The Health Experiences of Asylum Seekers and Refugees in Wales




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Public Health Wales

“The experience that I have is killing me every day”

Quote from participant talking about seeking asylum in the UK

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Glossary

Asylum Seeker

A person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded.[i] An asylum seeker becomes a refugee on receiving leave to remain. There are various stages to the process of claiming asylum, which affect legal rights and entitlements.

Section 95 support

Asylum seekers are excluded from claiming mainstream welfare benefits and in most cases from working. Section 95 of the Immigration and Asylum Act 1999 gives the Home Office power to grant support to asylum seekers, and their dependents, whose claims are ongoing, or who are destitute or about to become destitute. Support is usually provided in the form of furnished accommodation (free rent and utilities), plus a weekly cash allowance of £37.75 to enable the persons to meet other "essential living needs". This cash allowance was increased from £36.95 in February 2018.

Section 98 support

Section 98 support is a form of temporary support that is provided to asylum seekers who appear to be destitute and who are awaiting a decision on their application for Section 95 asylum support. Section 98 support is supposed to be provided for a short period and includes accommodation and meeting "essential living needs".

Section 4 support

Section 4 of the Immigration and Asylum Act 1999 gives the Home Office power to grant support to some destitute asylum seekers whose asylum application and appeals have been rejected. To qualify for Section 4 support, refused asylum seekers must be destitute, or be likely to become destitute within the next 14 days (or 56 days if they are already receiving support); and satisfy one of the following five conditions:

- They are taking all reasonable steps to leave the UK or place themselves in a position in which they are able to leave the UK
- They are unable to leave the UK because of a physical impediment to travel or for some other medical reason
- They are unable to leave the UK because in the opinion of the Secretary of State there is no viable route of return
- They have applied for judicial review of the decision on their asylum claim and has been granted permission to proceed
- The provision of accommodation is necessary to avoid breaching their human rights

Those who receive the support are generally provided with accommodation and £35.39 loaded weekly onto a cashless payment card that can be used to buy food and other essential items where card payments are accepted.[ii]

i United Nations High Commissioner for refugees http://www.unhcr.org/uk/asylum-in-the-uk.html [Accessed 13 March 2019]
ii Asylum support, section 4(2): policy and process Version 1.0, Home Office, February 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/682495/asylum-support-section-4_2_-policy-and-process-v1.0ext.pdf

Refused asylum seeker

A person whose asylum application has been unsuccessful and who has no other claim for protection awaiting a decision. A refused asylum seeker may have the right to appeal the decision, or, if all appeal avenues have been followed unsuccessfully, may be 'appeal-rights exhausted'. At this stage, refused asylum seekers may have all financial support withdrawn and may have to leave their asylum accommodation.

Destitute refugees and asylum seekers

Destitute refugees and asylum seekers include anyone who has claimed asylum or is in the process of doing so, and is without any form of statutory support. This may occur at various stages of the asylum process, including though not limited to: through delays to Section 95 or Section 4 applications; withdrawal of support following a refusal; withdrawal of Section 95 or Section 4 support following a grant of leave to remain but before employment or mainstream benefits have been secured.

Community Sponsorship

The UK Government launched the Community Sponsorship Scheme in July 2016 to enable community groups, including charities, faith groups, churches and businesses to take on the role of supporting resettled refugees in the UK as 'sponsors'. Sponsors provide housing for the refugees, as well as helping them to integrate into life in the UK, access medical and social services, arranging English language tuition and supporting them towards employment and self-sufficiency. Groups must demonstrate evidence of available funding of at least £9,000 and meet a number of criteria to demonstrate their competence as a community sponsorship group. In Wales, there are currently a number of community sponsorship groups, including Croeso groups in Narbeth, Fishguard, Aberystwyth, Haverfordwest, Cardigan, Penarth and Bangor.

Family Reunion

After being granted leave to remain, refugees are entitled to apply for family reunion visas for their close family (partner and children under the age of 18). There is no fee for applying for eligible family members, but individuals do have to pay the cost of travel from country of origin to the UK.

