Refugees and Asylum Seekers in Norfolk

June 2023

What is the issue and why is it important for Norfolk?

The number of asylum applications made in the UK has increased significantly in recent years. This has resulted in an increase in the number of asylum seekers and refugees accommodated both nationally and locally. Refugees and asylum seekers are a vulnerable group of society and face inequalities in their health status. They have a variety of health needs impacted by conditions experienced in their country of origin, difficult experiences during transit, and conditions after arriving in the host country. These experiences make refugees and asylum seekers more vulnerable to communicable diseases, poorly controlled chronic conditions, and mental health conditions. The significant differences in the health systems in asylum seekers' countries of origin and the UK National Health Service (NHS) can also contribute to barriers to accessing healthcare. Health care delivery to this patient group has become a challenging public health focus in high income countries.

Executive summary

Under the 1999 Immigration Act the UK has a legal obligation to provide accommodation and other support to asylum seekers who would otherwise be destitute while their asylum claim is being considered. The number of asylum applications made in the UK has increased significantly in recent years and in 2022 were at their highest for almost two decades.

Asylum applications can take months or even years to decide.

Asylum seekers and refugees have a variety of health needs which are impacted by:

- Conditions experienced in their country of origin
- Exposure to adverse experiences during their transit time
- Conditions and experiences after arriving in the host country

These experiences make refugees and asylum seekers more vulnerable to the following:

- Communicable diseases
- Poorly controlled chronic conditions
- Mental health conditions

There is limited data on health issues faced by asylum seekers and refugees in Norfolk, but based on literature review and the main diseases and risk factors from the countries of origin, the main illnesses we expect to see in refugees and asylum seekers in Norfolk are as follows:

Non-communicable disease

- Cardiovascular diseases (ischaemic heart disease, stroke)
- Diabetes
- Chronic respiratory diseases
- Chronic kidney disease

Communicable disease

- Epidemic prone diseases i.e., Tuberculosis (TB), polio, viral hepatitis, malaria or schistosomiasis (parasitic worms), measles
- Diarrhoeal diseases

Mental health

- Anxiety
- Depression
- PTSD

Other

- Poor immunisation coverage
- Cirrhosis of the liver is a key cause of death in Syria – potentially due to viral hepatitis rather than alcohol consumption
- Sudan has a high prevalence of HIV
- Malnutrition/nutritional deficiency is a cause of concern in Syria and Afghanistan

Health behaviours and risk factors reported in the countries of origin are as follows:

- Dietary risk
- Smoking
- High blood pressure
- Poor immunisation coverage
- Poor travelling conditions

Once in the UK the main health risk factors for poor health outcomes in refugees and asylum seekers in Norfolk include:

- Living in proximity and poor conditions
- Spread of infectious diseases such as respiratory tract infections (including TB), diphtheria, scabies, measles, meningococcal meningitis.
- Poor nutrition (competing priorities)
- Lack of physical activity

Additional challenges and risks for asylum seekers include:

- Risk of exploitation.
- Risk of homelessness for new refugees due to delays to receiving mainstream benefits.
- Difficulty getting back to work due to lack of UK work experience and deskilling in the case of professions such as dentists and doctors.

There were around 670 asylum seekers staying in accommodation in Norfolk as of October 2022:

- Around 530 people are hosted across four **contingency hotels** for asylum seekers in Norwich and Great Yarmouth.
- 140 people reside in **dispersal accommodation**.
- Most asylum seekers in Norfolk are young single men.
- The main countries of origin for asylum seekers receiving support in Norfolk as of October 2022 are Afghanistan, Albania, Eritrea, Iran, Iraq, Pakistan, Sudan, Syria, and Turkey.

Asylum seekers and refugees arriving in Norfolk are settled by the People From Abroad Team (PFAT) at Norfolk County Council. This is a specialist team that supports a wide range of migrants.

Voluntary sector organisations provide support to refugees and asylum seekers in Norfolk. Their initiatives aim to address gaps in services and barriers to integration for refugees and asylum seekers. However, funding is often a limiting factor.

Challenges and barriers in health care delivery for refugees and asylum seekers include:

- Communication
- Continuity of care
- Confidence
- Cost of travel
- Lack of familiarity with the UK health care system

Good practice interventions which promote effective system responses to health challenges faced by refugees and asylum seekers would include addressing the wider determinants of health such as housing, education, employment, and health care.

Which population is this briefing about?

This briefing considers the health needs of refugees and asylum seekers.

A refugee is a person who is residing in a country outside of their country of origin due to threat of serious harm, conflict, violence, persecution and/or other human rights violations. Their claim for asylum has been approved and they have been granted protection and certain permissions in the country they have fled to (1, 2).

An asylum seeker is a person who has left his or her country of origin and formally applied for asylum in another country but whose claim has not yet been concluded (3). Applying for asylum is a right under international law, and anyone can apply for asylum in any country which has agreed to the 1951 Refugee Convention.

Refugees may also come to the UK through resettlement schemes such as the Vulnerable Persons Resettlement Scheme (VPRS), the UK Resettlement Scheme (UKRS) and Afghan Citizens Resettlement Scheme (ACRS). Schemes such as these allow local authorities to identify refugees and be better prepared for their arrival.

Following the invasion of Ukraine by Russia in February 2022, a total of 88,950 Ukrainian refugees have been granted permission to stay in the UK as of 30 June 2022 (4). Ukrainians seeking refuge in the UK have a broader range of routes into the UK and residence options available to them in comparison to asylum seekers from other parts of the world. Once in the

country, Ukrainian refugees can work and access benefits and public services, such as schooling and healthcare (5). Due to the differences in process and support accessible to them, Ukrainians refugees are not included in this assessment.

What is the focus of this briefing?

This document aims to provide relevant information regarding the health needs of refugees and asylum seekers in Norfolk, the services and resources available to this cohort, and the existing gaps and barriers to access. It has been developed by drawing on local and national sources of data and statistics. A literature search was undertaken to review the main health needs of refugees and asylum seekers, the services available to them, and the barriers they face. Interviews with key stakeholders were conducted to understand the local picture in Norfolk.

Challenges and risks facing asylum seekers

Finances and housing

In the UK, a person's asylum claim is determined by the Home Office or appeal courts. This process may take up to six months or longer (6). Once in the UK, asylum seekers are asked if they have relatives or friends they could stay with. If they have no family or friends in the UK then the Home Office provides accommodation. These are identified as destitute asylum seekers in Section 95(3) of the 1999 Immigration Act (7). Asylum seekers are not usually allowed to work while their claim is being considered, and destitute asylum seekers can be dispersed to anywhere in the UK (8).

