No refugees and asylum seekers in local authority ² | |
| Powys | 2 Single men ² | |
| Neath and Port Talbot | 'Homelessness section are not dealing with any such cases as present' ² | 0 |
| Swansea | No data | 715 (693 with NASS accommodation and 22 with NASS subsistence support only) |

Sources:

¹Audit Commission (2002)

²ASERT Local Authority Questionnaire: Refugees and Asylum Seekers, March/April 2003

³Audit Commission in Wales (2003)

⁴Cardiff Local Health Group Board meeting (2002)

⁵NASS statistics reported by WLACRAS (Refugee Matters Issue 6, June 2003). In June 2003 58 asylum seekers receiving NASS subsistence support only were reported to be in other local authorities (Cardiff data are for June 2005). According to NASS statistical report no. R35B (d. 06/02/05) there were 2,340 asylum seekers accommodated in the cluster areas: Cardiff, 980; Wrexham, 56; Swansea, 907; and Newport, 397.

2. Women's health

Several studies report low uptake of breast and cervical screening among refugee and asylum seeker women. There are also some reports that female asylum seekers tend to have a lower uptake of health promotion programmes. Other concerns specific to women that are reported in the literature include female genital mutilation and domestic violence. In Blackwell *et al.*'s (2002) study of asylum seekers in north east England, over a quarter of the women (25.5 per cent, 27/106) reported gynaecological symptoms for which they believed they needed to seek medical help.

2.1 Antenatal care and pregnancy outcomes

A number of studies report the maternity experiences of asylum seekers. Based on semi-structured interviews with 33 female asylum seekers carried out between March and September 2001, a report by the Maternity Alliance (Mcleish, 2002) portrays a devastating picture of the lives of asylum seekers who are pregnant or who have had a baby in England. Half of the women experienced neglect, disrespect and racism from the maternity services. Full board emergency accommodation hotels have put the health of pregnant women and babies at serious risk through the provision of unsuitable meals at fixed times, the lack of formula milk and baby food at the hotels, and the placement of some women in hotels dominated by single men. Women with young babies have been repeatedly moved around by accommodation providers. Restrictions on access to the £300 maternity grant have left vulnerable mothers destitute, some forced to beg from strangers for nappies for their newborn babies. Interpreters were generally provided when necessary during pregnancy and labour, except for antenatal classes, which prevented many non-English speaking women from attending.

The investigator recommends that single women and families should always be accommodated separately from single men; pregnant women and new mothers should be placed in self-catering accommodation; more flexibility in the timing and location of meals in full board accommodation; meals should meet recommended nutritional and cultural standards; there should be proper provision in full board accommodation for mother and baby (formula milk, sterilising equipment, baby food, etc.), asylum seekers under 18 should be placed with a foster family or in supported accommodation; the Maternity Grant should be available to asylum seekers on the same basis as the Sure Start Maternity Grant; and specialist health visitor posts should be funded to meet the needs of asylum seekers.

This study was followed up by an investigation of pregnant asylum seekers and their babies in detention through in-depth, unstructured interviews with 4 women who were detained while pregnant or with a young baby (Mcleish *et al.*, 2002). Information was unavailable about the number of pregnant women or babies detained and length of detention. The women experienced discomfort and pain during pregnancy, restricted mealtimes, unappetising and repetitive food, being escorted to hospital appointments by detention centre staff, disruption to care (e.g. failure to forward results of blood tests), ad hoc liaison with external maternity services, petty rules on access to basic necessities such as baby milk and nappies, no access to an interpreter while in detention, use of fellow detainees to interpret for medical consultations, solitary and sedentary routines, and feelings of powerlessness, insecurity and stress arising from the indeterminate nature of detention and the unpredictable movement of detainees.

Different clinical outcomes for asylum seekers and refugees, including a higher incidence of diseases in the mother, are reported in other studies. A retrospective analysis of 271 women with confirmed refugee status who delivered at a Dublin hospital in 1999-2000 (compared with a residual hospital population of 7,337) provides important findings (Lalchandani *et al.*, 2001). There were specific medical problems in the asylum seeker patients: hepatitis B and C (17, 7 per cent), sickle cell disease (10, 3.8 per cent), HIV (7, 3.0 per cent), and tuberculosis (active) (2, 0.8 per cent), all more common than in the rest of the sample. Of the patients with HIV, this was known only after delivery, preventing treatment of mother and baby.

There was a difference in the average gestational age at booking (33 weeks amongst refugees versus 18.2 weeks in the other hospital patients ($p < .01$). Delayed booking has been reported for women from minority ethnic groups in other studies.

The majority of the refugees were multiparous (i.e. a woman who has given birth two or more times) (63 per cent vs. 55 per cent), had low rates of epidural analgesia (18 per cent vs. 50 per cent), instrumental delivery (8 per cent vs. 12 per cent), and episiotomies (11 per cent vs. 29 per cent). However, there were no differences in the gestational age at delivery, incidence of caesarean section, and birth weights from the hospital population. In the postnatal period 82 per cent of mothers in the refugee group breastfed their infants. However, there was a higher incidence of wound infection explained by the significant number of patients who underwent emergency caesarean section. There were four perinatal deaths amongst the 271 refugees, giving a high (corrected) perinatal mortality rate⁵ of 14.8/1000, almost three times that of the hospital population (5.6/1000).

There is only a limited literature on access to maternity services. In a case study of Somali women, several studies have found language and communication to be the most important issue in accessing maternity services. Davies and Bath (2001 and 2002) investigated the maternity information concerns of Somali women with respect to pregnancy, childbirth and postnatal care in a northern English city. Their findings included poor communication between the non-English speaking Somali women and health workers which made seeking information problematic, fears about misinterpretation and confidentiality when interpreters were used, and a perception that Somali women were denied information due to punitive attitudes and prejudiced views among health professionals. The Somali women sought and used information from several interpersonal sources and also favoured community health forums addressed by professionals. Recently Bulman and McCourt (2003), (see also Harper-Bulman and McCourt, 1997), have reported very similar findings in a west London study: a failure of Somali women to gain equal access to maternity services because of inadequate interpreting services, stereotyping and racism from health service staff, and a lack of understanding amongst staff of cultural differences. They also report the poor management of female genital mutilation in pregnancy and labour amongst Somali women. This finding of distressing birth experiences due to poor communication with their carers is in accord with much of the evidence relating to other ethnic minorities' contacts with maternity services.

⁵ Perinatal Mortality Rate - the number of stillbirths and number of liveborn babies who die before the end of the first seven days of life per 1,000 live birth and still births.

2.2 Maternal mortality

A number of recent reports have highlighted the higher risk of maternal mortality amongst asylum seeker women. In November 2004, the Confidential Enquiry into Maternal and Child Health published *Why mothers die 2000-2002* (Confidential Enquires into Maternal Deaths in the United Kingdom, 2004), a review of 391 maternal deaths in the UK over a two-year period. The enquiry reported that ‘...women from minority ethnic groups were, on average, three times more likely to die. Black African women, especially including asylum seekers and newly arrived refugees, had a mortality rate seven times higher than white women and had major problems in accessing maternal healthcare’.

2.3 Cervical screening

Low rates of cervical screening have been reported in many asylum seeker/refugee communities. In Blackwell *et al.*'s (2002) study of asylum seekers in Sunderland and North Tyneside, fewer than one quarter (24.5 per cent, 26/106) of the adult female asylum seeker population reported having had a cervical smear test and of these over three quarters had received the test within the previous year. Low rates for refugees are reported elsewhere. In an inner London study (Newham) only 53 per cent reported having had a cervical smear test (Gammell *et al.*, 1993) and in another investigation in London (Camden and Islington) less than 25 per cent of women refugees from the Horn of Africa reported having had a smear test (Bariso, 1997). This compares with an uptake of cervical screening of around 75 to 85 per cent among women aged 20 to 64 in the general population (somewhat lower in inner London).

Several studies report low Pap testing rates among refugees in the USA and complex reasons for such rates, requiring multifaceted targeted interventions. A study in Seattle, USA (Taylor *et al.*, 2000) of Pap testing among Cambodian refugees (413 achieved interviews, 73 per cent response rate) found that about one quarter (24 per cent) of respondents had never been screened and a further 22 per cent had been screened but did not plan to obtain Pap tests in the future. Fifteen per cent were in the ‘action stage’ (ever screened and planned to be screened in the future) and 39 per cent in the ‘maintenance stage’ (recently screened and planned to be screened in the future). Factors independently associated with cervical cancer screening stages were: previous physician recommendation; younger age; beliefs about Pap testing for post-menopausal women, screening for sexually inactive women, and regular check-ups; provider ethnicity; prenatal care in the US; and problems finding interpreters.

2.4 Breast examinations and screening

Very few studies of asylum seekers and refugees report rates. In an interview survey of 135 adults (66 women) living in Nottingham Health District (Nguyen-Van-Tam *et al.*, 1995), data on breast screening services suggested a pattern of low uptake and in the inner London study, only 5 per cent of women aged over 50 had gone for breast screening (Gammell *et al.*, 1993).

Evidence from the US supports these findings. In an interview survey of a random sample of 215 Vietnamese adults living in the San Francisco Bay area (women, n=99), amongst eligible women 28 per cent had never had a breast examination (compared with 16 per cent of US women) and 83 per cent had never had a mammogram (compared with 62 per cent of US women) (Jenkins *et al.*, 1990). In another study 201 Hmong women were surveyed in the

counties of California. Overall 51 per cent of respondents had ever performed a self-breast examination and 54 per cent of women had ever had a clinical breast examination. Only 27 per cent of the women had ever had a mammogram (Foo and Kagawa-Singer, 1999).

2.5 Female genital mutilation

A specific problem that affects some asylum seekers and of which healthcare professionals should be aware is female genital mutilation (FGM), banned in most countries, including Britain under the Prohibition of Female Circumcision Act, 1985 (although no prosecutions have been brought in the UK). It is performed across all ages, including infants, young children, teenagers and women. The main groups affected in the UK are from Eritrea, Ethiopia and Somalia. Some types of circumcision (type III procedure, including partial excision and infibulation) are surgically reversible (British Medical Journal, 2000). The procedure carries short- and long-term health risks, including those for childbirth. Both the BMA (British Medical Association, 2001) and Royal College of Paediatrics and Child Health (Levenson and Sharma, 1999) have issued guidelines for doctors which include FGM. They highlight the need for female and male asylum seekers to be educated as to the dangers of FGM. Immediate risks include pain and a risk of haemorrhage, infection, urethral damage, anal sphincter damage, and psychological trauma. Longer-term health risks include urinary obstruction, renal failure, obstruction in menstrual flow, haemosalpinx, pyelosalpinx, keloid, neuroma of dorsal clitoral nerve, vulval abscess, dyspareunia, infertility, and psychosexual problems. However, FGM requires a sensitive approach, as in other respects the parents may be caring and able.

2.6 Domestic violence

Burnett and Peel (2001b) highlight the potential for domestic violence in refugee and asylum seeker communities in circumstances where external violence gets played out within the family. They point to the vulnerability of refugee women who may lack family/community support, fear being alone, experience tensions (where family roles are reversed, e.g. the woman is working), and tolerate violence because of fears about the police or legal system, breach of confidentiality, and possible loss of refugee status. The individual needs of refugees and asylum seekers are covered in the Welsh Assembly Government's domestic abuse strategy (Welsh Assembly Government, 2005).

3. Children and young person's health

Over the last half-century many unaccompanied children have arrived in the UK to seek asylum. Home Office statistics⁶ show a rapid rise in the numbers of unaccompanied children seeking asylum in the UK over the last decade (see Table 2).

Table 2. Unaccompanied children seeking asylum in the UK over the last decade

| 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 |
|------|------|------|------|------|-------|-------|-------|-------|
| 190 | 275 | 416 | 597 | 633 | 1,105 | 2,833 | 3,349 | 2,733 |

These figures are confirmed by statistics from the Refugee Council. A recent sharp increase in 1999 was substantially due to the Kosovan crisis, with the arrival of 1,643 unaccompanied children between 1 January 1999 and 28 July 1999. Of the 2,733 applications from unaccompanied children in 2000, 1,394 were made at port and 1,339 in country, the main countries of origin being the Federal Republic of Yugoslavia (24 per cent), Afghanistan (11 per cent), Somalia (6 per cent), and Sri Lanka (6 per cent). By April 2000, there were reported to be over 5,000 unaccompanied children in the care of local authorities, around 80 per cent of whom were 16 and 17 year olds and mainly supported by the London boroughs but with concentrations in Kent and West Sussex (Audit Commission, 2000).

In the 2001 Census for Children in Need (CiN), the Department of Health for the first time asked councils to identify their asylum seeking children, whether unaccompanied or not. In England 12,600 *children in need* were identified as seeking asylum in the census (Department of Health, 2002), of whom 43 per cent were white, 53 per cent minority ethnic, and 4 per cent not stated. This compares with an estimate of approximately 6,500 *unaccompanied* asylum seeking children (just over half of the figure of all asylum seeking children in need reported in the CiN census). Of these asylum seeking children in need 1,500 (11.9 per cent) were looked after and around 11,100 (88.1 per cent) supported in their families or independently (compared with 28.1 per cent and 71.9 per cent, respectively, of all minority ethnic children) (National Statistics and Department of Health, 2002). Overall asylum seeking children represented 6 per cent of all children served by councils with social service responsibility. The CiN census showed that the average cost of an asylum seeking child was about 13 per cent higher than for a non-asylum seeking child; the average cost of an asylum seeking child being looked after was on average about 45 per cent higher than other children in need; and the average cost of an asylum seeking child supported in his/her family or independently was about 65 per cent higher than for other children supported in their families or independently. The number of asylum seeking children varied across the 139 local authorities: just over 70 local authorities had less than 10 asylum seeking children in need and around a further 40 had responsibility for 11 to 100. However, around 29 had responsibility for over 100 asylum seeking children in need. Amongst specific services developed to meet the local needs of asylum seeker children, the Social Services Inspectorate reported recruitment by Tower Hamlets of Somalian (and Bangladeshi) foster carers and eight family support workers from these communities (Cooper, 2002).

⁶ <http://www.homeoffice.gov.uk/rds/aboutrds1.html>

3.1 Post Traumatic Stress Disorder (PTSD)

Information on the incidence of PTSD amongst refugee/asylum seeker children from war zones and areas that have experienced 'ethnic cleansing' living in the United Kingdom is very limited. Hodes (2000) suggests that many of the around 50,000 refugee children and asylum seekers in the United Kingdom have been exposed to high levels of violence, disruption of social life and losses, all of which increase their risk for psychiatric disorders. He estimates that up to 40 per cent of these children may have psychiatric disorders, mostly depression, PTSD, and other anxiety-related difficulties.

A survey of Somali refugees in Cardiff (Davies *et al.*, 1997) revealed a large number of children with important health problems whose life experience included violence, bereavement, separation, disruption, homelessness, and poverty. Moreover, according to the investigators, distress was exacerbated by the inappropriate responses of the statutory services to the arrival of these children, arising from glib assumptions that they were developmentally intact and would fit easily into Western systems of education, health care, and welfare. While they reported that an increase in Somali workers at all levels would be essential for '*culturally appropriate care*' to be provided, the expertise within this community (which included doctors, nurses, pharmacists, and teachers) could not be tapped because of regulations preventing professionals qualified in Somalia from working within the agencies except as interpreters and linkworkers.

Prevalence of PTSD

Studies of such children in other countries suggest that the prevalence of PTSD is considerably higher than that reported for the population as a whole. No literature has been identified that addresses PTSD/mental health problems in asylum seeker/refugee children in the United Kingdom.