HC2 certificate

An HC2 certificate holder qualifies for the following:

- free NHS prescriptions
- free NHS dental treatment
- free NHS sight tests
- help with the cost of glasses or contact lenses
- help with the cost of travelling to receive NHS treatment
- free NHS wigs and fabric supports

From 3rd April 2000, the National Asylum Support Service (NASS) on behalf of the Department of Health has been issuing NASS supported asylum seekers directly with HC2 certificates to obtain full help with health costs together with the first support voucher they receive.

Health Literacy

A person receiving healthcare should have the capacity and ability to obtain, process, and understand basic health information and how to access services needed to make appropriate health decisions and follow advice for treatment. Health providers have a duty to ensure health information is adequately communicated so that everyone who needs it can access and understand it.[iii]

Initial Health Assessment

The initial health assessment is not a mandatory requirement; however the Home Office commissions a service to provide a health and well-being assessment to all asylum seekers and relevant family members newly dispersed to initial accommodation in Cardiff. In Wales, an initial health assessment is also offered after dispersal from Cardiff to more permanent accommodation. During the assessment the team offer public health interventions such as Tuberculosis (TB) screening and review immunisations. In addition the team will request General Practitioner (GP) allocation close to where people reside. They also provide signposting and advice on how to access healthcare services, and local support services.

Person/People Seeking Sanctuary

Throughout this report the term 'person seeking sanctuary' or 'people seeking sanctuary' is used to describe all asylum seekers, people refused asylum and refugees where there is no significant difference between the different legal categorisations: some issues affect all people seeking sanctuary regardless of where they are on the asylum 'journey'. This term aims to re-centre the discussion surrounding asylum and refugees on the individuals and communities who are affected by these issues. For the purposes of this study we explored variations between refugees (including comparison of those on resettlement programmes, compared with others) and asylum seekers (including comparison between current asylum seekers (Section 95) and refused asylum seekers (including Section 4)). Where we found variation by immigration status, we report the results using the relevant terms describing legal immigration status.

Refugee

Internationally the term 'refugee' is used to describe 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 living outside the country of his nationality.[iv]

In the United Kingdom, a person is officially considered a refugee when they have their claim for asylum accepted by the UK Government.

Syrian Vulnerable Persons Resettlement Scheme (VPRS)

The Syrian Vulnerable Persons Resettlement Scheme is a programme of the UK Government, launched in 2014, that plans to resettle 20 000 Syrian refugees by 2020. The focus of the scheme is to bring people most at risk to the UK, providing sanctuary to, for example, people requiring urgent medical treatment, survivors of violence and torture, and women and children at risk. In July 2017, the decision was taken to expand the scope of the scheme to include other refugees who have fled the conflict in Syria but who do not have Syrian nationality.

Although the scheme is primarily run by the UK Government in conjunction with UNHCR to identify eligible refugees and bring them to the UK, local authorities, statutory and third sector partners play a vital role in helping those arriving here to settle into a new life in the UK through housing, education, health and employment support.[v]

iii Parker RM, Gazmararian JA. Health literacy: essential for health communication. Journal of health communication. 2003 Jun 1;8(S1):116-8.
iv Hathaway JC, Foster M. The law of refugee status. Cambridge University Press; 2014 Jul 3.
v Syrian Vulnerable Persons Resettlement Scheme (VPRS) Guidance for local authorities and partners, Home Office, July 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/631369/170711_Syrian_Resettlement_Updated_Fact_Sheet_final.pdf

Executive Summary

Background

Asylum seekers have been dispersed to Cardiff, Swansea, Newport and Wrexham from other parts of the UK since 2001. Although there was a decline in the number of people seeking sanctuary (including asylum seekers, those refused asylum, and refugees) in Wales from the early 2000s to 2012, the number has steadily increased since then. International conflict and human rights abuse has contributed to the rise throughout Europe. Following the war in Syria and the introduction of the UK Vulnerable Persons Resettlement Scheme (VPRS) in 2014, all 22 Welsh local authorities are now home to people seeking sanctuary. There are now over 800 Syrian and associated refugees in Wales.