The Immigration and Asylum Act 1999 sets out the housing and financial support that asylum seekers are eligible to receive from the Home Office if they do not have accommodation and/or cannot afford to meet their essential living needs (9-12).

The table below shows entitlements for asylum seekers as part of state provision in March 2023. The Government publishes the latest updates to the support available here: Government's asylum support webpage.

Figure 1: Entitlements for Asylum seekers

Housing	Health services
Dispersal accommodation - **£45 pppw** Contingency accommodation - **£9.10 pppw** Children under 1 year – **additional £5 pppw** Children 1-3 years – **additional £3 pppw** Baby due in ≤8 weeks or baby <6 weeks old – **one off £300 payment**	Free primary and secondary care Free prescriptions Free dental care Free eye tests, glasses subsidised
	Education
	Free schooling 5–17-year-olds Eligible for free school meals

Once an asylum claim is successful, refugees receive a further 28 days of asylum support, during which they need to make their own housing and financial arrangements. People granted refugee status are given permission to work. New refugees are at considerable risk of homelessness due to delays to receiving mainstream benefits. Refugees can also have

difficulty getting back to work due to lack of UK work experience and deskilling in the case of professions such as dentists and doctors (13).

People granted refugee status are usually given five years leave to remain in the UK, after which they may apply to settle in the UK (14).

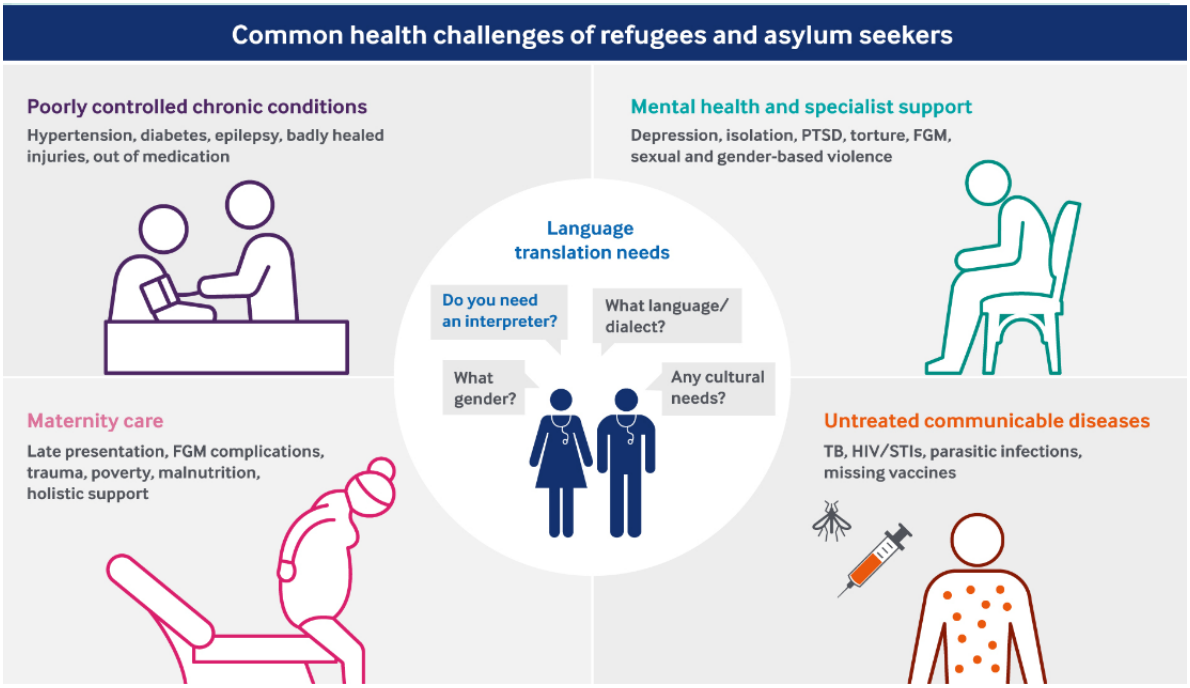
Exploitation

A joint report by UNHCR and The British Red Cross in 2022, has identified the risk of exploitation to asylum seekers. According to the report, risks of exploitation arise at key transition points in the asylum support system, including before entering the asylum support system, during dispersal and when exiting asylum support. The period immediately prior to entering the asylum support can be a particular risk point due to lack of information and support, and destitution experienced when attempting to access support (15).

Health needs

Refugees and asylum seekers are a varied group with diverse backgrounds. Conditions experienced in their country of origin, experiences during their transportation, and experiences after arriving in the host country impact the health needs of refugees and asylum seekers (16). These events make refugees and asylum seekers more vulnerable to the challenges shown in the chart below (13, 16, 17).

Figure 2: Common health challenges of refugees and asylum seekers (13).



Infectious diseases

There is an increased risk of infectious diseases for asylum seekers and refugees. Several factors make asylum seekers more vulnerable and susceptible to infectious diseases and outbreaks, including:

- Poor immunisation coverage in the country of origin

- Poor travelling conditions
- Living in proximity and poor conditions while in temporary accommodation in the UK

Studies have tried to estimate risk of infectious diseases associated with movement of people. The highest infectious disease prevalence in refugee and asylum seeker populations have been reported for latent tuberculosis (9–45%), active tuberculosis (up to 11%), and hepatitis B (up to 12%). We have included estimates from a range of studies. There have been recent case reports from the UK and other European countries of communicable diseases spreading in the asylum seekers dispersal units, including acute respiratory tract infections, louse-borne relapsing fever, diphtheria, scabies, measles, meningococcal meningitis, shigellosis, typhoid fever, hepatitis A, and malaria (18, 19).

There is no evidence that suggests this might increase the risk of infectious disease in the host population in Europe (20).

Non-communicable diseases

Refugees and asylum seekers living in high income countries, including the UK, have an increased risk of developing non-communicable diseases due to malnutrition at various stages over their life course (21, 22). The worldwide rise in chronic conditions suggests that refugees are increasingly affected by these conditions. Research suggests the most prevalent chronic conditions in refugees and asylum seekers are hypertension, diabetes, cardiovascular diseases, and obesity/overweight (23, 24, 13).