Of 76 Khmer 11 to 19 year olds and their parents resettled in the United States, half of the subjects survived violence directed at them and two thirds witnessed violence. Approximately one quarter either partially or fully met the criteria for PTSD, although most were functioning adequately (Berthold, 1999). The number of violent events they were exposed to in their lifetime significantly predicted their level of functioning and PTSD.

Ten Bosnian refugees (aged 13 to 19 years) resettled in the USA from the war in Bosnia-Herzegovina received a baseline assessment within the first year after their resettlement and a follow-up assessment 1 year later (Becker *et al.*, 1999). At baseline 3 subjects (30 per cent) met criteria for PTSD. At follow-up this diagnosis persisted in none of the subjects, although one subject met criteria at follow-up only. For the group mean PTSD severity scores at baseline and at follow-up were 8.9 and 4.0, respectively. At baseline, re-experiencing symptoms were present 43 per cent of the time, avoidance symptoms were present 33 per cent of the time, and hyperarousal symptoms were present 33 per cent of the time. At follow-up, these proportions were 35 per cent, 16 per cent, and 18 per cent, respectively.

The prevalence of PTSD and major depressive disorder was estimated in 61 randomly selected children aged 8 to 17 years old who escaped from Tibet and found refuge in Tibetan settlements in India. The study found 11.5 per cent of subjects met clinical criteria for PTSD and the same proportion met criteria for major depressive disorder (Servan-Schreiber *et al.*, 1998).

A study of 364 Bosnian children in the USA showed over 90 per cent met DSM-IV criteria for PTSD (Goldstein *et al.*, 1997).

Almqvist and Brandell-Forsberg (1997) assessed 50 pre-school children (4 to 8 years old) from 47 Iranian families living as refugees in Sweden. Information given by the children increased the prevalence of a diagnosis of PTSD from 2 per cent to 21 per cent in the 42 children with traumatic exposure through war and political persecution. The amount of traumatic exposure was strongly related to the prevalence of PTSD. The stability of prevalence was high in a follow-up two and a half years later, 23 per cent of the children with traumatic exposure still met the full criteria of PTSD.

A Swedish study of refugee parents of 311 children from the Middle East found that 28 per cent of parents had been tortured, 20 per cent of children had lost one parent, and 67 per cent of children were assessed as clinically anxious (Montgomery, 1998).

Macksoud and Aber (1996) found PTSD rates of 43 per cent in Lebanese children up to 10 years after exposure to war trauma.

These studies clearly show a wide range of estimates of PTSD that may be attributed to such factors as the heterogeneity of the populations, differing diagnostic criteria, and differences in sampling methods and study design. Perhaps the most reliable evidence is that reported in a systematic review and meta-analysis (Fazel *et al.*, 2005). Five studies of PTSD in children and adolescents younger than 18 years in high-income western countries were identified, yielding data for a total of 260 refugee children. Overall, 11 per cent (99 per cent CI 7-17 per cent) of refugee children were diagnosed with PTSD. No relevant studies of depression in children were found.

Rates of recovery

With respect to the general period of recovery, most of the research evidence relates to children's experiences in other countries (both host countries and in countries where the trauma took place).

In a longitudinal study in the Gaza strip of 234 children aged 7 to 12 years old who had experienced war conflict, 40.6 per cent ($n=102$) reported moderate to severe PTSD reactions on initial assessment. This decreased to 10 per cent ($n=74$) at 1 year follow-up (during the peace process) (Thabet and Vostanis, 2000).

In a review of the evidence, the American Association of Child and Adolescent Psychiatry Official Action (1998) reported that most studies found a gradual improvement of post traumatic symptoms, but with a high risk of relapse.

In a series of studies of Cambodian refugees, Savin *et al.* (1996) found PTSD to persist over time, although the intensity of symptoms dropped, with a marked decrease in depression. When first assessed in adolescence, 50 per cent had PTSD and 48 per cent had depressive disorder (Sack *et al.*, 1999). When reassessed 12 years later, 35 per cent had PTSD and 14 per cent had depression. While PTSD had remained relatively persistent, the prevalence of depression had diminished significantly in response to settlement, the development of social ties, and other factors.

Amongst displaced Kurdish children in Iraq following the Gulf War, all had PTSD symptoms and 20 per cent had PTSD, but with significant improvement when they returned to their home regions (Ahmad, 1992).

PTSD symptoms were assessed in 34 Bosnian refugees one year after resettlement in the USA (Weine *et al.*, 1998). Amongst those aged 18 years and under ($n=8$), two had a diagnosis of PTSD at baseline (on re-settlement) and one at one-year follow-up. Older refugees were significantly more likely to have PTSD than the younger refugees and older refugees had more severe symptoms.

Determinants of rate of recovery

Experience of earlier war trauma and resettlement stress is a key determinant of rate of recovery. A study of a sample of 170 Cambodian youths and 80 of their mothers resettled in the United States (Sack *et al.*, 1996) found a consistent relationship between earlier war trauma, resettlement stress, and symptoms of PTSD. The strongest relationship with depressive symptoms was found for recent stressful events. The investigators concluded that PTSD and depression in refugee youth appear to be different conditions following different pathways during adolescent development. In studies of 480 Latin American or Western Asian subjects and 156 Turkish and Iranian subjects resettled in the Netherlands, refugees attributed their somatic and psychological complaints to illness and torture with psychological complaints in particular to worries about the post-migration situation (Hondius *et al.*, 2000). In a study of 124 Cambodian adults (aged 18 to 76 years old) resettled in the USA, experiencing a greater number of war traumas increased the risk of both PTSD and major depression, experiencing a greater number of resettlement stressors during the past year increased the risk of both PTSD and major depression; and having financial stress increased the risk of major depression (Blair, 2000). In another study of Tamil asylum seekers ($n=62$), refugees ($n=30$), and immigrants ($n=104$) in Australia (Steel *et al.*, 1999), pre-migration trauma exposure accounted for 20 per cent of the variance in post-traumatic stress symptoms and post-migration stress contributed 14 per cent of the variance.

Gorst-Unsworth and Goldberg (1998) examined the importance of social factors in exile and of trauma factors in producing the different elements of psychological sequelae of severe trauma amongst 84 male Iraqi refugees. Social factors in exile, particularly the level of “affective” social support, proved important in determining the severity of both PTSD and depressive reactions, particularly when combined with a severe level of trauma/torture. Poor social support was a stronger predictor of depressive morbidity than trauma factors.

Gender also appears to affect the period of recovery. A total of 147 displaced children (5 to 12 years old) exposed to war and trauma residing in refugee centres in Bosnia were assessed at two time points approximately eight months apart (Stein *et al.*, 1999). Symptoms of PTSD, anxiety and depression showed a greater decrease in boys than girls over time. Thus, gender may be an important factor in the natural course of trauma-related symptoms among war traumatised children, although further research is needed. In an Australian study of anxiety, depression, and PTSD in 40 consecutive asylum seekers attending a community resource centre, anxiety scores were associated with female gender, poverty, and conflict with immigration officials, while loneliness and boredom were linked with both anxiety and depression (Silove *et al.*, 1997). Amongst 50 Cambodian young adults resettled in the USA who had survived massive trauma as children, females were found to suffer from somatoform

pain disorders and they had higher levels of current and lifetime PTSD symptoms (Hubbard *et al.*, 1995). Amongst Vietnamese boat refugees aged 15 to 58 years old resettled in Norway (Hauff and Vaglum, 1993), being females, having witnessed other people being wounded or killed in the war, and previous mental health problems all showed an independent significant association with high psychological distress on arrival in Norway.

Psychological resilience may be a further factor. A study of 98 adolescent Bosnian and Croatian refugees, aged 13 to 18 years old, resettled in the USA found that PTSD positive subjects exhibited higher perceived self-efficacy than non-traumatised subjects in five of nine areas (Ferren, 1999). The investigator suggests that surviving traumatic experience and preserving social support networks may be protective factors for maintaining high levels of perceived self-efficacy.

The treatment options available may also affect rates of recovery. A range of treatments for PTSD in children and adults are reported in the literature. Refugees have developed counselling services themselves, with refugee doctors becoming counsellors to their own communities (Dihour and Pelosi, 1989). A specialist service, the Medical Foundation for the Care of Victims of Torture, was established in London to provide care and treatment for torture victims. Much of its work involves psychiatric assessment and treatment, with users including families and young children. Refugee children and adolescents have recently been targeted through special school-based mental health projects. This provision of psychological help in schools may include therapy for the children and families and consultation with teachers, educational psychologists, and social workers. Liaison with the school health service to which children may present with physical symptoms will be facilitated (Hodes, 1998).

Delayed onset of PTSD and effects of PTSD on educational placement and progress

Clearly, delayed onset of PTSD in children could have significant resource implications for the treatment of asylum seeker and refugee children. Only one study (Sack *et al.*, 1999) was identified that provides such evidence. In this study, 27 of 40 Khmer adolescent youths who had survived the Pol Pot regime (1975-1979) as children and 4 of 6 who had escaped the war were reinterviewed for the fourth time in the summer of 1996 (following interviews in 1983-1984 and again 3 and 6 years later) to determine their diagnostic status for PTSD and/or depression and their functional status with respect to occupational and educational pursuits. The point prevalence rates of PTSD were comparable with those found 6 years earlier and rates of depression were much lower but had increased somewhat over the ensuing 6 years. The onset of PTSD was quite variable, with 18 per cent of subjects developing PTSD at least five years after cessation of the Pol Pot hostilities. Subjects with PTSD were more likely to recall specifically traumatic war memories, whereas those without PTSD were more likely to recall loss and/or displacement.

No studies have been identified that report on the effects of PTSD on educational placement and progress. However, there is general agreement on the importance and therapeutic value of schooling for refugee/asylum seeker children (Burnett and Peel, 2001a; Melzak and Kasabova, 1999), although there is the possibility of bullying. Further, contact with the school can be very helpful for a health worker. In some areas refugee support teachers have been employed who provide help to refugee children in school and may be in a position to identify difficulties (Burnett and Peel, 2001a). The group most at risk are unaccompanied children, for whom ongoing contact with social services is important to ensure that they have a needs

assessment and care plan that is regularly monitored. There was anecdotal evidence that the geographical dispersal of refugees under the UK's new Asylum Act had resulted in a substantial number of refugees/asylum seekers opting out of the voucher system and other administrative arrangements and relocating to London, with serious consequences for the integration of their children in the local school community.

3.2 Emotional and behavioural difficulties

Most of the literature focuses on PTSD and only one study has been identified that reports on emotional and behavioural difficulties. Fazel and Stein (2003) examined rates of psychological disturbance in a refugee sample of UK children ($n=101$) and compared them with individually matched samples of ethnic minority and white children. In each group were 61 boys and 40 girls and ages ranged from 5 to 18. Regions of origin for the refugee children included the Balkans (48), Kashmir (16), and Afghanistan (10). Teachers assessed the children's emotional and behavioural adjustment using the Strengths and Difficulties Questionnaire (SDQ). Comparisons showed significant differences with 27 per cent (95 per cent CI 19 per cent to 36 per cent) of refugee children, 9 per cent (95 per cent CI 5 per cent to 16 per cent) of children from ethnic minorities, and 15 per cent (95 per cent CI 9 to 23 per cent) of white children meeting case criteria (for significant psychological disturbance). Significantly more refugee children were cases than children from ethnic minorities ($p<0.01$). The refugee children showed particular difficulties in emotional symptoms. The investigators conclude that these children may have large unmet mental health needs.

3.3 Young People

Unaccompanied asylum seeking children are entitled to medical treatment on the NHS. Under the new legislation, social services departments continue to have responsibilities to support them under the Children Act 1989 (which is maintained by the Department of Health). Local authorities in all their functions have a corporate parenting responsibility for them.

However, in spite of their multiple needs including experiences of separation, loss and social dislocation, there is evidence that they do not receive the same standard of care routinely afforded to indigenous children (although legally entitled to do so). According to survey evidence (Audit Commission, 2000) many authorities did not offer 16 and 17-year-old unaccompanied children a full needs assessment and only one third had individual care plans in place for all those in their care. Moreover, according to this evidence, over half of children aged over 16, and 12 per cent of those aged under 16, were in bed and breakfast, hostels, and hotel annexes in October 1999. Fieldwork authorities reported to the Audit Commission that uncertainty about the age of some claimants had resulted in such young people often being placed in unsupported accommodation as a matter of course. Also, many authorities were reporting increasing difficulty in identifying foster care or residential places for unaccompanied children, resulting in some cases in them being placed in accommodation in neighbouring council areas. Further, some local authorities were spending substantially in excess of government grants to meet the needs of this group.

There are also issues relating to what happens to unaccompanied children when they reach 18, including how young people still awaiting a decision on their application will be supported when they transfer to NASS support arrangements. Also, where the former unaccompanied asylum seeking child was 'looked after' (Section 20 of the Children Act 1989) and considered

to be a 'former relevant child' (Children (Leaving Care) Act 2000), his or her responsible authority has a continuing duty to support and assist him or her to age 21 and possibly beyond. The difficulties young people experience in transition from care are well documented and such difficulties may well be greater amongst those who have experienced traumatic events.

A broad spectrum of unmet needs (including many of the above) has been identified in a major study of young separated asylum seekers (Save the Children, 2001) and in a number of individual research reports (Stanley, 2001; Hedges *et al.*, 2001). The Save the Children study involved interviews with 125 young separated asylum seekers/refugees and 125 professionals working with these young people and found:

- about a fifth of young separated refugees had chaotic and disturbing experiences on arrival and little or no support;
- many of the young separated refugees had a substantial wait for their initial asylum decision;
- the level of care and support depended more on which social services department they arrived at rather than individual needs;
- particularly disadvantaged circumstances for 16- and 17-year olds, many living in poor quality or inappropriate accommodation;
- some care and accommodation contracts with private companies leave young people without adequate support and a long distance from their area;
- access to opportunities for learning English and the level of support varied widely from area to area;
- bullying and harassment in and outside education had affected 30 per cent of those interviewed;
- considerable confusion among young separated refugees about what will happen when they reach 18;
- and many had emotional and possibly mental health problems but few had accessed mental health services.

Two in-depth studies of the needs among young refugees/asylum seekers confirm some of these findings. In a needs assessment of young refugees in Lambeth, Southwark and Lewisham (Community Health South London NHS Trust, 2002), those consulted during the research included 34 refugee children aged 12 to 16 years of age, 211 service providers and policy officers from health, education and social services, and 20 community and youth workers. The refugee children reported a range of issues that negatively impacted on their health: poverty, housing circumstances, being bullied at school (reported by a significant number of children), separation from family members and worrying about their parents or other family members, problems related to language barriers and lack of interpreters, loneliness, and the pressure put on them by the role of interpreting for their parents or relatives (which involved missing school to accompany them to medical appointments). In one group interviewed, more than half felt their health had deteriorated since being in the UK. Nearly all the young people interviewed were registered with a GP and most had been to a dentist. However, more than half were critical of the service they had received from GPs, the main criticism being that they did not feel listened to. The minority of young persons who had not experienced problems with accessing services had family members who spoke English and had a good knowledge of the system. Few had contact with youth or community groups and most wanted more information about services, especially via an advice worker, a telephone hotline and a website.

Interviews with 18 young separated refugees in Yorkshire and Humberside (Dawson and Holding, 2001) found that few had experienced ill health and most were registered with a GP and knew how to use this service. However, difficulties were encountered by young people whose care had been contacted 'out of area', including failure of the housing provider to provide access to a doctor when needed, fear of complaining about lack of support, not being registered with a GP and not knowing how to register, lacking appropriate forms, and difficulties getting an interpreter. Feelings of isolation and loneliness were widely expressed.