Wales is working toward being the world's first *Nation of Sanctuary*, building on the UK-wide City of Sanctuary movement, which aims to create a hospitable environment for those in need of sanctuary. The Welsh Government recently published its *Nation of Sanctuary – Refugee and Asylum Seeker Plan*, which details a number of actions relating to health. These are further detailed by the recently published Policy Implementation Guidance on the Health and Well-being Provision for Refugees and Asylum Seekers. The ambition to make Wales a Nation of Sanctuary is in the context of the Well-being of Future Generations Act, which aims to improve the social, economic, environmental and cultural well-being of Wales. The Well-being of Future Generations Act furthermore provides the legislative framework for a rights-based approach to health.

There has been concern that some of those seeking sanctuary have unmet health needs and experience difficulty in accessing services, but there is little evidence other than anecdotal. There has also been concern that possible stigma of disclosing mental and physical health problems, and fear of adverse effects on their immigration status, can deter individuals from accessing care. In 2017, the National Assembly for Wales' Equality, Local Government and Communities Committee Inquiry produced the report *I used to be someone: Refugees and Asylum Seekers in Wales*. The inquiry found that refugees' and asylum seekers' experience of service provision across Wales generally lacked consistency. However, there has been little progress or research to understand the effect health service experiences have on the health and well-being of adult asylum seekers and refugees in Wales. This study addresses these gaps to inform policy and practice with the view to realising Wales' ambition to become a *Nation of Sanctuary*, and supporting universal health coverage in line with the Well-being of Future Generations Act.

Aims

To investigate the health, well-being and healthcare experiences of adult asylum seekers and refugees in Wales, including the views and experiences of both healthcare recipients and providers.

To establish what helped or hindered the healthcare access and experiences of those seeking sanctuary.

Methods

We searched electronic databases to identify published evidence about factors influencing access to and use of health and related services by people seeking sanctuary in high income countries. We mapped findings against themes we identified in the literature.

We conducted a survey of 210 people seeking sanctuary to explore their experiences of accessing health services, including what helped or hindered obtaining care. We recruited a team of eight voluntary peer researchers from sanctuary seeking communities and trained them to administer the survey. They worked in small groups with support from team members. Respondents were recruited through third sector organisations, at multicultural events and through the peer researchers' own networks. We used IBM SPSS Statistics for Windows Version 25 to describe, analyse and present results.

We conducted eight focus groups across Wales with 57 people seeking sanctuary and those employed or volunteering to support those seeking sanctuary. Interpreters were present when needed. We asked about experiences of accessing and receiving care.

We also interviewed 32 health professionals and third sector support workers individually by telephone about their experiences of delivering care or supporting patients from this population. We digitally recorded and transcribed all interviews and focus groups. We used framework analysis to analyse transcripts according to our research aims.

Results

1. Evidence map

We identified five themes from our literature search which help or hinder people seeking sanctuary in accessing healthcare. These were: language and communication; cultural understanding and values; the presence or absence of trusting relationships; structural barriers, such as out of pocket expenses; and knowledge of the health system.

2. Cross-sectional Survey

Of the 210 total respondents, different numbers replied to different questions. For example, only 90% (190) reported their asylum status; these comprised 47% (90) asylum seekers, 47% (89) refugees and 6% (11) refused asylum. Of 201 respondents who reported whether they had received an initial health assessment on arriving in Wales, 79% (159) had attended. Reassuringly, 94% (182 out of 193 respondents) reported that they were currently registered with a GP; however, only 36% (64 of 178) found it easy or very easy to make an appointment. Awareness of other services was mixed. The best known was the 999 emergency service, with 77% (142 of 185) of respondents reporting that they could access it. Sixty-six per cent (132 of 199) of respondents

reported using healthcare services within working hours (8am – 6:30pm Monday to Friday), and 28% (54 of 194) reported using services out of hours. Barriers to access included: language and communication difficulties; cultural factors; and knowledge of, and ability to navigate, the systems of NHS Wales.