Challenges around chronic health conditions are related to poor nutrition. This may be before or after arriving in the UK due to the following reasons:

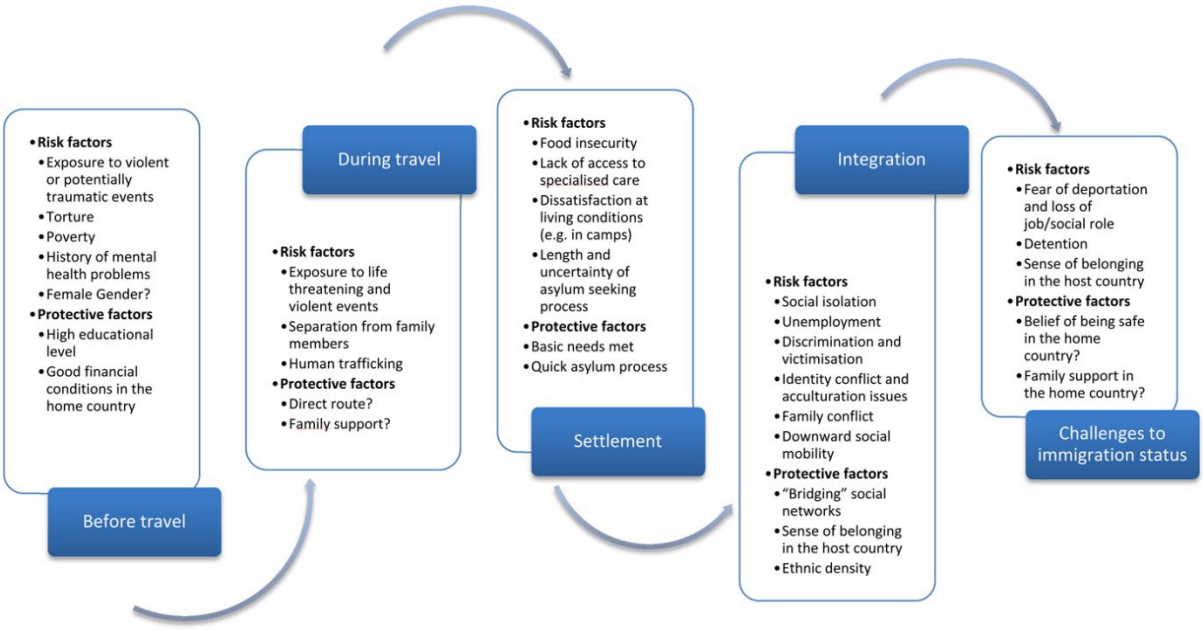
- Conflicting priorities and living in insecure and poor-quality housing, often with unsuitable or no kitchen facilities (21).
- Poor adherence to long term treatment due to poor health literacy and/or lack of medication (25).
- Lack of screening for chronic conditions (25).
- Low rate of follow ups or continuity of care (25).

Migrating to a high-income host country, such as the UK, is likely to increase the risk of overweight, obesity and/or micronutrient deficiency in refugees and asylum seekers. This may be due to an increase of food intake and an environment which may discourage physical activity and healthy diets while promoting sedentary activities and consumption of unhealthy foods and beverages (26, 22).

Mental health

Asylum seekers and refugees face unique and complex challenges related to their mental health because of the difficult experiences and conditions faced before, during and after transit, as shown in the chart below.

Figure 3: Critical points in time for the mental health of asylum seekers and refugees and the risk and protective factors at play (27).



The World Health Organisation (WHO) has identified the following risk factors contributing to mental health conditions (28):

- Unemployment
- Poor socioeconomic conditions
- Lack of social integration
- Separation from family
- Difficulties with asylum procedures
- Poor accommodation
- Discrimination
- Racism

The prevalence of common mental disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) tends to be higher among refugees and asylum seekers than among host populations (28). Research suggests that asylum seekers are five times more likely to have mental health needs than the host population, and more than 61% will experience serious mental distress (29).

Refugees and asylum seekers may lack access to mental health services or encounter barriers in accessing services. They may also experience disruptions in continuity of care (30).

Expected burden of disease in refugees and asylum seekers in Norfolk

There is limited data on the health issues faced by refugees and asylum seekers in Norfolk. Based on literature review and the main diseases and risk factors from the countries of origin, we would not expect Norfolk to be significantly different from the health needs identified in the national research shown above.

Health care systems and health by country of origin

In Norfolk, the main countries of origin for asylum seekers receiving support as of October 2022 are Afghanistan, Albania, Eritrea, Iran, Iraq, Pakistan, Sudan, Syria, and Turkey. The health care systems and notable health issues in these countries are summarised below.

Afghanistan

Afghanistan has been subject to war and civil unrest for several decades which has had a significant impact on its healthcare system and services. Prior to the Islamic Emirate of Afghanistan taking control of the country in 2021, the Afghan healthcare system had been largely supported by international aid since 2002. Around 80% of health services are provided by NGOs and the remainder by the Ministry of Public Health. The recent Sehatmandi 3-year programme (2018-2021) implemented by the ministry of Public Health and coordinated through the Afghanistan Reconstruction Trust Fund (ARTF), was providing health services across Afghanistan by contracting out services to various non-governmental organisations. Service providers were funded on a ‘pay-for-performance’ basis where NGOs were paid based on predefined health targets. Under these programmes, health outcomes including new-born and under-5 mortality rate and immunisation coverage were improving (31, 32). However, Afghans still face many barriers to accessing healthcare including distance to travel to healthcare facilities and paying for health services and medications (33, 34).

Since the Islamic Emirate of Afghanistan took control of the country in August 2021, funding from various development agencies and international sources were stopped which impacted the health sector greatly with major disruption to service provision and workforce loss (35, 33). The strain of this on the country’s infrastructure and health care system has had many consequences including increased poverty, malnutrition, and outbreaks of communicable diseases such as measles and polio (36-38). Leading causes of death in Afghanistan in 2019 included ischaemic heart disease, neonatal death, violence, stroke and respiratory infection and TB (39).

Albania

Healthcare in Albania is organised by primary, secondary and tertiary health care services. It is funded through statutory insurance as well as taxation. All citizens are entitled to equal access to healthcare. Healthcare provision varies between urban and rural areas, with urban areas having access to specialist outpatient clinic care which can be a first point of contact for patients. Health services in rural areas are generally provided by primary health care doctors. Access to healthcare is mostly free, with the use of private healthcare increasing. Pharmaceutical and dental services are largely private (40).