4. Mental health

Many asylum seekers report symptoms related to mental health, including PTSD, and seek help for these conditions. Typical conditions presented to GPs include neuroses, anxiety, depression, and phobias (Mental Health Foundation, 1999) and for those who have experienced war, torture, or imprisonment, PTSD may be experienced. The Department of Health (2005) has identified within the document 'Delivering Race Equality in Mental Health Care' that more appropriate and responsive services for asylum seekers and refugees are needed⁷.

There is evidence that mental health is one of the most frequently reported health problems amongst dispersed asylum seekers. In a study of a sample of 397 newly arrived asylum seekers in Sunderland and North Tyneside (Blackwell *et al.*, 2002), almost 40 per cent of the drugs used by asylum seekers were for conditions of the central nervous system (CNS), double the national prescribing rate. The investigators concluded: '*The large number of reported CNS-related symptoms and the reports of feeling tense, nervous, worried and the need for help with these items seems liable to increase need for access to primary care and mental health services in the region*'. Acute affective symptoms were frequently reported by these asylum seekers: appetite changes by 80 (20.2 per cent), sleep disturbances by 133 (33.5 per cent), depression by 75 (18.9 per cent), and being worried or tense by 117 (29.5 per cent). Many of the 52 health needs assessment forms completed by asylum seekers in Middlesbrough and Eston mentioned mental health problems such as insomnia and depression (Hope and Nuttall, 2001). Mental health was the issue most often raised in interviews with 27 asylum seekers in West Yorkshire (Wilson, 2001).

In areas of traditional settlement, studies report a high prevalence of mental health problems. This is over five times higher in the refugee sample than in the general population in Brent and Harrow. In Newham, 44 per cent of women and 25 per cent of men reported depression (Gammell *et al.*, 1993). Two thirds of the sample reported high levels of distress (and 83 per cent 'did not feel part of the community') in Carey-Wood *et al.*'s (1995) research. In Dublin 14 per cent of Bosnian refugees reported psychiatric symptoms (Murphy *et al.*, 1994). In a Birmingham study of detainees, 4 out of 15 had PTSD, 9 out of 15 depression, 5 out of 15 attempted self-harm, 1 out of 15 inpatient treatment and 3 out of 15 counselling (Pourgourides *et al.*, 1996). Several studies of mixed age refugee populations in other countries suggest high levels of PTSD symptoms. Weine *et al.* (1995) reported 13 of 20 Bosnian refugees (65 per cent) were diagnosed with PTSD just after being resettled in the US. This is similar to rates of PTSD reported in other traumatised refugee groups (Mollica *et al.*, 1987; Kinzie *et al.*, 1990).

High levels of poor mental health are also reported in a recent study of Kosovan Albanian refugees in the United Kingdom (Turner *et al.*, 2003). In 1999 the UK received 4,346 refugees from Kosovo and the investigators surveyed a sample of 842 adults to determine the prevalence of mental health problems in this group. All were asked to complete self-report questionnaires and a subset of 120 participants were subsequently interviewed using the Clinician Administered Post Traumatic Stress Disorder Scale and a depression interview to obtain estimates of the prevalence of PTSD and depression. The average age of subjects was 38.1 years and 52.9 per cent were women. Over 97 per cent reported that they had been forced to leave home, on average 2.5 times. Just under half of the group surveyed had a diagnosis

⁷ <http://www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf>

of PTSD and less than a fifth had a major depressive disorder, suggesting that self-reports overestimate the prevalence of these conditions. The investigators interpret the findings as indicative of both psychological resilience and also a need for psychosocial interventions.

These prevalence figures, however, are lower than those reported in a caseworker assisted survey of 129 Kosovar refugees aged 18 to 79 years old (55 per cent male) recently settled in the States of Michigan and Washington in the USA (part of a community of 14,000 who entered the USA since 1999) (Ai *et al.*, 2001). Of the sample, 101 cases (78.3 per cent) exceeded the recommended cut-off indicating the likely presence of PTSD and 83 cases (64.3 per cent) exceeded the cut-off indicating the likely presence of depressive disorder. The mean of war-related traumatic events reported was 15. Higher PTSD scores were associated with female gender, older age, more traumatic events, and more depressive symptoms. The Kosovan Albanian figures are similar to those obtained in Van Velsen *et al.*'s (1996) interview study of a mixed group of refugees in London, that is, 35 per cent with depression and 52 per cent with PTSD. However, this group had been specifically referred for specialist psychiatric assessment.

Again, studies indicate a wide range in prevalence of PTSD, major depression, and other disorders. Contributory factors may include the degree to which the refugee populations are selected, different diagnostic methods, and factors associated with study design and sampling. The systematic review and meta-analysis undertaken by Fazel *et al.* (2005) provides findings for PTSD and major depression. Seventeen studies of PTSD were identified, with data for a total of 5,499 adult refugees resident in high-income western countries. Overall, around 9 per cent (99 per cent CI 8-10 per cent) were diagnosed with PTSD. Fourteen studies of major depression were identified, providing data for a total of 3,616 adult refugees. Overall (in studies with at least 200 participants), about 5 per cent (99 per cent CI 4-6 per cent) were diagnosed with major depression. In addition, there was evidence of much psychiatric comorbidity. Finally, only two studies of psychotic illness were identified, consisting of data for 226 adult refugees. Overall, around 2 per cent (99 per cent CI 1-6 per cent) of refugees were diagnosed with a psychotic illness. Only 5 studies of generalised anxiety disorder were identified, with data for 1,423 adult refugees. Overall about 4 per cent (99 per cent CI 3-6 per cent) of refugees were diagnosed with generalised anxiety disorder.

Several studies (Turner *et al.*, 2003; Gorst-Unsworth and Goldenberg, 1998; Tribe, 2002; Summerfield, 2002) emphasise the importance of both pre-migration experience of violence and dislocation and post-migration social difficulties such as family separation, isolation and poor housing and their complex relationship with PTSD and depression. Gorst-Unsworth and Goldenberg (1998) focus on post-exile factors in interviews with 84 male Iraqi refugees and found that social factors, particularly the level of "affective" social support, were important in determining the severity of both PTSD and depressive reactions (especially when combined with a severe level of trauma/torture). Poor social support in exile was found to be a stronger predictor of depressive morbidity than trauma factors. In a longitudinal study of life events among resettled Iraqi and Kurdish refugees in Sweden, Sondergaard *et al.* (2001) found the number of negative life events in the host country showed a significant association with self-rated deteriorated health. Finally, in Steel *et al.*'s (1999) study of Tamil refugees in Australia, pre-migration factors were found to account for 20 per cent and post-migration factors 14 per cent of the variance in post traumatic symptoms.

5. Chronic conditions

There is a paucity of information in the literature on the prevalence of chronic conditions, although high rates of diabetes, hypertension, and coronary heart disease (CHD) are reported in refugees/asylum seekers from eastern Europe (Burnett, 1999). Only one study of asylum seeker/refugee populations in Britain has been found that provides self-reports of chronic conditions. Amongst the 397 asylum seekers aged 16 to 58 years old assessed by Blackwell *et al.* (2002) in north east England, 13 (3.3 per cent) reported that they suffered from asthma, 9 (2.3 per cent) from diabetes, 25 (6.3 per cent) from arthritic disease, 15 (3.8 per cent) from hypertension, and 14 (3.5 per cent) from heart disease. Two therapeutic categories accounted for around a fifth of prescribed/purchased medicines: cardiovascular medicines (19, 11.2 per cent) and musculo-skeletal medicines (18, 10.7 per cent).

Using data from a cross-sectional study of female Bosnian refugees in Sweden aged 18 to 59 years old (n=98) and Swedish-born controls (n=95) to investigate six primary diet cardiovascular risk factors, Sundquist *et al.* (1999) found Bosnian women aged 42 to 59 had substantially higher levels of body mass index, larger waist and sagittal diameter of the abdomen measurements (also found in Bosnian women aged 18 to 41), higher levels of S-triglycerides, and lower high-density lipoprotein cholesterol (also found in Bosnian women aged 18 to 41), all indicative of a poorer diet than Swedish women.

Two studies of South East Asian refugees report a high prevalence of cardiovascular risk factors. In a study of smoking and lipid cardiovascular risk factors in Vietnamese refugees in Australia (men, n=242; women, n=159) (Bermingham *et al.*, 1999), smokers had a significant risk of low high-density lipoprotein cholesterol, low apolipoprotein A-I, and high lipoprotein (a), smoking having a marked detrimental effect on lipids. Dodson *et al.* (1995) screened 155 South East Asian refugees in a primary care clinic in Seattle, Washington for CHD risk factors. Male gender (39 per cent), cigarette smoking (27 per cent) and hypertension (26 per cent) were the most common risk factors, with diabetes, obesity, and a family or prior history of CHD or cerebral/peripheral vascular disease being noted in less than 10 per cent of cases. Some 21 (66 per cent) of 32 patients who underwent lipoprotein analysis (14 per cent of all patients) were candidates for a therapeutic intervention for hypercholesterolaemia (when there is an excessive amount of cholesterol in the blood, also called 'hyperlipidaemia'.)

6. Disability

There is only limited evidence on the prevalence of disability amongst refugees and asylum seekers in Britain. Carey-Wood *et al.* (1995) found that 10 per cent of their sample of 263 people of various countries of origin with refugee status or exceptional leave to remain reported 'some sort of disability sufficient to affect their daily life'. A survey in Manchester (Girbash, 1991) found that 4.5 per cent of Vietnamese refugees living in Manchester were disabled. Duke and Marshall (1995) reported that 3 per cent of refugees from Vietnam who arrived in Britain after 1982 were chronically sick or disabled. In Camden and Islington 10 per cent of the respondents in the Horn of Africa Health Research Project (Bariso, 1997) had some form of long-term illness or disability.

More recent evidence is provided by research undertaken by the Social Policy Research Unit, York University (Roberts and Harris, 2002a, 2002b; Roberts, 2000). In a survey for their study, 44 refugee community groups and disabled people's organisations identified 5,312 disabled refugees or asylum seekers known to them. The project interviewers talked to 38 disabled refugees and asylum seekers (including 14 Somalis, 11 Vietnamese, 7 Tamils, and 4 Kurds). Of these 38, 20 had physical impairments, 6 hearing impairments, 3 visual impairments, and 9 multiple impairments. Unmet personal care needs, unsuitable housing, and a lack of aids and equipment were common. Other common themes were a lack of knowledge about their entitlements or how to get a community care assessment, communication difficulties, and extreme isolation.

A postal survey concerning development of services for minority ethnic adults with physical disabilities and/or sensory impairments, undertaken by the Social Services Inspectorate of all social services departments in England (60 per cent response), found little or no commissioning of services for refugees and asylum seekers (Department of Health, 2001). Some disabled members of these groups experienced difficulties in accessing the most basic of services. Bournemouth health and local authorities had jointly researched the needs of these groups and two London boroughs reported schemes (a joint finance small initiative fund to assist refugees and an asylum welcome scheme). However, it appears unlikely that services would have the flexibility to be able to respond to a sudden increase in numbers of disabled refugees/asylum seekers. The survey identified the lack of information on needs and location, uncertainties concerning responsibilities of statutory authorities, and the dispersal arrangements as barriers to service commissioning.

7. Communicable disease, gastrointestinal disease and infections

A wide range of communicable diseases has been found amongst refugees and asylum seekers, including malaria, tuberculosis, chronic hepatitis B, typhoid, and cholera (as well as HIV/AIDS and other sexually transmitted infections such as gonorrhoea and syphilis referred to in section nine).

7.1 Communicable disease

High rates of hepatitis B (a major cause of long-term morbidity and mortality from chronic hepatitis and other conditions) occur throughout south east Asia, the Middle East, and Africa, with a prevalence of hepatitis B virus infection ranging from 5-15 per cent or higher. In a study carried out in the United States, five per cent of Koreans and 15 per cent of Cambodians were found to be positive for hepatitis B surface antigen (Walker and Karanson, 1999) and 21 per cent of migrants from sub-Saharan Africa in Spain were chronic carriers of hepatitis B (Garcia-Samaniego *et al.*, 1994).

The only detailed UK study of refugees identified is that of the prevalence of hepatitis B core antibody and surface antigen in the Somali population of Liverpool (Aweis *et al.*, 2001; Brabin *et al.*, 2002). A total of 439 people aged from 10 months to 80 years old from 151 households were screened, 194 (44.2 per cent) of whom were children aged less than 15 years. Of the enrolled subjects 309 (69 per cent) were born in Somalia and most of the remainder in the UK. Of the full study population, 5.7 per cent were carriers of the surface antigen, the highest prevalence occurring in adults aged 20 to 44 years old (9.4 per cent). Prevalence of hepatitis B core antibody was 27.5 per cent, and increased with age over the first four decades, circumcision performed 'in the community' being a risk factor. Of 80 children born in the UK and aged 5 or younger, 8.7 per cent had evidence of exposure to hepatitis B, of whom only one had a close family member who was a carrier, suggesting that horizontal HBV transmission continues at an early age amongst Somali migrants. The investigators suggest there would be benefit from screening high-risk ethnic groups and vaccination of susceptible children.

Some data are available for Ireland (Southern Health Board, 2000). Records show that, 558 Kosovar refugees were received in Cork and Kerry in 1999. Health screening was offered to all refugees and uptake was 99 per cent. The results of the screening programme mirrored the experience of screening in the camps prior to departure. The prevalence of hepatitis B is reported to be moderately high (5-6 per cent) in Kosova and Albania and screening in the Irish centres showed a carriage rate of 3 per cent (chronically infected). A further 15 per cent were immune which almost certainly indicated previous infection, as hepatitis B immunisation was not standard practice in Kosovo. No case of active TB was detected in any of the refugees in the Cork and Kerry centres. The health screening included a question on diarrhoeal disease, stool specimens of those with symptoms revealing only 4 positive cases (one giardia, two shigella, and one shigella and campylobacter). There were 8 cases of mumps in children on one of the Kerry centres which occurred shortly after the children arrived (evidence that they had contracted the infection before they arrived in Ireland).

Hepatitis C infection is also common in Asia and Africa. Depending on country of origin, hepatitis A and meningitis may also be found (Burnett, 1999). Diphtheria has been reported in families from eastern European countries. Some of these diseases have long latency periods.

Benign tertian malaria may not be seen until several years after arrival (Walker and Karanson, 1999). Around 300 to 400 children per year are diagnosed with imported malaria and the diagnosis is often delayed.

7.2 Gastrointestinal disease

There are few specific reports of gastrointestinal infections in asylum seeker/refugee populations. Amongst the 397 asylum seekers in Sunderland and North Tyneside who completed health needs assessment forms (Blackwell *et al.*, 2002), 31 (7.8 per cent) reported gastrointestinal symptoms and gastrointestinal medicines represented 11.8 per cent of all prescribed/purchased medicines in this population. Gastroenteritis may occur amongst refugees/asylum seekers and gut helminth infections are common in children arriving from Africa and Asia. There are also reports of more serious gastrointestinal infections (such as cholera, typhoid and bacillary dysentery). There are around 20 imported cases of cholera in England and Wales per year, and on average around 150 to 250 and 100 to 150 imported cases of typhoid and paratyphoid, respectively, per year; some of which are among refugees and asylum seekers, although the public health risk is small. Generally, routine screening for gastrointestinal disease has not been found to be cost effective.

7.3 Tuberculosis (TB)

Over the last decade the incidence of TB in greater London has risen from 23 to 35 per 100,000, the highest rates (over 50 per cent) occurring in those recently arrived in the UK. There is also increasing concern about the spread of multi-drug resistant TB. TB screening, vaccination, prophylaxis and treatment is, therefore, a major issue in meeting the health care needs of asylum seekers.

