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Briefing

Paper 8

Care of Asylum Seekers, Refugees and Undocumented Migrants

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Collaborative Quality Improvement in General Practice Clusters

This paper is the eighth in a series that relates to areas of quality and safety on which general practice clusters could usefully focus improvement activity. Each paper summarises research, guidelines and other evidence about areas of care which can be improved, and improvement methods and interventions.

Care of Asylum Seekers, Refugees and Undocumented Migrants

Migration to Scotland is increasing, with migrants coming from both outside and within the European Union for work, study and family reunification. One group with particular health and health care needs are asylum seekers, refugees and undocumented or refused migrants. Such patients are likely to be in particularly marginalised situations and have particular health and access needs. This paper describes the current situation – as far as is known – on the size of the population; summarises health needs and access issues and outlines areas which could be the focus of quality improvement projects for practices caring for these populations.

The problem

Migration to Scotland is on the increase; between 2004 and 2012 the foreign-born population of Scotland increased from 204,000 to 357, 000 [1]. Using the 2011 census data, Vargas-Silva reported that 7.2% of Scotland's population was born outside of the UK, with 5.5% reporting foreign nationality [1].

Migrants live in all council areas of Scotland, with the largest numbers found in Glasgow City (86,000 in 2012), followed by Edinburgh City Council then Aberdeen [1,2]. However, migrants are a heterogenous population, including those who come for work, to study, and for family reunification. There are also those who are fleeing persecution and war or who are being trafficked – see Appendix 1 for a list of recognised international definitions in relation to migration.

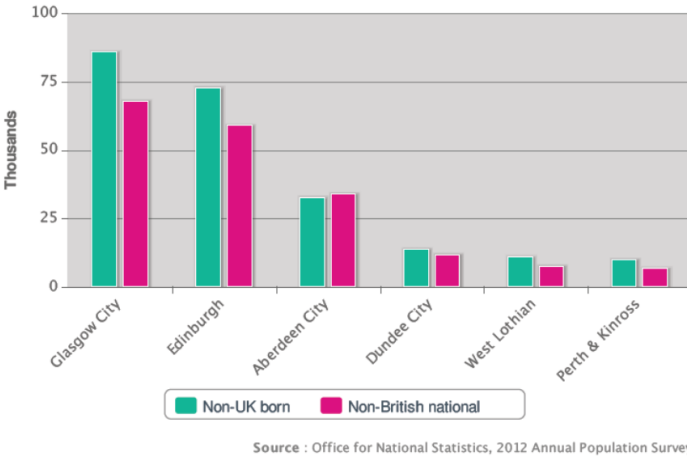
The particular focus of this briefing paper is those who we would consider to be in marginalised situations, including asylum seekers, refugees, undocumented migrants, victims of trafficking and economic migrants in unskilled, low paid employment.

Many of these migrants live in areas of deprivation, with an estimated 1 in 3 migrants classified as being in lower socio-economic groups (despite what their situation may have been in their country of origin) [2]. Asylum seekers and refugees are concentrated in the West of Scotland, due mainly to the Home Office dispersal scheme, with an estimated 3000-4000 asylum seekers/ refugees living in Glasgow.

Migrants in Scotland come from a range of countries; the greatest proportion comes from Poland, followed by India, Germany and Pakistan (Figure 1) [1]. However, data in relation to the country of origin of asylum seekers is not available at Scottish level; in 2012, the most common countries of origin at UK level were Pakistan, Iraq, Sri Lanka, Nigeria, Syria and Afghanistan [3]. While these countries remain main origins of asylum seekers, the escalation of the war in Syria has led to an increasing population of Syrian refugees either crossing continental Europe to reach the UK or relocated as part of the UK integration programme [4]. There is little data on the number of victims of trafficking, although the CLANDESTINO project estimate the number in the UK to be between 417,000 and 863,000 [3]. What is clear is that each of these groups have different health needs and issues when accessing health care.

Figure 1. Number of migrants in selected areas of Scotland

(From Vargas-Silva, 2013; chart from www.migrationobservatory.ox.ac.uk) [1]



Source : Office for National Statistics, 2012 Annual Population Surve

Health needs and access to health care

Health needs

Research often refers to the "healthy migrant" effect, namely that migrants are often younger and, relative to the native population, healthier [5]. While this can be true initially, migrants in marginalised situations have often experienced trauma on their journey to the UK, may be fleeing war and persecution and may be coming to the UK with pre-existing chronic disease and physical ill-health, as well as mental ill-health [5]. Country of origin, reasons for migration, socio-economic status, age and gender are all factors that influence their health [6]. Many come from low and middle income countries which are also experiencing an increase in non-communicable diseases, such as diabetes, cardiovascular disease, depression and anxiety disorders [7].