The Ministry of Health and Social Protection is moving towards universal health coverage with a ‘people-centred approach’, having an initial focus on primary health care after

pledging this in 2013. In 2015, a national preventative check-up programme, free to all including uninsured people, was implemented to improve health relating to noncommunicable diseases and associated risks. Since this, screening and preventative services uptake has increased and attitudes of the public to primary health care has improved (41).

Albania has the fewest number of healthcare professionals per capita in Europe and one of the lowest doctor-patient ratios in the world as many healthcare professionals are migrating to work in other countries. The strain of this was particularly evident during the COVID-19 pandemic when health care services struggled to meet demand (42).

The leading causes of death in Albania include cardiovascular disease, dementia, chronic lung diseases and cancer (39).

Iran

Following the 1979 revolution, the Iranian health system has been redeveloped. The government spends 17.5% of its total expenditure on health. The healthcare system comprises of public and private health services as well as service provision from NGOs. Iran's Health Transformation Plan which started in 2014 is part of the government's commitment to work towards universal health coverage and provision of insurance to all citizens. There are four types of health insurance in Iran and more than 90% of the population are covered by at least one. The most common in the Social Security Organisation which provides coverage for people working in the formal sector providing services for free or at very low cost. Government workers, students and people living in rural areas are covered by the Medical Service Insurance organisation (43).

Around 60% of hospitals are public and the Health Transformation Plan has increased population access to emergency care and specialist services. Maximum inpatient service fees for public hospitals are 6% (44). Privatisation of healthcare is increasing in Iran with private healthcare now delivering more than 70% of outpatient services and comprising of 17% of hospitals in Iran. Most private hospitals are in urban areas with access favouring those who are wealthier. Increasing privatisation has resulted in huge rises in healthcare expenditure, with patients who have cancer or undergo dialysis experiencing the highest rates (45).

There has also been a focus on improving primary care and access to health services in rural and urban areas through the development of health houses and health centres (44). These are the first point of contact for people living in these areas with basic health services provided by local community members known as *Behvarz* in health houses and physicians, nurse aides and health technicians in health centres and patients can be referred from here to more specialist services. Beharvz are normally local community members with primary or secondary education who have received some training for this community role. Services provided by health houses include family planning, maternal and child health care, oral health care, occupational health and health education (46, 47).

The leading causes of death in Iran are noncommunicable diseases including cardiovascular disease, diabetes, kidney disease and chronic lung diseases (39).

Iraq

The Iraqi healthcare system has been greatly impacted by decades of conflict, lack of funding and economic sanctions. Many health services lack medication and basic medical supplies and are unable to meet the needs of the population. Furthermore, the number of health professionals is very low. Around 20,000 doctors having fled the country since 1990.

Public sector health services in Iran are provided through the primary health care centre (PHCC) network and public hospital at low cost. Patients can access preventative and basic services from the PHCCs which are important sources of health services particularly for the poor. Patients can be referred to secondary and tertiary centres from PHCCs, however, many Iraqis are not able to access these referral services due to uneven distribution of hospitals. Patients can also access health services from private sector hospitals, but they must make out-of-pocket payments as there is no formal health insurance system in Iraq (48).

Around 55% of deaths in Iraq are due to noncommunicable diseases including cancer, cardiovascular conditions, diabetes, and chronic respiratory diseases. Over 30% of the population have hypertension, 14% diabetes and over 30% of the population are obese (49). Mental health conditions such as depression and anxiety due to psychological trauma are also increasing in the Iraqi population (48).

Syria

The health system and population health outcomes in Syria have been disrupted by ongoing conflict since 2011. Many healthcare facilities have been under attack with 60% of public hospitals destroyed by 2013. Large numbers of the population have been displaced and many healthcare professionals have fled the country. Consequently, humanitarian aid has increased and became the sole hospital care provider in non-state-controlled areas and many face barriers to accessing health services (50).

Prior to 2011, primary healthcare was organised by the Ministry of Health in three tiers in provinces, districts and villages based on population in that area. Healthcare provision ranged from basic maternal and child health services at tier one in villages up to specialised hospital and polyclinic services at tier three in major towns. Healthcare services were provided by both public and private sectors. Public hospitals were largely free of charge with some hospitals charging for services at low cost in comparison to private hospitals.

The most common causes of illness among the Syrian population include nutritional deficiency especially in children; non-communicable diseases including arthritis, diabetes, chronic respiratory and cardiovascular disease; and epidemic prone diseases such as polio, viral hepatitis, TB, and schistosomiasis. This has been exacerbated by the mass displacement of Syrians during the ongoing conflict, which results in reduced access to safe water, sanitation, and hygiene services. Women are also particularly at risk of sexual and gender-based violence, issues surrounding pregnancy such as preterm birth, unintended pregnancies, and increased morbidity. Syrian refugees may also experience higher levels of post-traumatic stress disorder (PTSD) (51).

Health needs and screening of refugees in Norfolk and Waveney by country

Refugees and asylum seekers in Norfolk and Waveney are screened for non-communicable and communicable health conditions which have high prevalence in their country of origin.

They are offered the same up to date immunisations which are offered to the general UK population, as screening and immunisation may differ in their country of origin. Below is a summary of screening, immunisation, and nutritional considerations for each country of origin, as specified by UKHSA to be used by healthcare staff when screening and/or treating refugees and asylum seekers (52).