Practice is reported to be very variable. The most comprehensive study is the retrospective analysis of the results of screening of 53,911 asylum seekers arriving at Heathrow Airport between 1995-1999 (Callister *et al.*, 2002). The overall prevalence of active TB in asylum seekers was 241 per 100,000, with large variations depending on country of origin. Low rates of prevalence were found in those from the Middle East and high rates from the Indian subcontinent and Sub-Saharan Africa. There was a high frequency of drug resistance: 22.6 per cent of culture positive cases were isoniazid resistant, 7.5 per cent were multidrug resistant, and 4 per cent of cases diagnosed with active disease had multidrug resistant TB. More M tuberculosis isolates from asylum seekers are drug resistant than in the UK population.

In a recent study of 58 general practitioners in Ealing, Hammersmith, and Hounslow Health Authority, most of whom had refugees on their lists, only four referred asylum seekers to a chest clinic for TB screening. Some 48 (82.8 per cent) were unaware of the TB screening programme, although most thought that some screening should take place (Hargreaves *et al.*, 1999).

In a recent survey carried out by Northern and Yorkshire Public Health Observatory (PHO) (Wilson, 2001), the 7 health authorities (HA) were asked what proportion of asylum seekers in their area had been screened for TB in a recent, defined time period. Bradford HA replied that *'Virtually all asylum seekers offered TB screening (and most accept) via the Health Visitor for Asylum Seekers, unless have moved elsewhere'*. East Riding and Hull HA reported that between April 2000 - November 2001, 2,107 asylum seekers had been dispersed, of whom

1,309 (62 per cent) had been located and screened. A lower percentage (50 per cent) was given by Sunderland HA and a higher rate by Wakefield HA (147/193 [76 per cent] between 1st May 2001 and 12th November 2001). Two health authorities were unable to supply figures. In other studies within this region Blackwell *et al.* (2002) report low rates of screening for TB in Sunderland and North Tyneside and Hope and Nuttall (2001) the fact that many people had not had a chest X-ray. In contrast all the Kosovan refugees - for whom services tended to be better planned - sent to Liverpool were offered screening for TB. Of the 272 refugees, 252 (93 per cent) were screened with a heaf test, results revealing 51 grade 3 and 6 grade 4 results (all referred to a TB clinic and discharged after clear chest radiograph results; 4 (1.5 per cent) had been given prophylaxis) (Ghebrehewet *et al.*, 2002).

In 1991 Asghar (2000) investigated the level of TB screening among overseas students at an UK university through a mailed questionnaire (150 achieved responses, 25 per cent response rate). The main ports of entry were Gatwick (40 per cent) and Heathrow (46 per cent) but only 7 per cent received an examination at the port of entry (17.8 per cent at Gatwick and 1.5 per cent at Heathrow). Only 27 per cent of students got an invitation to attend the chest clinic but of those who were invited 73 per cent of the students attended the clinic. The investigator recommended that educational institutions should refer overseas students to chest clinics, health visitors should pursue non-attendants, and registration staff at GP/ student health services should be educated with respect to high-risk regions.

These studies suggest that the port of arrival scheme has had a poor yield, with as few as a half of dispersed asylum seekers getting TB screening. Alternative settings include GP practices.

7.4 Immunisation

Amongst some nationality groups refugees and asylum seekers may not be familiar with the concept of immunisation and in others children may not have been immunised against common communicable diseases or have had their immunisation schedules interrupted. Low rates of vaccination for children and poor provision are reported in a number of studies in dispersal areas. Based on a sample of 397 newly arrived asylum seekers in Sunderland and North Tyneside, Blackwell *et al.* (2002) state: *'An issue of public health concern is the overall low rate of immunisation within the asylum seeker population'*. The overall rates for common communicable disease, in particular for mumps, measles and rubella (MMR), were reported to be low and for BCG (TB vaccine) the mean rate for the entire sample was below that required to provide adequate population immunity. Vaccination rates for the other common communicable diseases were variable: diphtheria vaccination was recorded as being administered to 177 (45 per cent) subjects; those reporting vaccination to mumps, measles and rubella were much lower, none showing an overall rate higher than 16 per cent. The investigators suggest that the effects of these low rates of immunisation may be exacerbated by housing the asylum seekers in close proximity. In the survey of the health of asylum seekers in Northern and Yorkshire Region (Wilson, 2001), of the 7 health authority respondents, only one had made special provision for the immunisation of asylum seeker children (*'Asylum seekers' health visitor discusses and refers asylum seeker children to health visitor attached to their GP practice they're registering with'*).

Somewhat higher rates have been reported in London, with 85-90 per cent of refugee children immunised (90 per cent in Camden and Islington [Bariso, 1997]; around 88 per cent in Newham [Gammell *et al.*, 1993]; and 85 per cent in Brent and Harrow [Brent and Harrow Health Agency *et al.*, 1995]).

The failure to offer permanent GP registration and the lack of access to interpreters and health advocates may impact unfavourably on the achievement of routine immunisation. Further, the type of immunisation that has been offered - primary immunisation or pre-school boosters and range of vaccines (diphtheria, tetanus, pertussis, polio, MMR, meningitis C, TB, hepatitis B) - may depend on the country of origin, immunisation history, and child's age. Asylum seeker children may have had their schedules interrupted or not started.

8. Injury and torture

Reports of the prevalence of injury are few. In Blackwell *et al.*'s (2002) sample of 397 asylum seekers in north east England, 43 people (10.8 per cent) reported that they had suffered significant injury. Most of the literature relates to injuries arising from torture. Estimates of the proportion of asylum seekers who have been tortured vary from 5-30 per cent, depending on the definition of torture used and their country of origin (Burnett and Peel, 2001b). In excess of 5,000 individuals each year are referred to the Medical Foundation for the Care of Victims of Torture in London (Hargreaves, 2002). In 1999 Amnesty International reported that around 6,000 people (8.4 per cent of all applications) sought asylum in the UK on the basis of torture, although this is almost certainly an underestimate. Local studies support these figures, injuries caused by persecution or torture being the fourth most frequent issue raised amongst 27 asylum seekers in West Yorkshire (Wilson, 2001), after mental, sexual, and dental health.

The range of injuries reported by Burnett and Peel (2001b) include fractures and soft tissue injuries; head injuries, including epileptiform convulsions and post-concussion syndromes; ear injuries, including traumatic perforation and drum scarring; sexual violence and rape, with possible risk of HIV infection; physical manifestations of emotional distress arising from torture, such as sleeplessness, weakness and lethargy, headaches, abdominal pain, and neck and back pains; and psychological effects, including anxiety, depression, guilt and shame. PTSD is frequently associated with torture. For example, a study of Tamil refugees (Silove *et al.*, 2002) found that among those who had been tortured there were statistically significant higher scores for diagnosis of PTSD than other war trauma survivors. For survivors of torture the experience of detention may provoke feelings of fear and powerlessness and restimulate their distress (Pourgourides *et al.*, 1996; Summerfield *et al.*, 1991).

The prevalence of such injuries is sometimes difficult to determine through shame or unwillingness to disclose sensitive information. Twenty-five asylum seekers from countries where torture is practised and whose self-reported injuries related to torture were referred to specialist bone scintigraphy screening services in Austria (Mirzaei *et al.*, 1998). In 19 patients bone scans showed abnormalities in the area of alleged injury, whereas radiography yielded positive results in only five patients. Among 25 controls there was only one abnormal scan due to a known condition. MacDonald *et al.* (2001) draw attention to the possibility of head injury in survivors of torture, the consequences of which (including frontal lobe syndromes) may go undetected or be incorrectly ascribed to psychological factors.

9. Sexual health

9.1 Sexual health

Sexual health needs are prominent in assessment surveys undertaken in areas of dispersal. Amongst the 397 asylum seekers who completed health needs assessment questionnaires in Sunderland and North Tyneside (Blackwell *et al.*, 2002), 52 persons (13.1 per cent) - identical proportions of males and females - stated that they wished to receive contraceptive advice and 42 (10.6 per cent) - 10.0 per cent of males and 12.3 per cent of females - had matters about their sexual health that they wanted to discuss with a doctor. In 52 health needs assessment forms completed in an assessment of a pilot asylum seekers health service in Middlesbrough and Eston, Hope and Nuttall (2001) found that sexual health was raised mainly by single young men who needed advice regarding contraception and safe sex. Many married couples also required help with contraception. Others were concerned about fertility. Focus groups with 40 young male asylum seekers' to explore sexual health issues, undertaken by the Gateshead and South Tyneside Health Promotion Service (Smith, 2001), revealed mixed knowledge of service provision and of sexual health issues. Most of the subjects were, had been, or wanted to be sexually active, sexual health was viewed within the context of communication, integration and generic support, and a need expressed for sexual health information and/or provision. Sexual health was the third most frequent issue raised amongst 27 asylum seekers in West Yorkshire (Wilson, 2001).

9.2 Family planning

Studies in London (Aldous *et al.*, 1999) report that 6 to 23 per cent of refugee women use family planning services (10 per cent in Newham [Gammell *et al.*, 1993]; 20 per cent in Harrow [Brent and Harrow Health Agency *et al.*, 1995]; 23 per cent in Haringey and 7.8 per cent well woman clinics; 6 per cent in Camden and Islington [Bariso, 1997]). A low uptake of family planning services was also reported in Lambeth, Southwark and Lewisham (Lambeth, Southwark and Lewisham Health Authority, 1998). There is a lack of reports of take-up in areas of dispersal. These data suggest that, in some areas at least, there may be barriers to womens' ability to access family planning services.

9.3 HIV/AIDS

HIV/AIDS has important health implications for both young and adult refugees/asylum seekers but also for the children of women infected with HIV/AIDS (through the vertical transmission of infection). Prevalence of HIV/AIDS is likely to reflect that in the country of origin, although some refugees may have been placed at greater risk. Many studies report high incidence and low take up of HIV/AIDS treatment and care services amongst the African community in the UK (Kiwana, 1998; Kwok and Sseruma, 2002). Sesay and McLean (2000) also draw attention to the likely problems that will arise with respect to the dispersal programme, including separation from most of the specialist and other centres of excellence as well as culturally appropriate social care, the abandonment by asylum seekers of dispersal areas in search of appropriate care and support services, and, for those who remain, isolation, poor access to quality care and support, and the likelihood of local crises resulting from social, financial, and physical vulnerability. Few studies have investigated these matters, the Public Health Laboratory Service (2002) indicating that *'the dispersal of new migrants, including asylum seekers, to different parts of the UK increasing prevalence in previously relatively low prevalence areas'* was an area of continuing uncertainty with respect to diagnosed HIV infected people.

A study in Leeds found that asylum seekers and UK residents were equally satisfied with HIV/AIDS services, but identified unmet needs of asylum seekers with HIV/AIDS, including specialist services for torture victims, befriending schemes to provide informal social support, access to primary health care, and educational opportunities (Allan and Clarke, 2005). In a survey of English Genito-Urinary Medicine (GUM) clinics treating HIV infected patients to establish experience of dispersal of HIV positive asylum seekers, the 56 responding doctors cited as barriers to successful dispersal the short notice with no prior arrangement, lack of community support, lack of psychological support, low staffing levels in the receiving centre, and problems relating to unintentional interruption to antiretroviral therapy (Creighton *et al.*, 2004). Yoganathan (2004) reports similar problems from a Welsh hospital: a high proportion of vulnerable women, some with experience of rape and separation from their families; little notice of dispersal; inadequate supplies of drug treatment; no medical case notes; consequent strain on local service provision; and unknown effects on the long-term epidemiology of HIV in the receiving areas.

One recent report on the sexual health promotion needs of HIV positive Africans in South East London (Lambeth, Southwark and Lewisham (LSL), an area in which 36 per cent of the under 35 population are of black or other ethnic minority origins, many of whom are refugees) provides robust evidence (Kwok and Sseruma, 2002). In 1998 the rate of new HIV diagnoses amongst local residents (over 300) was more than twice that for any other health district in London. Around 40 per cent of the new HIV cases were heterosexually acquired, local antenatal screening finding 1 in every 155 women tested positive. In 2000, 2,801 LSL residents were diagnosed with HIV infection and sought HIV-related care, an 82 per cent increase from 1996. The investigators report that the majority of heterosexually acquired cases of HIV in LSL residents have occurred in Black Africans, the number of such diagnosed HIV infections having increased dramatically from 239 persons in 1996 to 788 residents in 2000 (a rise of 230 per cent). While many of the infections are believed to have been acquired abroad, the investigators report that there is evidence to suggest that transmission of the virus is also occurring locally. Also, rates of gonorrhoea amongst local residents are around 6 times higher than for the rest of the country and disproportionately affect those from black and other ethnic minority communities.

10. Oral health care

Dental problems are widely reported to be common amongst asylum seekers and refugees and accessing dental services is frequently identified as being difficult (Davies *et al.*, 2000; Burnett, 1999). These problems appear to be acute in areas of dispersal. Dental health was the second most frequent issue raised amongst 27 asylum seekers in West Yorkshire (Wilson, 2001). A large proportion (44 per cent) of the sample of 397 newly arrived asylum seekers in Sunderland and North Tyneside investigated by Blackwell *et al.* (2002) reported the need for dental treatment, ranging from routine check-ups to fillings, extractions, and repair of physically damaged teeth and 152 of the sample (38.3 per cent) reported dental pain. The 52 health needs assessment forms completed by asylum seekers in Middlesbrough and Eston (Hope and Nuttall, 2001) also identified dentistry problems, as did interviews with asylum seekers in Leeds (Wood, 2001). In a survey of a range of agencies (consortia, GPs, health authorities, housing providers, NASS, Primary Care Groups/Trusts, Personal Medical Services (PMS) Pilots, voluntary and community organisations, and others) in Northern and Yorkshire region (Wilson, 2001), 'dental health' (n=21) was identified as the health issue most frequently encountered among asylum seekers after 'mental health issues' (n=62). Problems are also found in more traditional areas of settlement. Examination of 268 Vietnamese children in Lambeth, Lewisham, and Southwark showed a high caries rate in deciduous teeth and a low rate in permanent teeth. Five-year-olds had a mean DMFT⁸ of 8.3 and none were caries free, the mean DMFT being significantly related to the length of time the children had lived in Britain (Todd and Gelbier, 1990).

Similar problems are reported in refugee and asylum seeker communities in other countries. In an Australian based volunteer study of Tamil asylum seekers (n=62), the majority (more than 60 per cent) reported serious difficulties accessing medical and dental services (exceeding the proportion in a control sample of 30 refugees and 62 immigrants) (Silove *et al.*, 1999). In another Australian study of 40 asylum seekers attending a community based asylum seeker centre in Sydney, 27 (68 per cent) reported major difficulties in accessing dental services (Sinnerbrink *et al.*, 1996). In a study of 263 Tamil asylum seeker patients examined in a Public Health Department at Wuppertal (Germany) between 1986-1995, isolated front tooth gaps were observed in more than 60 per cent of patients.

Access to services appears to be an issue in some areas (Lambeth, Southwark, and Lewisham Health Authority, 1998) but not in others (Bariso, 1997). Moreover, few interventions have been found in the literature.

⁸ The number of decayed, missing, and filled teeth, used to describe the amount - the prevalence - of dental caries in an individual.

11. Lifestyle factors

There is a dearth of information on health related behaviour, including smoking, alcohol misuse, illicit drug use, exercise, and diet in asylum seekers and refugees.

11.1 Smoking

Only two studies have been identified that report the prevalence of smoking. In a survey undertaken in Nottingham in May 1993, involving interviews with 135 Vietnamese adults (66 women), the prevalence of male smoking was estimated to be 47 per cent (Nguyen-Van-Tam *et al.*, 1995). Somewhat lower levels were found by Blackwell *et al.* (2002) amongst 397 asylum seekers (291 males and 106 females) in Sunderland and North Tyneside. Most of these asylum seekers (241, 60.7 per cent) were non-smokers. Of the 156 who smoked (39.3 per cent), most (62.8 per cent) smoked less than 25 cigarettes per week. Males were more likely to smoke than females (43.6 per cent vs. 21.6 per cent, respectively).