3. Focus groups

Asylum seekers and refugees said specialist health professionals and support workers helped them to access health services. Reported barriers included: feeling their needs were not recognised; language difficulties, including lack of interpreters; and out of pocket expenses, particularly for travelling to appointments, both for themselves and for those family members or friends who travelled with them to support and sometimes help interpret. Respondents generally understood GPs' roles in providing and coordinating care, and accepted that they themselves also had responsibility for maintaining their own health. They acknowledged the importance of mental health and expressed regret at the poor provision of mental healthcare. Some asserted that the stress of being an asylum seeker or refugee contributed to their poor physical and mental health.

4. Interviews

Specialist health professionals and support workers acknowledged that they potentially had resources and skills to help people seeking sanctuary, notably knowledge, time and flexibility. In comparison, mainstream health professionals reported that they lacked adequate resources to deliver healthcare effectively to these groups, notably staff time, specific knowledge relating to people seeking sanctuary (available healthcare in person's country of origin for example) and information resources in appropriate languages. They recognised that such patients sometimes needed repeated contacts to receive appropriate healthcare. Providers suggested that pressures on the healthcare system in general and the lack of appropriate tailored services to meet the needs of people seeking sanctuary combined with their isolated social conditions, contribute to poor mental and physical health outcomes. Further, that lack of understanding of the NHS by people seeking sanctuary may lead to inefficient use of services.

Discussion

This is a rare study that reports the experiences of people seeking sanctuary of health and healthcare services from multiple perspectives, and is the largest exploring this topic in Wales. It describes the health experiences of people seeking sanctuary living in Wales, including both barriers and enablers to accessing healthcare services. Although health is a devolved matter, many of this study's findings will have relevance to other countries within the UK, particularly where they arise from the nature of seeking sanctuary or from UK-wide asylum policy rather than country-specific health policy.

Our discussion covers five overlapping themes:

1. **Beliefs of people seeking sanctuary about what helps and hinders them to access services;**
2. **Views of people seeking sanctuary of the role of primary and secondary care health services in improving their health and well-being;**
3. **Primary care professionals' views on facilitating access to, and use of, health services by people seeking sanctuary**
4. **Level of awareness amongst health professionals of the care needs of people seeking sanctuary**
5. **The impact of social determinants of health**

Beliefs of people seeking sanctuary about what helps and hinders them to access services

The value of specialist health and support services was clear throughout the study, both in helping people navigate new systems and building trust that is essential to access to services. The study provides evidence of challenges for people seeking sanctuary in making appointments and barriers created by out of pocket expenses. The most common challenge that people seeking sanctuary identified was language and communication. We found that interpretation services are essential in NHS services, but are not currently universally available. NHS staff would benefit from training and clear procedures on how to use interpretation services. Individuals, who felt they had to take friends or family members with them to appointments to interpret, had to bear the relatively high cost of transport when managing on an allowance of £37.75 a week per person. Refugees on resettlement programmes were more likely to report lack of English as a barrier to accessing health services, perhaps owing to having spent less time in the UK than other groups of people seeking sanctuary. These issues highlight the importance of access both to English for Speakers of Other Languages (ESOL) classes, and information about services in relevant languages soon after arrival, as well as provision of interpreting services.

Views of people seeking sanctuary of the role of primary and secondary care health services in improving their health and well-being

Although the findings of this study portray informed, responsible use of NHS primary care services within daytime hours, there is also evidence of a significant lack of awareness about services out of hours, particularly pharmacy and primary care. This is aggravated by variable awareness of the entitlements provided by the HC2 certificate. As a result, the majority of respondents used primary care services in the daytime but did not know how to access care out of hours. There was also lack of awareness of services like cancer screening or specialist clinics, such as drug and alcohol services.