Communicable diseases

Figure 4. Screening and immunisation considerations by country

Country	Tuberculosis	Hepatitis B	Hepatitis C	Typhoid	Polio	Malaria
Afghanistan	High incidence Routine screening	Intermediate prevalence Offer screening to pregnant women and new arrivals	Higher prevalence than UK Consider screening	High risk of infection	Endemic Provide vaccination as appropriate	Some risk Consider diagnosis
Albania	Low incidence Routine screening not required	Intermediate prevalence Offer screening to pregnant women and new arrivals	Higher prevalence than UK Consider screening	Some risk Consider enteric fever diagnosis	No perceived current risk	No perceived current risk
Eritrea	High incidence Routine screening	Intermediate prevalence Consider screening	Higher prevalence than UK Consider screening	Some risk Consider enteric fever diagnosis	No perceived current risk	High risk Consider diagnosis
Iran	Low incidence Routine screening not required	Low prevalence Offer screening to pregnant women and new arrivals	No perceived current risk	Some risk Consider enteric fever diagnosis	No perceived current risk	Some risk Consider diagnosis
Iraq	High incidence Routine screening	Low prevalence Offer screening to pregnant women and new arrivals	No perceived current risk	Some risk Consider enteric fever diagnosis	No perceived current risk	Low risk
Pakistan	High incidence Routine screening	Intermediate prevalence Offer screening to	Higher prevalence than UK	High risk Consider enteric	Endemic Offer immunisation	Some risk Consider diagnosis

		pregnant women and new arrivals	Consider screening	fever diagnosis	as appropriate	
Sudan	High incidence Routine screening	High prevalence Offer screening to pregnant women and new arrivals	Higher prevalence than UK Consider screening	Some risk Consider enteric fever diagnosis	No perceived current risk	High risk Consider diagnosis
Syria	Low incidence Routine screening not required	Intermediate prevalence Offer screening to pregnant women and new arrivals	Data not available	No perceived current risk	Some risk Offer immunisation as appropriate	Low risk
Turkey	Low incidence Routine screening not required	Intermediate prevalence Offer screening to pregnant women and new arrivals	Higher prevalence than UK Consider screening	Some risk Consider enteric fever diagnosis	No perceived current risk	Low risk

Nutrition

Figure 5. Nutrition and metabolic concerns				
Country	Anaemia	Vitamin D	Vitamin A	Iodine
Afghanistan	Moderate risk in adults High risk in pre-school children	Risk of vitamin D deficiency	High risk of vitamin A deficiency	No perceived current risk
Albania	Moderate risk in adults and pre-school children	Risk of vitamin D deficiency	Risk of vitamin A deficiency	No perceived current risk
Eritrea	Moderate risk in adults High risk in pre-school children	Risk of vitamin D deficiency	High risk of vitamin A deficiency	No perceived current risk
Iran	No perceived current risk	Risk of vitamin D deficiency	No perceived current risk	No perceived current risk
Iraq	Moderate risk in adults and pre-school children	Risk of vitamin D deficiency	High risk of vitamin A deficiency	No perceived current risk
Pakistan	Moderate risk	Risk of vitamin D deficiency	Risk of vitamin A deficiency	Risk of severe iodine deficiency
Sudan	Moderate risk in adults High risk in pre-school children	Risk of vitamin D deficiency	High risk of vitamin A deficiency	Risk of mild iodine deficiency

Syria	Moderate risk in adults and pre-school children	Risk of vitamin D deficiency	High risk of vitamin A deficiency	No perceived current risk
Turkey	Moderate risk in adults and pre-school children	Risk of vitamin D deficiency	High risk of vitamin A deficiency	Risk of moderate iodine deficiency

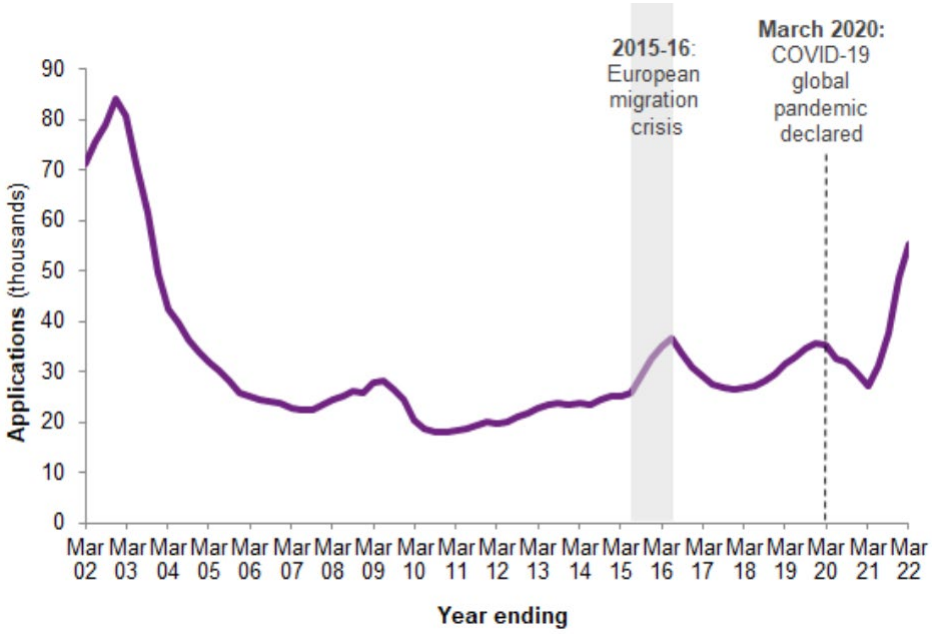
HIV and sexual health

The Office for Health Improvement and Disparities (OHID) recommends screening for HIV and sexually transmitted infections to be offered according to current UK national guidelines. Afghanistan, Albania, Eritrea, Iran, Iraq, Pakistan, Syria, and Turkey all have low rates of HIV (≤1%). Therefore, OHID recommends asylum seekers from these countries should be offered HIV testing only if they fall under a HIV high risk group or are registering in an area of high prevalence (52). A full sexual health screen and safe sex health promotion advice is recommended to be offered to all sexually active individuals from Sudan because of the high rate of HIV (53).

Scale of the issue

A total of 552,525 applications relating to 63,032 individuals (main applicants and dependents) were made in the year ending September 2022 in the UK (54). This was 56% more than in the year ending March 2020 and the highest number for almost two decades (55).

Figure 6: Asylum applications lodged in the UK, years ending March 2002 to March 2022 (55).



Iran was the top nationality claiming asylum in the UK in the year ending March 2022 (10,289 applications) and has been every year since 2016.

Local data

Data from the current nationally commissioned accommodation provider for asylum seekers SERCO shows that there are around 670 asylum seekers staying in contingency hotels and dispersal accommodation in Norfolk as of October 2022.

Asylum seekers in contingency hotels

In 2022 four contingency hotels for asylum seekers opened in Norfolk which host around 530 asylum seekers. Three of the hotels are in Norwich and one in Great Yarmouth. One contingency hotel in Norwich houses children and families (around 14% of asylum seekers) whereas the remaining three hotels house single males (around 86% of asylum seekers). The accommodation is full board, providing meals and other household essentials.

Figure 7: Percentage of males and females in contingency hotels (56).