11.2 Alcohol use

Again, there is a lack of studies. Amongst the 397 asylum seekers in Blackwell *et al.*'s (2002) study, only 38.3 per cent reported consuming alcohol; nearly all these drinkers (95.4 per cent) consumed alcohol at below recommended levels (21 units for males and 15 units for females). The prevalence of alcohol consumption was higher amongst males than females (45.4 per cent vs. 18.9 per cent, respectively) and also differed by region (44.5 per cent of those from the Middle East, 33 per cent amongst east Europeans, 29.5 per cent of those from Africa, and 22.7 per cent of Asians). Amongst those describing their religion as Muslim, 39.8 per cent (100/251) consumed alcohol.

11.3 Illicit drug use

There is only limited evidence on illicit drug use among refugees and asylum seekers in Britain. A recent review of the delivery of drug services to black and minority ethnic communities, commissioned by the Home Office to support the Government's 10-year drug strategy, reported a lack of data relating to refugee and asylum seeker communities (Sangster *et al.*, 2002). However, the investigators' data showed that there was problematic drug use in Vietnamese and Somali communities, although mainly limited to men. Particular concern was expressed about the effects of PTSD, the role of khat⁹ within Somali communities, and the availability of drugs unknown in Somalia and Vietnam. Griffiths (1998) has reported on a study of khat use among Somalis living in London. In a sample of 207 subjects, 78 per cent of men and 76 per cent of women (aged between 18 and 78 years) had used khat, two thirds in the week prior to interview. On average khat chewing started at around 21 years of age. Only six per cent of respondents were using khat on a daily basis but 64 per cent of respondents were using more khat at the time of the interview than one year earlier and 76 per cent more than they had in Somalia. Although a high proportion of respondents (85 per cent) reported feeling tired and depressed after khat chewing sessions, for the majority the use of khat did not give rise to serious problems. A small group of respondents who were using large amounts of khat on a regular basis, however, did have dependency and other problems, for which the investigator

⁹ Khat (qat) is a green-leafed shrub that has been chewed for centuries by people who live in the Horn of Africa and Arabian Peninsula. It is a stimulant drug with effects similar to amphetamine.

http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=wip\1\1\1\1\khat.html

suggested that formal interventions might be appropriate. Strategies that reduce the amount of time individuals spend consuming khat may be appropriate to reduce the likelihood of problems developing.

In the wider literature there is some evidence that substance misuse is used as a coping strategy or as self-medication. In a study of displaced persons in Croatia (157 men and 211 women), alcohol dependence was reported in 60.5 per cent of men and 8.1 per cent of women and alcohol dependence comorbid with PTSD in 69.6 per cent of men and 11.7 per cent of women, the rate of alcohol dependence increasing in relation to current PTSD in men but not in women (Kozaric-Kovacic *et al.*, 2000). Other studies suggest that adjustment and mental health problems, together with lack of social and institutional support, may be one of the main reasons why refugees turn to psychoactive substances to alleviate stress (Yee and Nguyen, 1987). Amongst a sample of Cambodian refugee women in the USA (n=120), about 45 per cent of 'East Coast' women reported that they used alcohol for nervousness, stress, headaches, insomnia and pain and 15 per cent that a family member used street drugs and was having dependency problems (D'Avanzo *et al.*, 1994). Amongst women of Cambodian national origin interviewed in the USA and France (n=155), 23 per cent of the women residing in the USA drank during the first trimester of their pregnancy, with 18 per cent continuing to drink during the second and third trimesters (D'Avanzo and Barab, 2000), suggesting the need for programmes to educate such women with respect to the problems associated with drinking during pregnancy.

11.4 Diet and nutrition

Few studies have reported on diet and nutrition in refugee/asylum seeker communities, yet there is some evidence that poor nutrition may be going undetected in newly arrived asylum seekers. A study was undertaken by Sellen *et al.* (2002) of a purposive sample of 30 households with children under 5 years old who were recently arrived refugee families in east London. All the households were what the investigators call 'food-insecure'¹⁰ and 60 per cent of index children were experiencing hunger as defined on the Radimer/Cornell scale (Radimer *et al.*, 1992; Keenan *et al.*, 2001). Child hunger was significantly associated with recent arrival and marginally significantly associated with receipt of fewer benefits and younger parenthood.

A questionnaire survey, undertaken by the charity Milk for Schools, sought information from the 90 local education authorities (response rate, n=27, 30 per cent) which Home Office information indicated would be recipients of asylum seekers (Milk for Schools, 2002). Amongst the key findings, in 22 areas there were 8,865 children of asylum seekers in 2001; only 8 areas were screening for communicable diseases such as TB and only 4 areas were screening for malnutrition; only 9 areas provided free milk for asylum seekers and some was age restricted; some London boroughs have very large intakes of asylum seeker children relative to their capacity (e.g. 1,650 asylum seeker children absorbed into 60 schools); some areas were not ascertaining the nutritional requirements of incoming children that related to their health or religion; only two areas were offering lactose reduced milk; one area claimed not to know that NASS supported children should have free school meals; and access to EU school milk subsidy was unacceptably low or non-existent.

¹⁰ Food insecurity is a lack of access at all times, due to economic barriers, to enough food for an active and healthy lifestyle. (Quandt *et al.*, 2004).

There would appear to be grounds for supporting both rapid assessments of the prevalence and causes of child hunger among this group in specific community settings and broader population based assessments of food insecurity (Sellen *et al.*, 2002). Indeed, the BMA has argued that asylum seekers need a full assessment of their dietary requirements on arrival (BMA, 2002). Further, work needs to be undertaken on health promotion strategies to preserve the healthy aspects of traditional diets in refugee/asylum seeker communities, given that dietary patterns change with increasing acculturation (often leading to increased consumption of high fat foods).

12. Access to and use of services

12.1 Rates of GP registration and use

Barriers to access of primary care services are likely to be related to many factors, including how these services are provided and the backgrounds and experiences of the different asylum seekers/refugees wishing to use these services. The spectrum of service provision extends from the routine integration of asylum seekers into existing mainstream services to dedicated services in areas where there is high demand. Some practices may allocate space on their General Medical Services (GMS) surgery lists for asylum seeker populations while others use Personal Medical Services (PMS) to set up surgeries for local vulnerable populations. A few practices have set up specialist solutions, such as a dedicated resource of a salaried GP, and these tend to be in areas with a high density of refugees/asylum seekers. The NHS (Primary Care) Act 1997 gives PCTs some flexibility to improve the development and responsiveness of services for particular target groups through Local Development Schemes and Personal Medical Services pilots. Information on the prevalence of these different models of care with respect to provision for refugees/asylum seekers is lacking, the evidence suggesting that for most such groups specialist support and resources may be poorly developed or lacking.

Although GPs have the choice of accepting asylum seekers either as fully registered patients - or as temporary residents if they are in an area for more than 24 hours but less than 3 months - varying levels and types of GP registration and of usage are documented in a number of studies. Overall levels of registration amongst refugees in London varies from 90-94 per cent (93 per cent in Haringey [Haringey Council]; 90 per cent in Newham [Gammell *et al.*, 1993]; 94 per cent in Brent and Harrow [Brent and Harrow Health Agency *et al.*, 1995]). In a study by Carey-Wood *et al.* (1995), 99 per cent were registered with a GP, although only 40 per cent of those who said they had a medical or psychological problem had actually sought help. Outside London data on registration levels and use of GP services is more limited. With respect to Kosovan refugees, for whom arrangements were better planned than for dispersed asylum seekers/refugees in general, nearly all (266, 98 per cent) of the 272 who arrived in Liverpool in May/June 1999 were registered with GPs in the city within two weeks of their arrival (Ghebrehewet *et al.*, 2002). Although no data are available on registration levels, in the sample of 397 newly arrived asylum seekers in Sunderland and North Tyneside (Blackwell *et al.*, 2002), almost 40 per cent had seen a doctor and 8 per cent had received hospital treatment since arriving in the UK. From this sample, 216 (55 per cent) reported symptoms about which they felt it necessary to consult a doctor and 69 per cent reported needing to consult a dentist.

In addition to varying levels of registration (fairly high in established communities but probably lower in areas of dispersal), some GPs offer only temporary registration. Information on both levels (and type) of GP registration is limited in areas of dispersal. In a survey of health authorities in Northern and Yorkshire region about registration of asylum seekers with GPs (Wilson, 2001), 6 of 7 health authorities (HA) stated that data were not available on the total number of asylum seekers with temporary registration (East Riding and Hull HA stated 'none'). With respect to permanent registration, four HAs stated that data were not available (Bradford, 1,133; Leeds, 800; and Wakefield, 330, compared with around 400, 500, and 50, respectively, 'not registered'). Moreover, these same four HAs stated that data were not available on the number of GP practices with asylum seekers.

There is some evidence of higher use of Accident and Emergency (A&E) services amongst asylum seekers than the general population (Brent and Harrow Health Agency *et al.*, 1995; Cole, 1996), perhaps reflecting a lower rate of registration with GPs. A low uptake of counselling services is also reported (Haringey Council, 1997; Brent and Harrow Health Agency *et al.*, 1995).

12.2 Barriers to access

Nearly all studies of asylum seekers and refugees identify barriers and problems in accessing health services. A very wide range of access issues are identified by these people, including:

- not being registered with a GP (Dawson and Holding, 2001) or difficulties in registering (Wood, 2001);
- not knowing how to register/no guidance on where to go for services or what to do (Dawson and Holding, 2001; Wilson, 2001);
- difficulties with the GP appointments system (Wood, 2001);
- difficulties in access to dental treatment (Blackwell *et al.*, 2001);
- lack of knowledge of existing services (Smith, 2001);
- difficulties for young refugees when care is contracted out (Dawson and Holding, 2001);
- difficulties getting an interpreter/importance of language services/support (Dawson and Holding, 2001; Kibondo *et al.*, 2000; Wood, 2001);
- difficulties during the GP consultation because of levels of English usage (Nguyen-Van-Tam *et al.*, 1995);
- immediate need for access to health services/specialised treatment and time delays (Kibondo *et al.*, 2000);
- concern that denial of access may be on the basis of discrimination (Kibondo *et al.*, 2000);
- lack of awareness and understanding amongst health professionals (Kibondo *et al.*, 2000);
- distance from health care and lack of money for transport (Kibondo *et al.*, 2000);
- the capacity of the service (lack of staff, lack of staff time, and lack of specialist knowledge) (Kibondo *et al.*, 2000);
- difficulties in gaining access to female doctors (more likely to have been achieved by refugee women able to speak English) (Grant and Deane, 1995).

Capacity issues are illustrated by the workload impacts resulting from the inflow of Kosovan refugees to Liverpool. For example, between 20 April 2000 and 22 August 2000, Liverpool Health Authority made 559 allocations (each involving one or more asylum seekers) to GPs (Ghebrehewet *et al.*, 2002). An indication of the relative caseload in individual GP practices in different parts of the city is given by the range in the percentage of the allocations (1-48 per cent).

In addition to refugee and asylum seeker accounts, other reports (including those of providers and other health care professionals) identify:

- confusion amongst GPs about rights of registration (Jones and Gill, 1998; Refugee Health Consortium, 1998);
- problems registering with a GP (Islington Refugee Working Party, 1992; Jones and Gill, 1998);
- patients being asked for passports when trying to register (Grant and Deane, 1995);
- varying willingness to register asylum seekers (even amongst neighbouring practices), creating an unfair distribution of care for this group (Jones and Gill, 1998; Audit Commission, 2000);
- temporary rather than permanent registration (Jones and Gill, 1998; Audit Commission, 2000), perhaps to minimise the impact on their targets for immunisations, cervical smears, and related payments;
- failure to offer a new patient health check to asylum seekers and refugees, including many in a recent survey of 56 GP practices in London (Hargreaves *et al.*, 1999);
- low awareness amongst asylum seekers of what services GPs can provide and how they are delivered (Audit Commission, 2000);
- lack of knowledge about the special needs of asylum seekers, making GPs reluctant to accept them as patients (Audit Commission, 2000);
- reports (including those of GPs) of anxiety in dealing with refugee and asylum seeker patients and their demands on time (Ramsey and Turner, 1993; Audit Commission, 2000);
- language difficulties at reception and in the consultation (Ramsey and Turner, 1993; Jones and Gill, 1998) with some GPs advising the Audit Commission that asylum seekers' consultations took on average three to four times longer than those for other patients (Audit Commission, 2000);
- GP concerns about increased administrative workload arising from asylum seekers' mobility, e.g. following up child immunisations, vaccinations and cervical screening (Audit Commission, 2000);
- the possibility of serious medical errors arising from lack of interpreters at consultations (Refugee Council, 1999);
- lack of knowledge about the languages spoken and the extent of need for interpreting services (Jones and Gill, 1998; Ghebrehewet *et al.*, 2002);
- the non-availability of interpreting services outside working hours (Hicks and Hayes, 1991) and for acute consultations (Jones and Gill, 1998);
- lack of adequate professional interpreting services (Jones and Gill, 1998);
- underdeveloped telephone interpreting services (Jones and Gill, 1998).

Clearly, the type and frequency of barriers experienced varies across client groups and services. In health care, screening and health promotion programmes for women, a choice as to the gender of the health care professional and interpreter is often important as is the need to have an independent interpreter rather than a family member. Older people may have lower skill levels in English and be less able to learn a new language. Services need to be sensitive to the

requirements of specific cultures, taking into account such matters as religious needs, attitudes to physical examinations and invasive procedures, and the desired level of involvement of family members. For example, Bernard-Jones (1993) cites a lack of cultural understanding with respect to mainstream services amongst Somali and Eritrean women in Haringey, even though they were registered with GPs.

Communication Barriers

There is substantial evidence that communication issues (especially those relating to language) are a major barrier to accessing primary care and other services, including out-of-hours services. The diversity of languages amongst asylum seekers and refugees makes the provision of language support critical yet problematic for primary care and local councils who are responsible for ensuring adequate access. For example, within the 397 newly settled asylum seekers in north east England assessed by Blackwell *et al.* (2002), 33 different first languages were reported (Farsi, Albanian, Russian, Czech, Kurdish, French, and Dari accounting for 84.8 per cent of the sample, none of the other 25 reported languages having more than 7 subjects reporting them as their primary language). English was the first language of only 13 (3.3 per cent) and of those who reported English as an additional language (152, 38.3 per cent) two thirds stated that their knowledge of English was basic in nature. An interpreter was recorded as being used in 262 (66 per cent) interviews and the proportion may have been higher as data were missing in a further 69 cases. Solutions have included the sharing of language resources across sectors (including pooling of PCT resources amongst GPs, dentists, health visitors, and others) and the use of telephone-based interpreting. Limitations of the latter include inability to assess non-verbal communication, lack of familiarity with medical terminology, and lack of support once the consultation is over.