Research has identified that migrants are often suffering from poorer health than the native population of the country they have moved to [8,9], particularly when the migration journey is taken into account [10]. Non-communicable chronic disease, including coronary heart disease and diabetes, mental health needs and communicable diseases such as tuberculosis, hepatitis. parasitic diseases and HIV are health issues to be aware of in migrant populations [5,11]. The prevalence and pattern of disease mirrors the country of origin, as

well as the route of migration to Scotland.

Little is known about the prevalence of multimorbidity in migrant populations. Recent work using a population -level disease registry in Norway found that, compared to those migrating for family reunification, multimorbidity was lower for those migrating for work (Men: OR 0.23 (95% CI: 0.21 - 0.26); Women: OR 0.45 (95% CI: 0.40 – 0.50)) but higher for refugees (Men: OR 1.67 (95% CI: 1.57 – 1.78); Women: OR 1.83 (95% CI: 1.75 – 1.92)). For all groups, multimorbidity doubled after a 5 year stay in Norway [12]. One issue that likely contributes to this, particularly for asylum seekers and refugees, is the precarity of their situation, with worry and uncertainty over asylum claims taking its toll on their physical and mental health (Isaacs, Burns, Macdonald & O'Donnell, unpublished work).

Access to health care

Once in a new country, multiple factors influence migrants' ability to access and use health care. These include legal entitlement; knowledge and awareness of the health system in a new country [13]; previous experience of health care [14]; language and cultural barriers [15]; health beliefs and attitudes [16]; and, importantly, how the new country's health system is itself configured. Research conducted with asylum seekers and refugees in Glasgow found that differing expectations of care and a lack of experience of a GP gatekeeper system leads to a lack of trust in the GP and a mismatch in expectations especially in relation to issue such as referral to secondary care, expectations of receiving antibiotics and pain relief [13,14]. However, countries with a strong system of primary care are well placed to deal with the multiple challenges and health needs that migrants, especially those who are marginalised, bring to the health care encounter [3]

There are also issues and concerns for health care professionals caring for these populations. As well as dealing with language and expectations, there are also concerns related to specific health issues, notably severe and enduring mental health issues, previous history of sexual violence and assault and female genital mutilation.

Female genital mutilation

One area of particular concern relates to female genital mutilation (FGM), with work within general Practice and Primary Care highlighting this as an area of concern for GPs (Matthews, Burns, Mair & O'Donnell, unpublished research). Accurate data on the prevalence of FGM amongst women living in Scotland is not available. Recent work, funded in part by the Scottish Government, identified almost 24,000 men, women and children living in Scotland who come from countries which practice FGM [17]. However, as the prevalence rate for FGM varies across countries, this reduced the potential population to just over 8,000. In 2012, there were 363 girls born in Scotland to mothers from FGM-practising countries FGM [17]. Policy has identified two important health care encounters where FGM might be detected: women attending ante-natal appointments; and when attending primary care to see either a GP or practice nurse, especially in relation to cervical screening.

With FGM illegal in the UK, English hospitals are now required to record all episodes of FGM detected (RCGP Guidance http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/FGM%20Clinical%20Paper.ashx). Mandatory reporting of FGM detected in girls under 18 years is in place for all health care professionals working in NHS England (https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare). However, the impact in terms of damaging the patient-professional relationship and the need to ensure there is support for victims and training for professionals has been recognised [18].

Health prevention, with particular reference to cervical screening

Cervical screening rates are known to be lower amongst minority ethnic women, including asylum seeking and refugee women than amongst the native population in countries of settlement [19-21]. Reasons include a lack of awareness of cervical screening, embarrassment and fear, lack of time and a lack of knowledge of the risk factors associated with cervical cancer. Research in Glasgow with asylum seeking women indicates that stigma, views from countries of origin that cervical cancer is associated with sex workers and the role of the husband also appear to be important (Matthews, Burns, Mair & O'Donnell, unpublished work). Finally, other work with Sub-Saharan migrants in Glasgow found that, for many, there was a general lack of knowledge about the potential risk of developing chronic diseases such as heart disease, cancer and diabetes and the role of prevention in ameliorating that risk [16].

How can care for asylum seekers, refugees and undocumented migrants be improved?