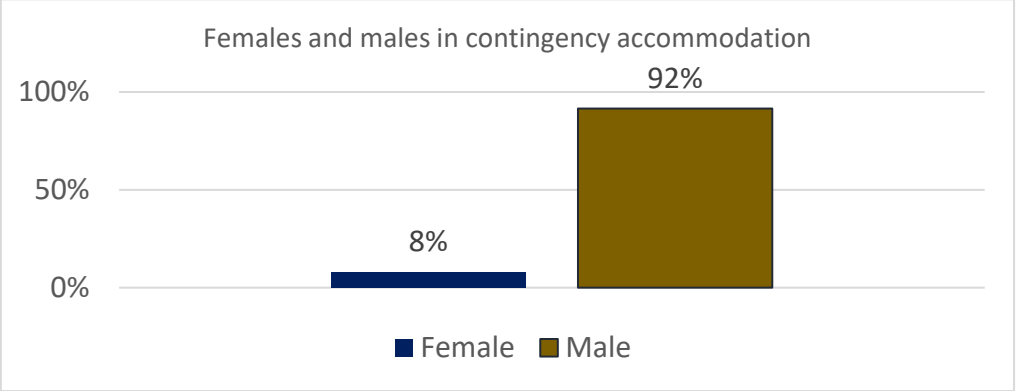
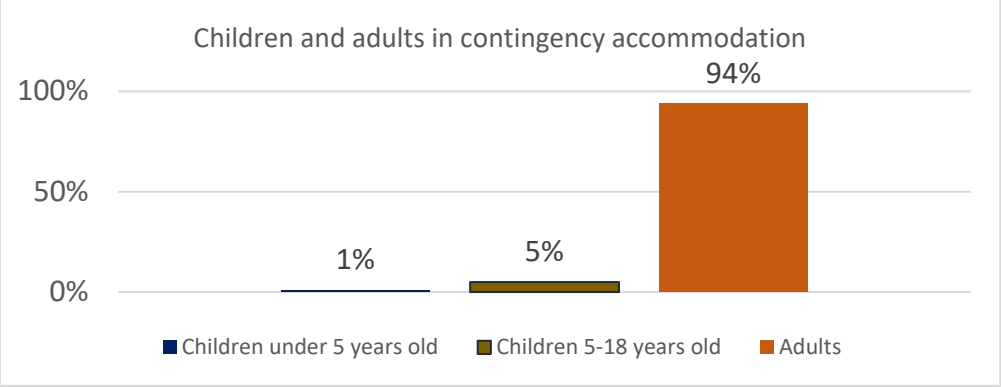


Figure 8: Percentage of adults and children in contingency accommodation



Asylum seekers in dispersal accommodation

There are around 140 people housed in asylum dispersal accommodation in Norfolk, which typically may comprise of houses, flats, or individual rooms in houses of multiple occupation (HMO). The dispersal accommodation is currently located in Norwich City Council's local authority area, plus one property in Broadland. Asylum seekers in dispersal accommodation receive a weekly allowance and are responsible for their own meals and living costs.

Under the Home Office Asylum Dispersal Scheme published in May 2022, local authorities receive a grant of £250 per asylum seeker in Home Office supported asylum seeker accommodation. Consequently, the number of dispersal accommodation spaces is likely to increase, alongside a decrease in the numbers housed in contingency accommodation (57). This policy is likely to see dispersal accommodation offered more broadly across the seven district councils in Norfolk.

Existing services

Refugees and asylum seekers in Norfolk receive support from statutory and voluntary and community services. Asylum seeker statutory support is not as intensive as statutory support for refugees; therefore, asylum seekers may need to rely more on the voluntary and community sector.

Local authorities

Asylum seekers and refugees arriving in Norfolk are settled by the People From Abroad Team (PFAT) at Norfolk County Council. This is a specialist team that supports a wide range of migrants.

Figure 9: Norfolk People from Abroad Team

Core Team	Allied team
• Service manager, team manager • Social workers with Practice Consultant Social Worker • Two specialist nurses, paramedic • Development workers, Employment skills adviser • Creche manager • Business support staff, logistics and warehouse coordinator	• Health visitor • EAL specialist teacher • ESOL lead • Housing officer

An initial general health screening of refugees and asylum seekers is led by specialist nurses and a specialist paramedic practitioner. The screening considers the person's physical and psychosocial needs. The health team is linked to all practices in Norwich and central Norfolk and supports onward referral pathways such as maternity, mental health, safeguarding and children services. A welcome pack detailing useful contacts and information about accessing health services is provided.

The PFAT helps asylum seekers and refugees to register with GP practices in Norwich and they support GP practices with complex case management. The team's health funded developmental worker also supports a local surgery in Great Yarmouth, which is linked to the contingency hotel in Great Yarmouth. Training is provided for local GP practice to help staff recognise and manage barriers to healthcare for refugees and asylum seekers, for example with the use of interpreting services and longer appointments where appropriate.

Other support arranged or delivered by the PFAT team includes:

- **Resettlement Schemes:** Since 2017, over 200 people have been settled via the UK resettlement scheme (UKRS), formerly the Syrian Vulnerable Persons Resettlement Scheme (58). Over 100 people have been settled from the Afghan Resettlement

Scheme since July 2021 (58). Norfolk PFAT work with volunteers, the Job Centre, Adult Learning, schools, and health workers to provide a 12-month intensive support programme.

- **English for Speakers of Other Languages (ESOL) programme:** The programme delivers 16 hours of ESOL classes per week in partnership with Norfolk County Council Adult Learning. Refugees are eligible to attend fully funded ESOL classes for 37 weeks. Volunteers run a creche facility for attendees and provide further informal support with language development.

- **Befriending programme:** The programme consists of over 100 volunteers who support with
    - ESOL classroom support and creche facility
    - Allocated family support for integration
    - Social activities and events
    - House preparation and practical tasks

- **Asylum Migration Integration Fund (AMIF) Employment Support programme:** The programme is funded by the EU to provide employment support until March 2024. An employment skills advisor provides one-to-one assessments and group support.

- **Repatriation support**

- **Safeguarding for vulnerable people**: For victims of human trafficking and modern slavery.

Education

All current asylum seeker children settled in Norfolk are enrolled in schools. The Norfolk County Council learning and inclusion advisor works closely with the PFAT team to enrol children as well as help with school and education related barriers such as accessing school uniform.