There is substantial evidence of the barrier posed by language to accessible health care. For example, Murphy *et al.* (2002) used a postal survey to obtain the views of inner city GPs (n=435) about language barriers. Of the 257 (59 per cent) that replied, three quarters were not satisfied with the arrangements for interpreters, there being long delays in obtaining assistance through a professional interpreting service. A telephone-interpreter system, used in urgent situations, was criticised as being expensive and unsuitable for the exploration of complicated psychological problems. Fears about confidentiality were expressed with respect to volunteer interpreters. Nguyen-Van-Tam *et al.* (1995) reported extremely low levels of English usage in Vietnamese adults in Nottingham, resulting in considerable difficulties for 27-69 per cent of respondents in GP consultations. In a pilot survey in the inner London boroughs of Lambeth, Southwark and Lewisham in 1997, all those who telephoned the GP out-of-hours co-operative over one weekend were investigated via GP completed questionnaires asking the patients about their language skills. Less than 1 per cent (95 per cent CI 0.1-2.1) of callers to the GP out-of-hours co-operative (308 completed questionnaires, 95 per cent response rate) did not speak English well (Free, 1999). A survey of the English language skills of attenders at one of the three A&E departments in the same area (606 completed questionnaires) found 9.1 per cent (95 per cent CI 6.8-11.4) did not speak English well (Leman, 1997), 2.7 per cent of whom were tourists. Vietnamese refugees with limited English language skills have reported that they are unable to use services which require the use of English language on the telephone, making the GP out of hours service unavailable and creating difficulties in making appointments (Free *et al.*, 1999).

There is some evidence that in primary and community health care settings, language, communication, and other barriers to accessing services can be addressed by the recruitment of linkworkers to liaise with the different refugee communities and the introduction of models of service delivery based upon the needs identified by the clients themselves (Shea, 1997; Yee and Heath, 1997). For example, it may be necessary for interpreters and linkworkers to interpret the nuance and body language as well as the words spoken, to be sensitive to cultural norms of politeness, modes of speech, and self presentation, to be responsive to gender preferences with respect to health practitioner, and to maintain a supportive, yet neutral, presence.

Cultural perceptions

For certain refugee/asylum seeker groups, cultural perceptions in some service delivery areas - especially mental health - may constitute a barrier to access. Both Somali and Ethiopian refugees consider 'mental illness' in a spiritual or religious framework. With respect to the former, the Department of Health and the Refugee Council (2003) identifies the need for sensitivity with respect to their beliefs:

'Mental health is linked to the spiritual world. Men, women and children are deeply religious beings living in a religious universe. Genies (spirits with strange powers) can interfere with daily life if their needs are not acknowledged and met. Every individual has one. By fulfilling genies' needs, mental health may be recovered. This must be done through special ceremonies over a number of years'.

Papadopoulos *et al.* (2002) have documented similar issues with respect to Ethiopian refugees:

'Mental illness or 'madness' carries a stigma in Ethiopian culture. It is believed to be the work of the devil and a punishment for the sins of the patient or a person close to them. Madness is thought to be due to spirit possession such as by 'Zar' spirits. 'Buda' (evil eye) is also believed to cause mental illness. Depression is perceived as having both natural and supernatural causation and remedies'.

These different beliefs lead to help seeking and coping strategies with mental health problems that do not easily fit into western conceptions of mental illness.

13. Wider determinants of health

13.1 Environmental factors: housing

The Immigration and Asylum Act 1999 imposes a general duty upon both local authorities and registered social landlords (RSLs) in England and Wales to assist the Secretary of State in providing accommodation for asylum seekers where 'reasonable in the circumstances'. The scale of housing required by NASS - emergency accommodation and housing in the consortia areas - to support the dispersal programme is considerable, including an estimate of 37,120 units of accommodation in the first year of dispersal (2000-2001). By the end of January 2000 less than 10 per cent of the number of units required had been identified, necessitating a decision to phase in provision. Moreover, not all locations would be suitable to house asylum seekers. The Audit Commission (2000) suggested areas with a multi-cultural population, ideally including people of the same nationality as the asylum seekers, with established refugee communities or support available to develop new community networks, school places available and language support for asylum-seeking children, adequate translation and interpretation facilities, availability of immigration lawyers, longer-term employment opportunities, places of worship to meet the religious needs of asylum seekers, and walking distance access to local colleges and health and other services.

However, pressures on housing stock, especially in London, have forced councils to house asylum seekers in unsuitable accommodation. A survey undertaken by the Audit Commission (2000) - which asked local authorities what types of housing were used to accommodate asylum seekers - found that over one third of family households were placed in bed and breakfast accommodation, hostels, or hotel annexes in October 1999. Over 35 per cent of unaccompanied children aged 16 to 17 were in bed and breakfast and around 25 per cent in private rented property. While around 80 per cent of unaccompanied children were with foster carers or in care homes, small proportions were in bed and breakfast, hostels, and hotel annexes. Generally, hostel accommodation is suitable for single adults but not families who fare better in self-contained accommodation. In grouped accommodation, communal areas and play space for children are important. Suitable packages of support are needed for asylum seekers, including social support, guidance on basic living skills, advocacy, and advice.

Problems may arise when asylum seekers receive a positive decision on their claim and are expected to leave their NASS accommodation within 14 days. Families may have built an attachment to an area with children settled in local schools and there may be limited alternative local authority or RSL stock in the area. Single asylum seekers may lack money for a deposit and fieldwork indicates that the average time taken to secure social security benefits is four to six weeks. Single adult asylum seekers who receive a negative decision have no further entitlement to NASS housing and eviction may place their welfare in jeopardy. It is perhaps too early to assess how satisfactorily NASS is meeting the accommodation needs of asylum seekers, although there have been widely publicised difficulties.

13.2 Socio-economic factors: employment, income and poverty

Recent research has demonstrated that asylum seekers and refugees experience significantly higher levels of unemployment than the population as a whole. In a study of 236 qualified and skilled refugees and asylum seekers living in London in 1999 (Peabody Trust and London Research Centre, 1999), 42 per cent of refugees and 68 per cent of asylum seekers were

unemployed. This is in spite of the fact that many asylum seekers arrive in Britain with professional qualifications, are strongly motivated to work, and most have a right to work in a paid or voluntary capacity after six months' residence.

Many barriers to employment have been identified, including: lack of information about job seeking; difficulties and expense of re-accreditation for overseas qualifications and experience; language barriers; lack of work experience in Britain; discrimination; confusion amongst employers over asylum seekers' status and entitlement to work; difficulties in obtaining national insurance numbers; uncertainty about the length of time people with exceptional leave to remain will remain in the country; and lack of money to buy clothes, attend interviews and to pay for childcare.

Some of these difficulties have been tackled in innovative ways, including the use in London of Single Regeneration Budget and European funding to provide a multi-lingual one-stop information point for local refugees seeking employment and training opportunities and the retraining of refugee doctors (Department of Health, 2000).

13.3 Educational factors

Access to education

Asylum seeking children (including those unaccompanied) are entitled to the same educational opportunities as other children. Education authorities have a legal responsibility to ensure that education is available for all children of compulsory school age in their area, irrespective of the child's immigration status. Also, all asylum-seeking or refugee children qualify for free school meals and milk if it is available. The benefits of such enrolment are well recognised. Burnett and Peel (2001b) state that the most therapeutic event for a child can be to become part of the local school community. However, standards of good practice are not being met in a number of key areas. According to research by the Refugee Council, in 1999 there were 63,000 refugee children in schools but about 2,000 children had no school place (Refugee Council, 1999). The Audit Commission (2000) also reported that in one London borough 189 secondary school children were waiting for school places, of whom 66 per cent came from outside the UK (mostly asylum seeker countries of origin).

Barriers identified by the Audit Commission (2000) include: resistance by schools to offer places because they cannot offer the language and other support that the child requires; concern that new arrivals will adversely affect key stage test results; low levels of collection of information about the number of asylum-seeking/refugee pupils in schools or those awaiting admission; unawareness by receiving local education authorities (LEA) that there were refugee children housed in their area by other councils; lack of understanding of educational responsibilities among asylum seeking parents; and difficulties in meeting the cost of school uniforms.

The provision of other types of support may also need to be reviewed by LEAs, including early years provision and youth and community services.

Specialist services

Once placed in schools, asylum seeker children may require specialist education services to meet needs arising from, for example, disruption to their education, their lack of English, loss of family/relatives, emotional and behavioural problems arising from the experience of war

and violence, and bullying because of their race/ethnicity. The Audit Commission (2000) suggests a number of measures to facilitate integration: induction programmes and befriending schemes for new pupils; offering language support and addressing issues of cultural difference through the mainstream curriculum; policies that deal satisfactorily with problems of racial harassment or bullying; appointing specialist staff, such as refugee support workers and bilingual assistants; promoting parental involvement; funding local refugee community groups that offer supplementary education; and different provision as an alternative to mainstream education (e.g. special 'access' courses and special reception classes), although educational professionals report benefits of mainstream education in asylum seeking children of primary school age.

English language support

There is substantial evidence that lack of good written or spoken English and a dearth of professional interpreting services present a major barrier to accessing health and other services. The lack of language skills may also limit refugees and asylum seekers from finding work and participating in the wider community. There is a major need for special language classes (such as English for Speakers of Other Languages or ESOL) which are free or charge low rates, perhaps provided in partnership with refugee community organisations, as courses run by adult and further education colleges are frequently over-subscribed. Further, the quality of ESOL provision needs to be monitored as there is evidence of dissatisfaction, one study of 236 qualified and skilled refugees in London reporting that over one third of recipients of language training were dissatisfied with this (Peabody Trust/London Research Centre, 1999).

13.4 Social support and social inclusion

The potential for social exclusion in the government's new dispersal arrangements has been recognised. Some areas to which asylum seekers have been dispersed are run down housing estates with limited employment opportunities and limited public services, compounding other difficulties with respect to integration and community participation. Outlying, predominantly white housing estates may be equally unsuitable, the Audit Commission reporting on one fieldwork authority that had housed 30 Somalian families in such circumstances, all but 3 of whom left within a few years because of harassment and isolation from their own community groups. The Housing Corporation's model - Housing Plus - promotes community sustainability through the use of community action plans that seek to match the social and demographic profile of tenants to community facilities and to identify initiatives to combat social exclusion and poverty (Housing Corporation, 1997). This model could be used to develop childcare services, leisure facilities, and community safety schemes and mediation services to resolve conflicts between residents.

Several experts have commented on the threat to social inclusion posed by proposed accommodation centres for asylum seekers. The BMA, for example, has expressed concern that children claiming asylum are to be educated in accommodation centres, raising serious questions about social exclusion and long-term psychological wellbeing (The Asylum Coalition, 2002).

II. Health and Social Care Interventions

There is a dearth of robustly evaluated interventions that address the health and social care needs of asylum seekers. Most reports of interventions are descriptive with no formal evaluation of their effectiveness. There are examples of good practice but the judgement is invariably made by the professionals and workers involved based on perceptions rather than outcome measurement.

The following interventions have been graded according to the strength of evidence for them. A number of schema are available, the most widely recognised being those based on the Agency for Health Care Policy and Research (AHCPR, 1992; Petrie *et al.*, 1995). The former, resulting in a grade of A, B or C (see Appendix 3) has been used.

1. Enrolment of asylum seeking children in school

The Audit Commission (2000) recommends as good practice: the informing by NASS of LEAs of the likely number of children to be placed in their area and as much detail as possible about these children to enable LEAs to monitor admissions and provide targeted support through education welfare officers; ensuring that school admission and appeal arrangements are clear, fair, and objective; liaising with neighbouring LEAs to find school places when schools are full; better information for parents on the education system; increasing the awareness of the needs of this group among teaching staff and governors; and explicit policies on additional support (grants for school uniforms, help to meet certain transport costs etc.). It cites as an example of good practice an asylum seekers conference for local teachers, held by Cardiff's Education Department in partnership with the Refugee Council, which included a series of practical workshops covering such topics as working with parents in the community and meeting children's psychological and language needs. **(Grade C)**

2. Support projects for young separated refugees/asylum seekers

Around half a dozen statutory/voluntary partnership pilot initiatives were set up across England in July 2001 with funding for 12-18 months to meet the needs of young separated refugees/asylum seekers and are subject to evaluation in 2002-2003 (Save the Children, 2001).

- The Young Person's Adviser at Heathrow Airport to support young unaccompanied minors through the reception process and training and guidance to personnel working with unaccompanied minors at ports of entry in the south east (European Refugee Fund and Refugee Arrivals Project: <http://www.refugee-arrivals.org.uk/>).
- Young Women Asylum Seekers Project, west London, to provide a support network for isolated young women aged 13 to 18 including vocational training, peer support group, and voluntary work opportunities (Portobello Trust's Youth Enterprise Scheme and a west London social services department [Save the Children, 2001]).
- Young Refugee Rights Project, west London, run by young refugees, to inform young refugees about their rights and to provide information about local services and support (Save the Children's London Development Fund [Save the Children, 2001]).
- Mental Health Resource Project, Hull, to provide training to statutory agencies to enable them to carry out sensitive needs assessment of young separated refugees and improve

professionals' understanding of the impact of loss and trauma (The Tuke Centre [Save the Children, 2001]).

- Connexions Project, West Midlands, which allocates young people a personal adviser to help them to maximise their educational opportunities and also provide advice and support in other aspects of their lives (Coventry and Warwickshire Connexions [Save the Children, 2001]).
- Young Separated Refugees Support Worker, Newcastle, involving the recruitment of a worker to support young separated refugees, including facilitating access to education and training opportunities, health services and local leisure facilities (Newcastle Social Services Department [Save the Children, 2001]).
- Youth Mentoring Project, Oxford, to establish a team of volunteer mentors to support young separated refugees in Oxford to live independently and make use of services available to them. **(Grade C)**

3. Care of unaccompanied asylum seeking children by statutory services and transition from care arrangements

A number of reports (Save the Children, 2001; Stanley, 2001) state that social services departments should ensure that: every young unaccompanied child or separated refugee/asylum seeker should receive a full needs-led assessment in line with the national framework for the assessment of children in need under the Children Act, 1989, and ensure that every one has an allocated social worker; appropriate accommodation for young separated asylum seekers is provided by reducing reliance on unsupported hostel and bed and breakfast accommodation; that all placements are monitored regularly, including 'out of area' and private provider placements, in line with statutory obligations; that health authorities and primary care trusts provide access to mental health provision appropriate to the needs of young separated asylum seekers; and that LEAs and learning and skills councils facilitate the provision of appropriate English language courses and access to educational provision and learning. **(Grade C)**

The Audit Commission (2000) reports that a proper care plan to inform the transition from care arrangements is vital. It also suggests that the development of central provision might improve standards of care for this group, a possible model of provision being small hostels such as those provided in the early 1980s for Vietnamese unaccompanied children which were staffed by members of their community and offered proper follow-up support.

4. Training of refugee doctors

There are several examples of good practice in this area. The University of London's Queen Mary College has established a programme to enable 50 refugee doctors a year to train to work in the UK (including preparation for the English language qualification required by the General Medical Council). Funded by a £300,000 grant from the Mercer's Co., East London and The City Health Authority has established a project to facilitate recognition of refugees' medical qualifications. Redbridge and Waltham Forest Health Authority is funding further qualifications in health promotion. **(Grade C)**

5. Patient-held records

Patient-held medical records for asylum seekers and refugees have been recommended by a number of sources. Jones and Gill (1998) have argued that the Department of Health needs to develop patient-held medical records for this group and that healthcare facilitators should be recruited from each specific refugee population who could help to provide these records with an accurate and detailed medical history. In a House of Lords Debate on asylum seekers, (Lords Hansard, 2003), Lord Hunt expressed the view: *'There is no doubt that hand-held patient records are the most appropriate method for dealing with the problem referred to (asylum seekers who are pregnant) and for recording health information. The asylum seeker would keep the hand-held record and take it to health appointments... Many areas have developed their own hand-held records for issue to asylum seekers. My department is working with front-line staff on the development of a national record'*. In their response to the Government's consultation on the White Paper Save Haven, Secure Borders, the Refugee Council (2002) states: *'Important, relevant information gathered at the initial health assessment should not be lost and Hand-Held Records should be established to ensure continuation of care, avoid duplication and to ensure that information gathered is not lost'*.