Cross-cultural communication

Improving cross-cultural communication is a key requirement in caring for this population. The inability to communicate within health care consultations has recognised consequences. Patients visit their health care provider less [22]; when they do visit, consultations are longer, and there is poorer mutual understanding which can result in increased non-compliance with medication and treatment advice [23] and fewer referrals to other services, especially psychological services [24]. Other issues include the increased risk of misunderstanding and misdiagnosis [25-27], extensive clinical testing required to compensate for poor communication [28] and prolonged administrative procedures.

Research has shown that the use of professional face-to-face interpreting can overcome many of these barriers. Professional interpreters lead to a decrease in communication errors, increased patient understanding, a reduction in inequity in service use, and improvements in clinical outcomes and patient satisfaction [27,29]. However, a lack of interpreting provision can still lead

health care professionals to rely on untrained ad hoc interpreters – often family members or friends. This can lead to poorer quality care, more errors in interpretation and less satisfied patients [25,26]. Migrants also had concerns about confidentiality and appropriateness of the interpreting when ad hoc interpreters were used [30,31].

However, communication and understanding goes beyond just language, with health beliefs and expectations shaped by cultural background. As the recent Lancet Commission on culture and health stated, "intercultural health communication is not only about language translation, but also situated beliefs and practices about the causation, local views on what constitutes effective provision of health care, and attitudes about agency and advocacy" [32]. This lack of cultural understanding can lead to some of the issues outlined above, such as a lack of trust in GPs [14].

To date, there has been little or no work on assessing the cost effectiveness of providing interpreting services. While effort has been put into calculating the costs to the NHS in England of providing interpreting services and translated materials (estimated at £23.3 million in 2011), no one has calculated the related costs of not providing such services in terms of late presentation of symptoms or use of more accessible services inappropriate to the clinical need, for example using A&E departments. Recent work from Germany has shown that restricting access to health services for asylum seekers – albeit by restricting entitlement rather than by reducing interpreting services – resulted in higher health care costs when asylum seekers eventually were able to use services [33].

Rights and entitlements

The issue of rights and entitlement to health care is also a key issue. Research shows that these change, not only across countries but also within countries, depending on the legal status of the individual (e.g. asylum seeker, refugee with leave to remain, undocumented migrant) [3]. In the UK, while immigration law is reserved to the UK-level, health care and decisions relating to health care access is a devolved issue. This has resulted in some key differences in relation to rights and entitlement,

Refugees and those granted leave to remain may use the NHS free of charge (emergency, primary and secondary care). Citizens of the EU may be entitled to free treatment similar to those resident in the UK through use of the European Health Insurance Card (EHIC). Everyone, regardless of legal status, is entitled to free emergency treatment. Similar to England, asylum seekers have free access to NHS services throughout the time of application for refugee status and during the appeals process. However, while refused asylum seekers in England may be charged for secondary care, in Scotland refused asylum seekers have full and free access to all sectors of the health care system (Scottish Health Directorate, 2010):

Anyone who has made a formal application for asylum, whether pending or unsuccessful, is entitled to treatment on the same basis as a UK national (2010:9)

In contrast to this, the public rhetoric, especially in the media, is often focussed on the notion of "benefits scroungers" and "health tourists" [34]. This can lead to confusion amongst health care professionals about the rights of marginalised migrants to access and use all aspects of health care in Scotland (Matthews, Burns, Mair & O'Donnell, unpublished research).

Core elements for improvement

There are a number of areas which are amenable to improvement, both for patients and for the health care professionals providing that care.

Ensuring all staff are aware of rights and entitlements

Education of all staff working within general practice clusters as to the rights and entitlements of migrants accessing primary care is paramount. Reception and administrative staff, as the first point of contact with patients, are a particularly important target group. Their role is key to welcoming and supporting such patients.

Access to timely, high quality interpreting services

As described above, professional face-to-face interpreting is the gold standard and – as such – should be the default option for all patients accessing primary care. Where there are difficulties with this, for example due to a small number of interpreters in a particular language or due to urgency of need, other options may be sought, for example telephone or video interpreting. The use of ad hoc untrained interpreters or members of staff should be discouraged (see the EU funded RESTORE project for further information).

To date, there is no high quality evidence comparing the effectiveness of face-to-face interpreting with other forms of interpreting, such as telephone or video. While not a key activity for general practice clusters, they could contribute to the generation of such evidence.