Far fewer resettled refugees reported finding registration, and booking an appointment with a GP easy, compared with other respondents, namely other refugees and all asylum seekers. While this is an area that warrants further investigation, this is likely due to the differences in time spent in the UK. Resettled refugees had spent significantly less time than other refugees or Section 95 asylum seekers, who had in turn spent less time in the UK than other asylum seekers.

Primary care professionals' views on facilitating access to and use of health services by people seeking sanctuary

While mainstream services understand the need for person-centred care, we found that they often lack the resources or training to tailor the service to the needs of people seeking sanctuary. It is difficult to book longer appointments to allow time for interpretation, for example.

Mental health was a key concern raised throughout the study, linked to trauma experienced before or during the journey to the UK and to social exclusion experienced during the asylum process. Our findings point to the need for accessible foundation-level mental health promotion resources, to encourage self-help and mental well-being, and early access to adult primary mental health services or Child and Adolescent Mental Health Services (CAMHS) when needed to avoid escalation and greater need for resource later.

Level of awareness amongst health professionals of the care needs of people seeking sanctuary

We found a critical need for training to enable mainstream services to meet the needs of people seeking sanctuary better, and to empower more health professionals to contribute effectively to the health and well-being of this population. This training should cover health and healthcare issues associated with seeking sanctuary, but also include the legal and social circumstances of refugees and asylum seekers. In addition, it is essential that there are visible champions of the needs of people seeking sanctuary within the health sector, to advocate for them in planning processes.

The impact of social determinants of health

The adverse impact of seeking sanctuary in a new country subject to Home Office policies and procedures was clear throughout this study. Financial challenges came up in relation to transport and childcare, particularly for asylum seekers. People seeking sanctuary and health professionals both spoke of the detrimental effect of unexpected, short notice relocation of asylum seekers through the Home Office commissioned dispersal and accommodation, particularly for those with chronic conditions or during pregnancy. We found evidence that health outcomes and equity would improve if dispersal decisions considered the cultural, community and health circumstances of people seeking sanctuary.

Conclusion

This study provides valuable insight into asylum seekers' and refugees' experiences of health in Wales. It suggests that a compassionate, non-judgemental approach to providing care supports people seeking sanctuary to access healthcare with potential to reduce health inequities. These findings will be shared with NHS Wales providers and consideration given to providing: additional resources to train and support healthcare staff; specialist service support where needed such as designated health visiting and maternity services; and swift access to mental health support for those who have suffered trauma. Interpretation (oral) and translation (written) services should be accessible to both service providers and healthcare recipients. Statutory services should continue to work closely with the voluntary sector to enhance the ability of people seeking sanctuary to navigate NHS services and improve their health literacy.

Recommendations arising from this research

To reduce barriers to services, and improve the experiences of asylum seekers and refugees, we offer the following recommendations.

We could improve integration, health and well-being of people seeking sanctuary in Wales by:

Improving the ability of people seeking sanctuary to access health and well-being services by:

1. Providing people seeking sanctuary in Wales with written introductory information (in their own language wherever possible) about their rights and entitlements to NHS services upon arrival.
2. Improving health literacy of people seeking sanctuary, particularly through orientation support, advice, and translated literature.

Improving support for people seeking sanctuary in health and well-being settings by:

3. Training health professionals on the social and legal issues affecting people seeking sanctuary, as well as cultural health issues and health status and infrastructure in countries from where people seek sanctuary.
4. Providing adequate and appropriate access to interpretation and translation services at all levels of interaction with health services, and training for health professionals to access this resource.
5. Providing and promoting specialist services that meet the specific needs of people seeking sanctuary, especially in dispersal areas, including asylum nursing and designated health visiting services.
6. Providing accessible, foundation-level mental health promotion courses or resources, to encourage self-help and mental well-being and to prevent deterioration of mental health. This should be complemented by prompt access to adult primary mental health services or Child and Adolescent Mental Health Services where appropriate.