There are, however, a dearth of studies that have evaluated this intervention. Penny (2002) provides a comprehensive report on client-held records for people who are homeless or asylum seekers and a client health records booklet that is being piloted by Luton NHS primary care trust. **(Grade C)**

A hand-held record has also been developed by the Suffolk asylum team (Local Health Partnerships NHS Trust and Suffolk Primary Care Groups, 2001) in the form of a comprehensive booklet. The aim of this patient-held record is to provide a health needs assessment that can be utilised by all health service providers. It is designed to provide information to the patient, GPs, dentists, opticians, hospitals and other service providers, identify health needs, needs for disease prevention services, care given, and to provide continuity of care when asylum seekers are dispersed. Each page contains a different assessment or record: Personal information; emergency information; support workers; medical history; TB screening; immunisations; lifestyle assessment; practice nurse assessment; dental assessment/treatment; optical assessment/treatment; information about health services, appointments/record of visits; and a care plan. **(Grade C)**

Hand-held medical records have been formally tested in other populations, including maternity services. One randomised control trial (RCT) reported that women holding their own notes felt more in control than those holding only co-operation cards but there were no differences in health outcomes or health behaviour (Elbourne *et al.*, 1987). **(Grade A)**

Another RCT with patients with mental illness showed no effect on patient outcomes or admission rates and take-up amongst patients was poor (Warner *et al.*, 2000). **(Grade A)**

A further RCT of hand-held records in radiotherapy patients concluded that they made no difference to patient outcomes (Drury *et al.*, 2000) **(Grade A)**.

Throughout 2003 the Department of Health undertook work on a national patient-held record for asylum seekers and refugees, including a workshop for NHS staff from across the country. The content has since been revised¹¹ and the records printed and despatched to the first of the induction centres in East Kent. 'Patient instructions' have been translated into the major languages (Albanian, Arabic, Farsi, French, Kurdish [Sorani], Pashto, and Somali). All newly arrived asylum seekers residing at induction centres will be issued with a printed copy of the record. A 'children's' version of the patient-held record is also available.

6. Hand-held cards (childhood immunisation)

In a study of immunisation coverage for measles amongst an African American child population in Chicago (n= 2,545 households) factors significantly associated with receipt of measles vaccine by age 19 to 35 months included having a hand-held immunisation card (Rosenthal *et al.*, 2002). Children with hand-held cards had higher measles vaccination rates (94 per cent) compared to vaccination rates of children with only provider records (80 per cent). In fact, in a logistic regression model, children whose parents had a hand-held card were significantly more likely (16 times) to be up to date with measles vaccine. Similar results have been reported in other studies (Bobo *et al.*, 1993; Guyer *et al.*, 1994; Hamlin *et al.*, 1996; Morrow *et al.*, 1998; Wood and Halfon 1998; Bolton *et al.*, 1998; Guyer *et al.*, 2000). Only one study has been identified where children with hand-held records had lower coverage (Shaheen *et al.*, 2000). The magnitude of the association was higher in the impoverished community studied by Rosenthal *et al.* (2002). The investigators speculate that the card could represent a proxy for parental and provider attitudes and practices that positively influence immunisation coverage. Another study has shown that information on hand-held records is a reasonably accurate predictor of providers' reports of immunisation completion status (Rickert *et al.*, 2003). Although none of these studies takes place in a refugee/asylum seeker community, many relate to inner city and/or minority ethnic children. **(Grade B)**

No UK studies or evaluations have been identified, although the need for vaccination cards was reported in asylum seeker interviews in Leeds (Wood, 2001).

7. Dedicated GP practices

In 2002 a GP surgery catering exclusively for refugees and asylum seekers opened in the London Borough of Hackney (McKenna, 2002). The practice is the first of its kind in London and was established by Hackney PCT to meet the needs of the growing size of these groups in the Finsbury Park area of Hackney. It is anticipated that most of the practice's patients will come from the nearby Pembury Hotel (run by the UK's Refugee Council) where around 250 refugees and asylum seekers live. Hargreaves *et al.* (1999) have advocated specialist centres for refugees, while Hawthorne (1994) has suggested that this would lead to greater marginalisation. They are likely only to be practical in areas with a high density of refugees and asylum seekers. **(Grade C)**

¹¹ http://www.dh.gov.uk/PolicyAndGuidance/International/AsylumSeekersAndRefugees/AsylumSeekersAndRefugeesGeneralArticle/fs/en?CONTENT_ID=4080751&chk=Vw8xyG

8. Dedicated GP for high mobility populations

Another approach has been to establish a dedicated resource for high mobility groups within a GP practice. South Camden Primary Care Group used part of its staff budget to employ a salaried doctor for a year to work in a practice with an open registration policy and a high intake of transient patients including those from named hostels. One doctor has overall responsibility for organising care for transient patients and promoting better access to services. No evaluations of this model have been identified. The Audit Commission (2000) suggests that while it can work well in an area with a high density of refugees, other areas have found that local practices use such dedicated resources to offload their own asylum seeker patients. **(Grade C)**

9. Health support teams to improve access and ease burden on GPs

Parkside Health Trust in west London set up a health support team (HST), including nurses and advice workers, to improve access to primary healthcare services for asylum seekers and other persons in temporary accommodation and to ease the burden on GPs. A registration protocol is used to assess health needs prior to registration with a practice and to collect information that practices will need for the new patient registration process. The assessment record, subsequent care plan, and client-held records (which patients are encouraged to share with other agencies to promote continuity of care) are bilingual. Although no formal evaluation is available, the Audit Commission (2000) states that, according to initial feedback, this gives a comprehensive picture of individual health needs and eases administration for practice staff. The Audit Commission further reports that a protocol for nurse prescribing is in development. A practice nurse from a local surgery is seconded to the HST for one day a week to share skills and experience and to increase collaboration and funding is being sought for staff training. A series of 12 training sessions has been piloted on issues like working with victims of torture and benefits/entitlements for refugees/asylum seekers, open to any agency working with these groups. **(Grade C)**

A similar scheme is in operation in Swansea. The Morgannwg Asylum Seekers Health Team comprises a temporary sessional GP (to provide a link between local GPs and the asylum-seekers service) and a team of three nurses to provide short-term GP care for newly arrived asylum seekers not yet registered with a local practice. The Asylum Seekers Health Team carries out full health needs assessments on all newly dispersed asylum seekers and supports them in accessing local services. **(Grade C)**

10. Other changes in primary care practice

Permanent rather than temporary registration

Jones and Gill (1998) point out that on joining a GP's list, refugees are frequently registered on a temporary rather than a permanent basis with consequent disadvantages (loss of access to past records and financial incentives to undertake immunisation and cervical smear tests). They suggest that the justification for this (the high mobility of refugees) may be exaggerated. For example, a 1995 Home Office study reported that 70 per cent of refugees had been living in their current home for more than a year (Carey Wood *et al.*, 1995), although the recently introduced dispersal policy may have changed this. No evaluations of giving refugees

permanent registration status have been identified. However, Jones and Gill (1998) recommend that all practices should be provided with detailed guidelines for the process of registration and a mechanism introduced to ensure that ethical standards are adhered to. The Audit Commission (2000) is also critical of temporary registration because of the detrimental impact on continuity of care and the fact that it does not require a comprehensive new patient health check. **(Grade C)**

Special payments for GPs

Jones and Gill (1998) also argue that a separate capitation payment for refugee patients, together with a new item of service payment linked to the duration of each professionally interpreted consultation, should be introduced. **(Grade C)** The former need to some extent has been addressed by the provision offered in the PMS Pilot Projects.

11. Specialist expertise in refugee and asylum seeker issues

The recipients of the survey undertaken by Wilson (2001) for the Northern and Yorkshire Public Health Observatory were asked if they were aware of any examples of good practice in their own or other organisations that they had found helpful with regard to asylum seeker health and/or access to health services. More than 40 agencies/initiatives were named and a wide range of reasons given. Of the reasons cited by three or more respondents, specialist expertise/service provision ranked high: specialist team for asylum seekers (n=11), specialist health workers (GP/health visitor) (n=9), provision of screening/immunisation service (n=5), specialist services for children/families (n=5), national agencies with expertise (n=5), and local authority reception centre (n=3). **(Grade C)**

12. Specialist mental health services

Given the nature of mental health problems in refugee and asylum seeker communities, especially those following trauma, and the shortcomings in mainstream mental health services including long waiting lists, some health authorities have set up specialist services. The aim of these has been to provide culturally competent services including specialist post traumatic stress counselling. The Audit Commission (2000) cites two examples of good practice. The Refugee Support Centre provides bilingual counselling for refugees and asylum seekers who are experiencing severe emotional stress, supported by an annual grant of £37,000 from Lambeth, Southwark and Lewisham health authority. Most of the referrals are from GPs, other primary care practitioners, social services, and voluntary organisations. Similarly, a project in North Kensington and North Westminster provides refugees and asylum seekers with help in accessing mental health services, counselling (including PTSD counselling) and mental health advice. The project has the benefit of being multidisciplinary as these problems are best addressed on an interagency basis, the staff including a psychotherapist who co-ordinates the clinical and administrative tasks, two counsellors, one support worker and an administrator. **(Grade C)**

13. Specialist services for survivors of torture and organised violence

Under the Immigration and Asylum Act 1999, people who are assessed as in need of services as survivors of torture and organised violence have to be accommodated near London and their travel costs in attending appointments must be met: specialist support is offered by the London based Medical Foundation for the Care of Victims of Torture. The Audit Commission (2000) states that consortia need to identify those asylum seekers who fall into this category

during initial assessments and make arrangements to meet their travel costs. Moreover, where asylum seekers become clients of the Foundation after dispersal, consortia will have to relocate those who wish to move closer to London. **(Grade C)**

There is a growing body of evidence to support the need for specific good practices in this area (Burnett and Peel 2001b; Hargreaves 2002), including: survivors of sexual violence should be able to choose the sex of both their healthcare worker and interpreter; interpreters should not be relatives but professional persons; confidential voluntary testing for HIV and support should be offered to those at risk (survivors of sexual violence and rape); and a thorough assessment needs to be undertaken in an encouraging environment and with the dedication of appropriate time (in recognition of its therapeutic value and to enable adjudicators to make accurate decisions on asylum claims).

Appropriate specialist diagnostic services need to be available. For example, MacDonald *et al.* (2001) draw attention to the importance of detecting cognitive difficulties secondary to head injury in survivors of torture through 'bedside' cognitive testing rather than general examination. In such cases referral for appropriate treatment is important as there is evidence for the efficacy of neuro-rehabilitation even late after head injury, especially for cognitive training (Rice-Oxley and Turner-Stokes, 1999). Bone scans (scintigraphy) may be important in screening torture victims as it detects a higher proportion of cases than radiography.

14. Provision of translation, interpreting, and advocacy services

Several interventions have been documented to address language and other communication barriers, including translation of written materials, face to face interpretation, telephone interpretation, and advocacy. A wide variety of models are in use in London, including linked interpreting and advocacy through bilingual advocacy services (e.g. East London and City health authority), access to external services such as Language Line, and local and directly funded services managed by health authorities and NHS trusts (e.g. Lambeth, Southwark and Lewisham health authority has its own in-house interpreting service).

Face-to-face interpreting is generally provided in few areas and sometimes on an ad-hoc basis, although one NHS trust based service (Parkside) has specific named interpreters linked to particular GP practices, which have a large refugee caseload. Morgan and Lowdell (1999) review arrangements for interpreting and translation across 16 health authorities in London and arrangements for advocacy across 10 London health authorities. However, none of these different models has been subject to comprehensive evaluation. There is evidence of widespread use of telephone interpreting services but their interpreters may be unfamiliar with the medical context and these services incur significant costs for the NHS. The provision of a national service may address some of these problems. **(Grade C)**

15. Models of service delivery for health promotion

The literature describes a range of approaches but there is a paucity of formal evaluations. There is a widely acknowledged need for written information in a range of languages, although low rates of literacy in some groups (even in their own languages) makes this unsatisfactory as the only method. Video and audio cassettes are popular amongst minority ethnic groups (Health Education Authority Expert Working Group, 1998), although problems reported include quality, appropriateness of content, and sensitivity of language.

There is some anecdotal evidence of the benefit of outreach teams. Outreach workers attached to the Brixton Refugee Health Project provide workshops to refugee community groups and hostels about accessing local health services and relevant benefits that are very well taken up (Deane, 1997). **(Grade C)** Lambeth, Southwark and Lewisham's outreach team comprises: (i) Work with refugee communities - to raise awareness on primary care access and other issues including complaints, dental and optical services, ante and postnatal care, women's health and preventive measures for older people; (ii) Work with NHS trusts - to ensure that service providers are aware of refugee populations, their health and social care needs, health rights and their problems in accessing services; joint sessions between health professionals and refugee groups have led to better understanding of the issues among NHS staff and an increased range and detail of training offered to NHS staff. The sessions also bring refugees into direct contact with health workers from services they have never used or tried to access until then; (iii) Work with asylum seekers without access to welfare benefits - aimed at a more isolated group of asylum seekers in hostels, private rented accommodation or bed and breakfast accommodation to provide advice on registering with a GP and access to other services; (iv) Work with general practice - visits to practices to help staff develop a better understanding of refugees' experiences and needs, their rights and main health and health access issues; (v) Non-outreach work - ad-hoc research work, translation of health leaflets, specific case work, etc. Many of the London studies (Aldous *et al.*, 1999) call for more community health workers trained to give advice concerning services. In one or two schemes essential health and other information is provided as part of language courses. Telephone-based support services (such as NHS Direct) may be beneficial but there have been no evaluations in this patient group.

16. Improved initial health assessments at point of arrival

The Audit Commission (2000) has called for better follow-up procedures for passing on information from Port Health Control Units to asylum seekers' eventual area of residence. One option they suggest is to issue medical records to those assessed at the port of entry that asylum seekers could carry and pass on to local service providers. NASS should also inform receiving health authorities of asylum seekers dispersed to their area. Also, a more in-depth assessment could be carried out on arrival in a new health district. The Audit Commission cites as good practice the questionnaire based assessments, administered by interpreters and covering past medical history and the psychological impact of events, used by Leeds and Liverpool health authorities as part of the Kosovan Humanitarian Evacuation Programme. New arrivals were offered a test to identify possible cases of TB and the follow-up process included referrals to primary and secondary care, immunisation, the addressing of sexual health needs, and the establishment of an appropriate medical record system. Within the first few days of arrival 98 per cent of Kosovan evacuees were registered with GPs in Liverpool (Audit Commission, 2000). **(Grade C)**

This requirement has largely been met by the new procedures introduced into induction centres in October 2003. These include (i) health assessment for all asylum seekers that will comprise a health needs assessment, record a basic health history, address public health concerns, and include screening for TB; (ii) the use of patient-held records for the recording of this information, both for adults and children. Until April 2006 the Department of Health and the Home Office will be providing those PCTs with induction centres extra funding towards the cost of providing health assessments.