Housing

Under the Asylum Accommodation and Support Services Contracts (AASC), SERCO is commissioned by the Home Office to arrange provision of accommodation, transportation and subsistence payments for asylum seekers while their claims are being processed. There are no formal arrangements for providing accommodation to adult asylum seekers and families outside of the Home Office provision under AASC.

Children's Services at Norfolk County Council are responsible for Unaccompanied Asylum Seeking Children under Section 20 of the Children Act 1989 (59).

The PFAT staff support refugees with housing preparation and concerns. They help furnish houses and stock fridges for refugees in partnership with Mother's Union Norwich.

Norfolk and Waveney Integrated Care System (ICS)

Governance

The Asylum and Migration Strategic Board within the Norfolk and Waveney ICS provides governance, oversight, and strategic direction for the implementation of the asylum seeker full dispersal policy and use of contingency hotels in Norfolk. It is comprised of senior officers with overall responsibly for the delivery of programme workstreams, allocation and direction of resources, risk management and as the final escalation point for programme issues. The board has oversight of the Asylum Seeker Operational Group which is chaired by the senior manager for Inclusion Health and Asylum Seekers based at the Integrated Care Board (ICB).

Improving access to primary care

Since April 2022, Norfolk ICB have provided funding for GP practices to help improve access to primary care for refugees and asylum seekers. GP practices are funded to provide support for each registration and health assessment.

The ICB has an **inclusion health locally commissioned service** (LCS) for primary care under which asylum seekers are supported. The LCS provides three elements that aim to deliver inclusion, health assessment and outreach as follows:

1. Inclusion friendly
    - Training to ensure all practice staff members are inclusive to their patients.
    - Designation of an inclusion health reception champion to reinforce the need for reasonable adjustments, as well as ensuring no registration is turned down due to no ID or proof of address.
    - Access to resources and training recommendations for staff.
    - Support to register the practice as a safe surgery with Doctors of the World.
    - Pilot scheme allowing cards to be given to refugees and asylums seekers detailing how to access health services.

2. Inclusion health assessments
    - Undertaken for each registered asylum seeker, including physical health measurements/medical history, drug and alcohol usage, mental health, immunisations, blood screening as well as other screenings, to identify the patient's health needs.
    - Assessment is in addition to the initial health and social assessment and triage screening performed by the PFAT on arrival which does not include immunisation or blood screening.

3. Outreach provision
    - Practices provide outreach clinics to their local patient cohort.
    - Enables patients who are not accessing general practice to be able to receive primary medical services.

City of Sanctuary Scheme

Norwich is a city of sanctuary which commits organisations to building a culture of welcome for refugees and asylum seekers. Several organisations such as the local Theatre Royal,

local schools and Libraries have signed up and been awarded the status of places of sanctuary.

The University of East Anglia (UEA) has University of Sanctuary accreditation identifying them as a welcoming university for people seeking sanctuary including refugees and asylum seekers. They offer two scholarship types for asylum seekers and refugees who do not qualify for support from Student Finance England.

Voluntary sector, community and social enterprise (VCSE) support

Voluntary sector organisations provide support to refugees and asylum seekers in Norfolk. Many of these organisations meet regularly in a monthly multiagency meeting to help support each other's work and refer service users to each other as necessary. Initiatives aim to address barriers to integration for refugees and asylum seekers. However, funding is often a limiting factor.

Integration into community life:

- New Routes Integration provides opportunities for people to develop skills and deliver social activities including children's and young people's events, cooking workshops, sports and exercise activities, homework clubs and English language support.
- The Bridge Plus+ offers support to Black and minority ethnic (BME) people in Norfolk to promote race equality and community cohesion. They facilitate community engagement events as well as provide advice on welfare benefits and housing with a targeted approach for more vulnerable service users.
- In 2015 English+, New Routes and The Bridge Plus+ formed the Norwich Integration Partnership and began working more closely together to improve services providing advice and advocacy, opportunities for language development and more personalised support on a one-to-one basis where needed.

Understanding and accessing health services:

- New Routes Integration support asylum seekers to contact primary care, for example booking appointments and gaining familiarity with the UK health system.
- The Deep End East of England aim to improve education and training of healthcare professionals and signpost to resources regarding managing the health needs and barriers to health of vulnerable groups, including refugees and asylum seekers.
- Dentaid in conjunction with New Routes and English+ provided mobile dental care service in Norwich in October 2022 which allowed 20 people to receive non-emergency dental care. This service is intended to return to Norfolk in 2023 for a second session.

Mental health and wellbeing:

- St Barnabas Counselling Centre offers counselling services in Norfolk. They fund 20 spaces for 12 sessions offering trauma-informed psychotherapy and counselling for refugees and asylum seekers. Participation is through referral from a healthcare professional or support organisations.
- The Asylum Seekers and Refugees Clinic at the REST Hub offers assessments with sensitivity to cultural background, trauma, and complex cases monthly in Norwich.

The service is a single point of access referral-only from primary care and other services in Norfolk and Suffolk NHS Foundation Trust.

Language development:

- English+ run free group English classes from beginner to advanced level in person and online with trained English teachers.
- NILE (Norwich Institute for Language Education) offer free pre-intermediate (A2) and upper-intermediate (B2) English classes for adults online and in person as part of their Teaching English as a Foreign Language (TEFL) programme.

Support with school and education:

- The British Red Cross provide tailored support for young refugees and asylum seekers including English, maths and IT skills, community activities, and support with social and mental wellbeing.

Understanding the asylum claim process and accessing legal support:

- Migrant Help and Asylum Aid are national organisations which provide advice and legal support for the asylum process.
- The British Red Cross in Norwich helps people with understanding the asylum claim process, and their entitlements based on their status. They support service users with finding and contacting solicitors for asylum seekers to help asylum seekers to gain a better understanding of their claim.

Support with housing and finances:

- Asylum seekers may be supported with 12 weeks of cash support via a cash card, funded by independent donors through the British Red Cross. They help refugees and asylum seekers with settling into life in the UK by providing support with day-to-day life.

Contacting family and friends:

- The British Red Cross helps people to contact family and friends from their country of origin and in the UK through provision of phones, as well as their family tracing service and a family reunion service for refugees.