Employing a multi-agency approach to address the social determinants of health by:

7. Liaison with the Home Office and the asylum accommodation provider to settle people seeking sanctuary in areas with diverse communities or explicitly committed to supporting people seeking sanctuary, where possible. Short-term, temporary placements should be avoided and the Home Office accommodation and dispersal services should give careful credence to letters from medical practitioners requesting a delay in dispersal to ensure treatment is completed before patients are dispersed. In particular, we recommend that no woman should be relocated in the last trimester of pregnancy unless that yields a clear advantage.
8. Supporting initiatives to train people seeking sanctuary in legitimate volunteering roles such as peer supporters, interpreters or translators.
9. Continuing to ensure access to English for Speakers of Other Languages (ESOL) at the earliest opportunity, and Welsh when feasible, especially in areas with a high proportion of first language Welsh speakers.
10. Continuing to work with third sector partners to maximise support for those seeking sanctuary, including refused asylum seekers.

Contents

Background

Asylum seekers have been dispersed to Cardiff, Swansea, Newport and Wrexham from other parts of the UK since 2001. Although there was a decline in the number of people seeking sanctuary (including asylum seekers, those refused asylum, and refugees) in Wales from the early 2000s to 2012, the number has steadily increased since then.[1] In total, the UNHCR estimates that there are 151,681 refugees, asylum seekers and stateless people in the UK.[2] Figures collected by the Home Office show that the number of asylum seekers supported by the UK government under section 95 in Wales doubled from 1,370 in 2012 to 2,818 in 2018. [1] Almost half of these live in Cardiff, with others in Swansea, Newport, and Wrexham, the other three Welsh urban areas to which asylum seekers are dispersed. The National Assembly for Wales estimates that between 6,000 and 10,000 refugees are settled in Wales. [3] The commitment by UK government to receive 20,000 Syrian refugees and other refugees by 2020[4] has for the first time seen refugees settled in all 22 of the local authority areas in Wales through the Syrian Vulnerable Persons Resettlement Scheme (VPRS). Between 2015 and 2018, over 800 people have been resettled in Wales through this programme.[1]

Wales is working toward being the world's first *Nation of Sanctuary*, building on the success of both Swansea and Cardiff being designated a *City of Sanctuary*, a concept which is part of a UK-wide movement to create a hospitable environment for those in need of sanctuary. The Welsh Government recently published its *Nation of Sanctuary – Refugee and Asylum Seeker Plan*, which details a number of actions relating to health and public health. [4] Access to health services (including mental health services) throughout the 'asylum journey' was highlighted as one of the key issues by people seeking sanctuary during the development of the Plan. The ambition to make Wales a Nation of Sanctuary is in the context of the Well-being of Future Generations Act, which aims to improve the social, economic, environmental and cultural well-being of Wales, and particularly its goals of a more equal Wales, a Wales of cohesive communities and a globally responsible Wales. The Well-being of Future Generations Act furthermore provides the legislative framework for a rights-based approach to health.

There are many challenges associated with providing adequate and appropriate healthcare to people seeking sanctuary in host countries, particularly as this is a heterogeneous population, often with complex needs.[5] Minimum standards set by the UNHCR Executive Committee state that host nations must ensure access to basic healthcare for all people seeking sanctuary.[6] Meeting these standards, and refining and improving healthcare provision and use amongst people seeking sanctuary is in the interests of host nations.

Refugees arriving through the VPRS will have had a pre-entry health assessment at their place of origin (e.g. refugee camps). Information on health and social care needs, immunisation record and health screening is provided to the host Health Board on arrival in the UK. [7] The Health Boards receive reimbursement for healthcare costs from the UK Government for 12 months following the individual's arrival in the local area, or longer if an initial scheme of secondary care treatment lasting over a year is declared to, and agreed with, the Home Office on assessment. [8] People coming through the VPRS are awarded refugee status without the need to go through the asylum-seeking process. They may be housed outside urban areas.[9] Although rural areas may have relatively fewer transport links, and lower levels of language support including specialist health provision to support the needs of refugees, some local communities have ensured personalised welcome and orientation.