17. Tuberculosis (TB) screening of new arrival asylum seekers and refugees

The evidence for the effectiveness of this intervention appears to vary regionally. The only comprehensive evaluation of screening for TB compares the port of arrival scheme - a hospital based new entrants' clinic (1,262 referrals from the port of arrival) - with screening in general practice (1,311 new registrations) and centres for the homeless (267 individuals) (Bothamley *et al.*, 2002). Verbal screening limited tuberculin testing to 6 per cent of those in general practice but most were tested at the other two locations. Intervention (BCG vaccination, chemoprophylaxis or treatment) occurred in 27 per cent of those who received tuberculin testing. Attendance for screening was 17 per cent of the port of arrival notifications, 54 per cent in primary care, and 67 per cent in the homeless centres. Costs for screening an individual in general practice, hostels for the homeless, and the new entrants' clinic were £1.26, £13.17 and £96.36, respectively. The cost per person screened per case of TB prevented was £6.32, £23.00, and £10.00, respectively. This study shows that the screening for TB in primary care is feasible and could replace hospital screening of new arrivals. **(Grade B)**

A Home Office funded pilot scheme was established to screen asylum seekers for TB who enter the country via east Kent ports (Lords Hansard, 2002; Anon., 2002). In the 6 months between 18 June and 29 November 2002, 4,516 asylum seekers were screened for TB in east Kent (entering the UK via east Kent ports). Subsequently, 57 were referred to a chest clinic either with potential symptoms or high grade Heaf test results but none were diagnosed with TB (Lords Hansard, 2002).

There is some evidence that the yield of cases of TB detected by new arrival screening is low in some other areas of the UK. In a Newcastle upon Tyne study (Lavender, 1997) port of arrival forms and the Family Health Services Authority register were used to identify all new immigrants for screening during 1993 and hospital and practice records reviewed for evidence of screening up to the end of 1994. Only 99 (39 per cent) of all the immigrants identified on the port of arrival forms had been screened, resulting in the detection of one active case of TB. South Lancashire health authority screens on average 40 per cent of 110 new arrivals per year and no cases of TB have been detected in 5 years (Lamden, 2000). A similar view has been expressed by others about the effectiveness of screening in areas with a mobile new entrant population. Whitfield *et al.* (2002, 2003) report on the setting up of a holistic (including TB screening) clinic for new entrants in Croydon, many of whom are not notified through the port of arrival system. Of 2,855 patients screened over the period January 1999 - November 2002, only 3 cases of active TB (all mild or no symptoms and not infectious) have been diagnosed. BCG was given for 93 patients and chemoprophylaxis for 58. Over the same period, 110 cases of active TB were diagnosed in symptomatic new entrants presenting either through emergency departments or referred by GPs, most of whom were not known to the appropriate authorities and had not been screened. **(Grade C)**

However, it is clearly beneficial in other areas. Bothamley (1999, 2000) reports that screening for TB has been undertaken at a health centre in Lower Clapton in all those registering at the practice since April 1997. Verbal screening identifies new arrivals and those with a high risk of TB, followed by tuberculin skin testing in those under 35 years of age if required. During the period 1997-2000 there have been 12 cases of TB from the practice of 10,500 persons (approximately 1,000 new registrations each year). Four were identified through the screening process, of whom 2 were sputum smear-positive and therefore potentially infectious; the other

2 had smear-negative pulmonary tuberculosis, suggesting the benefit of screening. The investigator concluded that screening for TB in new arrivals taking place in general practice is effective in detecting cases early. **(Grade C)**.

Moreover, there is some evidence that screening should take place both in general practice and hospital settings because of the low registration of asylum seekers and refugees with a GP in some areas. Lavender (1997) has called for a national audit to assess the effectiveness of screening. Whitfield *et al.* (2002, 2003) argue for a fast track referral system to local chest clinics for patients with suspected TB and the screening of the children of new entrants (as there are clear benefits from BCG and antituberculosis chemoprophylaxis in this group).

18. Personal medical services (PMS) pilot projects, local development schemes, and the new GP contract: specialist provision for refugees and asylum seekers

PMS and Local Development Schemes under the 1997 (Primary Care) Act allow PCTs to use funding to assist in the provision of primary care services to target groups such as asylum seekers. The new GP contract (2003) also allows for the funding and provision of 'enhanced' services. Some of the PMS pilot projects, set up under the NHS (Primary Care) Act 1999, have been evaluated. These schemes enable enhanced or separate primary care services to be developed for asylum seekers and other vulnerable sectors of the population. In a PMS contract the pilot receives a set sum of money from the local NHS based on the services it is contracted to provide. This is worked out on the basis of the health needs of local people, what the practice aims to deliver to meet those needs and specifies targets to be achieved. The pilot itself then decides how to spend that money on staff and delivering the services. Non PMS GPs are paid directly through the existing national contract, not based on local circumstances. Just over 50 per cent of their income derives from the number of patients they have on their list. This system does not provide the flexibility of PMS to ensure that patients get the services they need, nor does it financially incentivise GPs to provide such a service tailored to local need.

Wilson (2001) reports on nine of the ten PMS pilot schemes working with asylum seekers in Northern and Yorkshire Region (4 with asylum seekers only and 5 with other client groups as well). Most work to provide a culturally sensitive, holistic service to meet the healthcare needs of asylum seekers and provide some or all of the following: screening; immunisation; initial health assessment; primary health care; help accessing other services; counselling; advocacy; health promotion; information; and social events. Pilot project staff network widely, provide training for other workers in asylum issues, and work to promote multi-agency working. **(Grade C)** However, none of the national evaluations of PMS pilots have evaluated those set up to address the needs of refugees/asylum seekers.

The Department of Health and Refugee Council (2003) have reported some examples of good practice in specialist provision via Local Development Schemes and PMS pilots. Kensington, Chelsea and Westminster Local Development Scheme has been established to improve access to primary care for refugees, asylum seekers and others in temporary accommodation. It has an advisory group comprising refugee voluntary organisations, the local interpreting service, a local mental health service targeting asylum seekers, a health support team, two GPs, a

practice manager and a member of the community development team. This local development scheme offers good practice in terms of the quality ethnic monitoring data that is collected.

Three PMS pilots - in Huddersfield, Suffolk, and Sunderland - are also described. The Whitehouse Centre (Huddersfield) has dedicated staffing (GP, health advisor, primary care nurses, social worker, and peer health educators) and addresses the need for longer consultations with asylum seekers and their social care needs such as housing. The Suffolk Community Refugee Team PMS Pilot provides a 'bridging service' to assist integration of asylum seekers and refugees into local communities and services. Again, there is dedicated staffing and management and the many project components include the facilitation of integration and registration with a permanent GP, full and holistic health and social care assessment and screening of needs, further development of hand-held records, a vaccination programme, the provision of interpreting for primary care and social care, and the support of clients with advocacy/liaison. The aims of the PMS Sunderland are similar: to provide a holistic, multi-disciplinary approach to asylum seeker and refugee health care and to integrate asylum seeker and refugee health care into mainstream health services in the community. Health screening is offered, including TB and vaccination screening and there are also research and training components. Evaluation research projects are planned for the Suffolk and Sunderland PMS pilots.

19. Culturally appropriate interventions for HIV/AIDS

Given the high incidence and low take-up of HIV/AIDS treatment and care services amongst refugee communities (especially those from Africa) in the UK, a number of attempts have been made to organise innovative and culturally appropriate interventions in this area and there have been some assessments of these interventions.

In an Institute of Education (University of London) study, Maharaj *et al.* (1996) report on a two phase assessment of HIV prevention initiatives, with particular reference to refugee and asylum seekers from the African continent. Key findings from Phase I (a review of published/unpublished studies, interviews with key informants from African community based organisations, and consultative meetings with members of African community groups) included: the importance of contextualising HIV/AIDS initiatives in relation to other health, social and legal concerns, the need to address cultural specificities and commonalities; the significance of denial and stigma within communities; the perceived value of single and joint gender work with men, women, and couples; the perceived merits of integrating HIV prevention into larger cultural events; and the need for a stable funding base for non governmental organisations. Informants emphasised the importance of the support of community-based organisations in undertaking this work. In phase 2 (case studies of 10 HIV prevention interventions) HIV prevention with refugees and asylum seekers appeared to work best when it involved those groups that initiatives sought to influence. **(Grade B)**

There are, in addition, reports of specific interventions. Kiwanuka (1998) describes an intervention for Africans from east, central and southern Africa in the UK, drawing upon the cultural experiences of African people living with HIV/AIDS, which aims to increase access to treatment and care services and to support compliance. The project provides peer advocacy and HIV/AIDS treatment information and education tailored to participants' cultural needs and experiences. Amongst the staff and volunteers are persons with AIDS working as peer educators and counsellors and the project is supported by qualified medical doctors from collaborating hospitals. It organises monthly information forums normally attended by about

60 people and produces a monthly newsletter with a circulation of 3,000. There is evidence that the intervention is effective, over a two year period the circulation of the newsletter and attendance at the project's forums and support groups has doubled; the project is making and receiving an increasing number of referrals from STI clinics and doctor-patient communication and compliance is improving. **(Grade C)**

Another important intervention, that of bottle feeding of infants by mothers with HIV/AIDS, is described by Kumalo (2002). There is strong evidence that breast feeding increases the risk of mother to child transmission and the World Health Organisation recommends that such women in developed countries should bottle feed their infants to reduce transmission. In a large African population of asylum seekers in Enfield and Haringey, women were not being compliant with such advice and so were putting their infants at risk of HIV infection. The stakeholders involved (North Middlesex Hospital, the health authority, and social services, with support of local HIV voluntary organisations, community pharmacists, and infant formula milk companies) set up an infant feeding programme using a multidisciplinary approach. Women who qualified were given a discharge pack consisting of sterilising equipment, bottles, and infant formula milk, the last given free until the child is one year of age. Social workers support and monitor the mother's progress. Using a holistic approach this intervention is reported to be effective and Kumalo (2002) argues that a similar national programme needs to be implemented to reduce mother to child transmission of HIV in asylum seekers. **(Grade C)**

Finally, Attaro *et al.* (1998) report the success of a four year old women's group mainly of poor asylum seekers in Newham, an area of east London with a high number of women and children with HIV, in influencing policy and service provision and in providing mutual self help. The success of such groups raises the need for support from government and voluntary agencies. **(Grade C)**

20. Maternity services

The Royal College of Obstetricians and Gynaecologists (2003) reports examples of special provision to meet the local needs of refugees and asylum seekers. There are special clinics for African women with issues around female genital mutilation (for example at the Whittington Hospital, London; Guys and St Thomas' Hospital, London and the Central Middlesex Hospital). In Wandsworth, which has a population of asylum seekers, refugees and second generation Asians, the open access family planning service has direct access to midwifery services so patients can easily flow between maternity and family planning to take advantage of appropriate care. Educational videos may also be useful, as used by Fife Acute hospitals NHS Trust. Queen Charlottes and Chelsea Hospital has developed a proposal for a midwife to work within the local Somali community in one particular Sure Start area where this community makes up the largest minority ethnic group. The midwife will provide antenatal information sessions in individual homes and group sessions in the homes of women identified as community leaders (an approach consistent with its long running one-to-one midwifery scheme) (Queen Charlottes and Chelsea Hospital, 2003).

Culturally competent components of good practice in health promotion, preventive care, and treatment interventions

1. The terms asylum seeker and refugee encompass a very wide and diverse range of people with respect to countries of origin, cultures, age groups, and family composition. The provision of health and social care needs to take into account all these differences.
2. As language is likely to be a major barrier to access for many nationality groups, particular importance needs to be accorded to the provision of interpreting services (e.g. via the telephone). This may be especially needed at the first point of contact with a service, e.g. the receptionist in GP practices.
3. Asylum seekers/refugees may be used to different systems for providing health care in their countries of origin, e.g. walk-in clinics or hospitals, and so be unfamiliar with the concept of GPs, appointment systems, etc. Patient expectations need to be addressed, including such matters as flexibility in offering appointments, recognition of different days of worship across the faiths, and acceptable naming conventions.

III. Recommendations

Based on this review of the literature on the health beliefs, health status, and use of services in the refugee and asylum seeker population, and of appropriate health care interventions, a number of recommendations for policy and practice are put forward.

1. Better information is needed on the size and location of the groups, although use could be made of the 2001 Census country of birth full tabulations.
2. Baseline health assessments, including co-ordination of those completed at entry (now being introduced by Government) are needed.
3. There is a lack of longitudinal data on the health experiences of refugees/asylum seekers that needs to be addressed.
4. There is a need for better information in administrative systems and ethnic monitoring.
5. There is a need for health needs based provision of services, the evidence base providing several examples of good instruments and research into practice models.
6. Projects focussing on this population require robust evaluation and outcome measurement, which is currently lacking.
7. Good practice examples should be built upon: support projects for the young, transition from care, training of refugee doctors, patient-held records, dedicated GPs/practices where justified by numbers, specialist services (e.g. effects of torture), culturally sensitive maternity services, etc.

Appendix I: Glossary of terms

Asylum seekers

These are people who flee their home country and seek refugee status in another, possibly because of war or human rights abuses. Under Part VI of the Immigration and Asylum 1999, the term asylum seeker includes people who claim that their removal will breach article 3 of the European Convention on Human Rights that prohibits torture, inhuman or degrading treatment or punishment.

Refugee status

A person is recognised a refugee when the government of the new country decides that they meet the definition of a refugee under the 1951 United Nations Convention Relating to the Status of Refugees. A person with refugee status is given indefinite leave to remain in the United Kingdom.

Unaccompanied asylum seeking child

This is a person who, at the time of making the asylum application: is, or (if there is no proof) appears to be, under eighteen is applying for asylum in his or her own right and has no adult relative or guardian to turn to in this country. The Immigration and Nationality Directorate (IND) does not consider a child to be unaccompanied if he or she is being cared for by an adult prepared to take responsibility for them. IND staff will involve social services in any case where there is concern about the child's relationship with the 'responsible' adult.

Exceptional leave to remain (ELR) or exceptional leave to enter (ELE)

This is granted to asylum seekers who, despite failing to meet the strict definition of a refugee, are allowed to stay in the country for a definitive period for other reasons - for example, because it would be dangerous for them to return to their home country. Those with ELR or ELE may apply for settlement after four years.

Settlement

This is the process by which refugees become integrated into society in their new country. When a person is granted indefinite leave to remain (ILR), this is sometimes also described as 'settlement'.

Appendix 2: Literature search strategies

Some 40 databases were searched using a variety of search strategies, including hierarchical search algorithms, Boolean searches, use of database thesauruses (MESH, Emtree thesaurus), and key word searches: ContentsFirst; Electronic Collections Online, Index to Theses; PapersFirst; Proceedings; UnCover; Web of Sciences Proceedings; Zetoc; ArticleFirst; Best Evidence; CHID; Cochrane Library Databases (CDSR, DARE, Cochrane Controlled Trials Register; NHS Economic Evaluation Database; Health Technology Assessment Database); EMBASE; HealthPromis; HMIC; HSTAT; Medline; PubMed; National Electronic Library for Health; PsycInfo; Science Citation Index; ASSIANet; EconLit; Social Science Citation Index; Social Services Abstracts; Sociological Abstracts; British Nursing Index; CINAHL; ENB Health Care Database; CRER; National Research Register; Regard; and HARPWeb (Health for asylum seekers and refugees portal).

The review was undertaken between February 2003 and March 2004. In a small number of cases, updates have been provided prior to publication.

Appendix 3: Evidence grading of interventions

Levels of evidence and grading of recommendations

| Level | Type of evidence |
|--------------|---|
| Ia | Evidence obtained from meta-analysis of randomised controlled trials |
| Ib | Evidence obtained from at least one randomised controlled trial |
| IIa | Evidence obtained from at least one well designed controlled study without randomisation |
| IIb | Evidence obtained from at least one other type of well-designed quasi-experimental study |
| III | Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case controlled studies |
| IV | Evidence obtained from expert committee reports of opinions and/or experiences of respected authorities |

| Grade | Type of recommendation |
|--------------------------|--|
| A (levels Ia, Ib) | Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation |
| B (levels IIa, IIb, III) | Requires availability of well conducted clinical (health services) studies but no randomised clinical trials on the topic of recommendation |
| C (level IV) | Requires evidence from expert committee reports or opinions and/or clinical (health services) experience of respected authorities. Indicates absence of directly applicable studies of good quality. |

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