Transport:

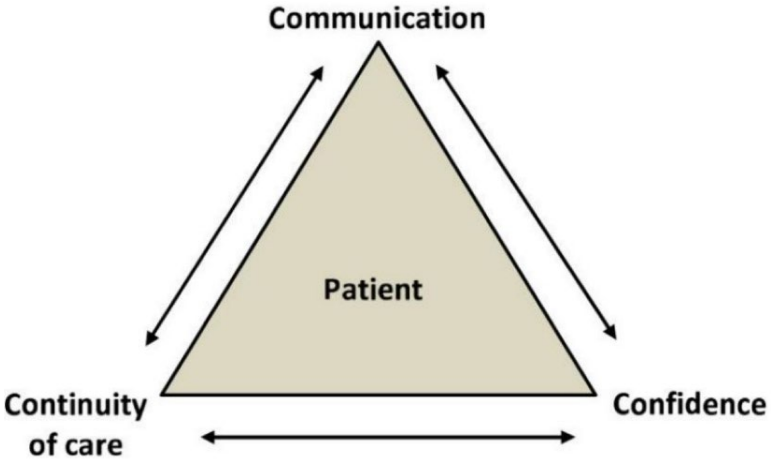
- Welcome Wheels campaign has allowed over 400 bike packages to be given to service users since 2019. This was a collaboration between New Routes, Norwich International Youth Project, English+ and Bicycle Links, funded through fundraising and support from The Bishop's Refugee Fund and the Social Enterprise Support Fund, and Norfolk County Council's Pushing Ahead programme.

Barriers and considerations

Three main challenges in health care delivery for refugees and asylum seekers include communication, continuity of care and confidence, known as the 3C model (60). The concept

of the three challenges provides a comprehensive, patient-centred summary of interrelated key challenges in health care delivery for this cohort. These challenges are reported for health care providers and patients alike.

Figure 10: Diagram of 3C model (60).



Communication

Language may act as a barrier to health care, potentially leading to misunderstanding.

Continuity of care

Influencing factors to continuity of care include:

a) Information and knowledge about the health care system of the host country.
b) Ease of access of health facilities.
c) Integration of medical appointments into the personal schedule of migrants and refugees.
d) Collaboration of different institutions, ensuring minimal loss of health care information.

Confidence

The challenge of confidence consists of two main parts: the development of trust in healthcare providers or healthcare institutions; and the ability to control a situation. The latter means patients' ability to be involved in health care decisions, understanding the information conveyed, and applying their own health beliefs and priorities for decision making. This is achieved when a patient feels self-sufficient and confident when booking an appointment or during appointments, and not having to rely on interpreters or other relatives.

The three categories of challenges are closely interrelated and influence each other. Communication is the first step allowing for confidence to build up. The confidence enhances the continuity of care. The quality of healthcare and the health status of the refugees and asylum seekers is affected negatively if one of the 3Cs is not effective or in place.

Other factors

Cost of travel is a significant barrier. There are currently no free or subsidised travel arrangements available for refugees or asylum seekers, so they must fund their travel from the small weekly allowance from the local authority, alongside other costs. Restricted travel reduces agency and can have a detrimental impact on mental health and wellbeing. It has the potential to worsen existing social isolation experienced due to language barriers. It may also make it difficult to attend appointments, local activities, or meet with others.

Primary and secondary care pathways in the UK rely heavily on appointments and referrals for non-emergency cases. This has sometimes left asylum seekers and refugees feeling that their health needs are not taken seriously as they are unable to access specialist services as easily as in their home country (61).

In addition, system barriers include:

- Cultural diversity and competency (62)
- A lack of targeted health policies or interventions for the cohort (63)
- Informal cooperation and coordination arrangements between stakeholders (64)
- Data collection and information sharing between providers (65, 66).

Health and healthcare systems by country of origin

A key barrier to accessing health care for asylum seekers and refugees is lack of familiarity with the UK healthcare system and adjusting to differences from the healthcare system in their country of origin. These differences are often not made clear to refugees and asylum seekers, and barriers are compounded by the language barrier and lack of understanding of refugee and asylum seeker status by healthcare professionals.

Information gaps

- There is a limited data available on the health needs of refugees and asylum seekers in Norfolk which makes it difficult to identify the level of need and the gaps in service provision.
- The scale of the issue and health needs of refugees and asylum seekers is a changing situation, determined by the multitude of external factors that influence asylum seeking.
- Patient, public and professional opinion on the services available is a gap.

Conclusions

- There has been an increase in the number of asylum seekers and refugees being accommodated both nationally and locally.
- Refugees and asylum seekers are a varied group with diverse backgrounds and life journeys. The health challenges they experience and barriers they face are wide-ranging and complex and require a whole system approach.
- There are considerable risks and challenges regarding the finances and housing of asylum seekers and refugees throughout the process of claiming asylum.
- Refugees and asylum seekers are a vulnerable group of society and are at risk of exploitation.

- Good practice interventions which promote effective system responses to health challenges faced by refugees and asylum seekers would include addressing the wider determinants of health such as housing, education, employment, and health care.

Glossary

Asylum dispersal: The policy of dispersal of those seeking asylum accommodation in the UK introduced by the Immigration and Asylum Act 1999. The legislative intention was that by distribution across the country no one area would be overburdened by the obligation of supporting asylum seekers (57).

Asylum seeker: Individuals who have entered the legal process of seeking international protection with their refugee status yet to be determined (3). Applying for asylum is a right under international law, and anyone can apply for asylum in any country which has agreed to the 1951 Refugee Convention. In the UK, under section 95 of the Immigration and Asylum Act 1999, the Home Office can provide housing and financial support to a person who has claimed asylum if they do not have accommodation and/or cannot afford to meet their essential living needs. This support will continue until the person's asylum claim is finally determined by the Home Office or appeal courts (9).

Contingency accommodation: Short term stop gap accommodation which may include hotels.

Dispersal accommodation: Primarily self-catering accommodation such as bed-sits, self-contained accommodation, maisonettes and rooms in houses of multiple occupation (HMOs), provided under Section 95 of the 1999 Immigration Act. Supported persons are provided with specific facilities as standard, such as cooking facilities, kitchen utensils, bathing facilities, linen, basic furniture and refuse disposal. If the household contains young children, additional specific equipment is provided as required, e.g., stair gate, cot and sterilising equipment (57).

Inclusion health: Inclusion health is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases) (67).

Refugee: Individuals residing in a country outside of their country of origin due to threat of serious harm, conflict, violence, persecution and/or other human rights violations. Their claim for asylum has been approved and they been granted protection and certain permissions in the country they have fled to (1, 2).

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