Education for patients with respect to the structure and operation of the Scottish primary care system

Many patients come from countries with poor, or even non-existent, primary care systems. The NHS primary care system, with appointment systems and GP gatekeeping to secondary care, is often new and leads to confusion and a lack of trust in the system [14]. Many patients are also often unfamiliar with preventive health care, including such systems as cervical screening or with childhood immunisation schedules that differ from their country of origin [13,16] (Matthews, Burns, Mair & O'Donnell, unpublished research). Support and information, for example through the use of peer support or mentor schemes, would help to counteract some of this and improve care for such patients.

Increasing knowledge of the need for, and role of, primary prevention

Evidence suggests a lower awareness of primary prevention from chronic diseases, including cardiovascular disease, diabetes and cancer. In addition, the precarity and vulnerability associated with being an asylum seeker or refugee makes consideration of health – and in particular preventive health care – a low priority in people's lives.

Arguably population-level interventions will have more benefit for this population, as for the wider native Scottish population. However, when addressing primary prevention at the individual level, health care professionals need to be aware of these wider issues and, if possible, seek to identify the underlying health beliefs of patients. For example, if a GP or practice nurse becomes aware that a woman may believe that only sex workers are at risk of developing cervical cancer, they may be better placed to discuss screening and prevention with that woman.

Sexual assault, gender-based violence and female genital mutilation

There is a clear need to support health care professionals deal with the needs to particular patients. GPs report feeling anxious about caring for patients who may have experience sexual assault, violence and/or FGM. There is, therefore a need to work closely with practitioners and to develop a cadre of GPs and nurses skilled in dealing with such issues who can then advise and support their colleagues.

Implication for collaborative quality improvement in general practice clusters

Not all general practices and clusters will have asylum seeking and refugee patient populations, although increasing numbers of practices will have migrant patients who have moved to Scotland for a variety of other reasons. Recognising the particular needs of practices caring for this population of patients, General Practice & Primary Care at the University of Glasgow have recently held two CPD sessions for GPs and other primary care professionals. This indicated a clear appetite for further meetings and support. This could be developed in conjunction with the Scottish Government, perhaps under the auspices of the Glasgow Refugee, Asylum and Migration Network (GRAMNet, http://www.gla.ac.uk/research/az/gramnet/), which has extensive experience of working across institutions and third sector organisations and with asylum seekers and refugee communities.

Further work to explore the most effective and cost effective ways of delivering interpreting services, including face-to-face interpreting, is also required. Finally, continuing to work with migrant communities, in conjunction with primary care, will help to ensure the delivery of effective care that is culturally appropriate and acceptable to all.

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Appendix 1: International Organisation of Migration Key Definitions (http://www.iom.int/key-migration-terms - Accessed 12th July 2016)

Asylum seeker

A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.

Country of origin

The country that is a source of migratory flows (regular or irregular).

Freedom of movement

A human right comprising three basic elements: freedom of movement within the territory of a country (Art. 13(1), Universal Declaration of Human Rights, 1948: "Everyone has the right to freedom of movement and residence within the borders of each state."), the right to leave any country and the right to return to his or her own country (Art. 13(2), Universal Declaration of Human Rights, 1948: "Everyone has the right to leave any country, including his own, and to return to his country. See also Art. 12, International Covenant on Civil and Political Rights. Freedom of movement is also referred to in the context of freedom of movement arrangements between States at the regional level (e.g. European Union).

Irregular migration

Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term "illegal migration" to cases of smuggling of migrants and trafficking in persons. N.B. Irregular migrants often referred to as **undocumented migrants**.

Migrant

IOM defines a migrant as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is. IOM concerns itself with migrants and migration-related issues and, in agreement with relevant States, with migrants who are in need of international migration services.

Migration

The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification.

Refugee

A person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country. (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). In addition to the refugee definition in the 1951 Refugee Convention, Art. 1(2), 1969 Organization of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country "owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country or origin or nationality." Similarly, the 1984 Cartagena Declaration states that refugees also include persons who flee their country "because their lives, security or freedom have been threatened by generalised violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order."

Resettlement

The relocation and integration of people (refugees, internally displaced persons, etc.) into another geographical area and environment, usually in a third country. In the refugee context, the transfer of refugees from the country in which they have sought refuge to another State that has agreed to admit them. The refugees will usually be granted asylum or some other form of long-term resident rights and, in many cases, will have the opportunity to become naturalized.

Trafficking in persons

"The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (Art. 3(a), UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention against Transnational Organized Crime, 2000). Trafficking in persons can take place within the borders of one State or may have a transnational character.