On arrival in Wales, asylum seekers not on the VPRS are housed in initial temporary accommodation in Cardiff. They are offered initial health assessment through the Cardiff Health Access Practice (CHAP). Specialist asylum seeker nurses and a General Practitioner (GP) provide basic health

assessment including Tuberculosis (TB) screening, signposting to support, arranging immediate and necessary healthcare services, maternity and child health services before people are relocated to accommodation in one of the four dispersal areas (Cardiff, Newport, Swansea and Wrexham). Once dispersed, local asylum seeker nurse-led services should be made aware and ensure the person is registered with a primary care provider, and signpost people to other local healthcare services such as dentists and opticians. Some asylum seekers are assessed in Initial Accommodation centres in England and may side-step CHAP altogether and present themselves in the dispersal areas. [8] Refugees may also arrive through family reunion; these are not provided with an initial health assessment or support to register with a GP.

Generally, people seeking sanctuary are liable to have unmet health needs and difficulty in accessing services [5, 10, 11] often leading to inequities in health when compared with the general population. [12] This variation can be due to extrinsic barriers to healthcare use, such as legal, practical or policy-based restrictions on provision of healthcare within the host nation. [10, 13] However, intrinsic factors can also affect refugees' and asylum seekers' experiences and patterns of healthcare use, including lack of confidence in healthcare services; [14] poor understanding of how to access the healthcare system; [15] language difficulties; [16] and the perceived impact of accessing services on immigration status. [17] Whilst most asylum seekers and refugees will need to seek care for ill health [18-20], cultural understanding of health conditions can also influence care seeking behaviour, in particular for mental illness. The stigma of disclosing mental health issues, low expectations of care for mental health and a belief that mental health can be addressed within their cultural communities can be barriers to seeking care. [17]

Primary care teams are usually the first point of contact for people seeking sanctuary. Staff may need to address complex health and social needs with limited resources, often in cross-cultural and bilingual interactions, which can affect the quality of care. [21] People seeking sanctuary report perceived discrimination at every level, from General Practice (GP) receptionists to healthcare provision in secondary care. [22] Access to services suffers from lack of knowledge of rights and entitlement and of how the NHS and care system works in the UK. [22, 23] Across the UK some people seeking sanctuary have been denied the chance to register with GP surgeries, refused treatment or wrongly charged for treatments. [24] Some are unaware of services available to support access to health services, notably interpreters. [24] The cumulative effect of difficulties in using healthcare services in a host nation may affect health. Evidence suggests that the health of forced migrants deteriorates over time after arrival before improvements are seen. [25]

Study Aims

To investigate the health, well-being and healthcare experiences of adult people seeking sanctuary in Wales, including the views and experiences of both healthcare recipients and providers.

To establish what helped or hindered the healthcare access and experiences of those seeking sanctuary.

The objectives of the research were to answer the following questions:

1. What do people seeking sanctuary understand about the role of health services in Wales in maintaining their health and well-being through primary and secondary healthcare?

2. What helps or hinders people seeking sanctuary in accessing and using health services in primary and secondary healthcare?

3. How aware are health professionals of the welfare and healthcare needs of people seeking sanctuary?

4. What role do specialist and generic primary care professionals play in maintaining health and providing appropriate healthcare for people seeking sanctuary?

Methods

We undertook a mixed methods study in three parts: (1) evidence mapping of the relevant academic literature; (2) a cross-sectional survey of people seeking sanctuary; and (3) focus groups with people seeking sanctuary and interviews with health professionals and support staff. These underpinned quantitative and qualitative analysis of the views and experiences of people seeking sanctuary and health professionals in Wales.

1. Evidence map

We produced an evidence map of factors influencing appropriate and accessible use of health services in high-income countries (as defined by the World Bank).[26] We searched the literature for the barriers, facilitators, experiences and perspectives of refugees, asylum seekers, refused asylum seekers, health practitioners, other health-service providers and patient advocates. We organised the map according to 10 topic areas of particular interest to public health and policy: primary care, secondary care, maternity care, dental and oral health, screening, immunisation, mental health, sexual and reproductive health, substance misuse and child health. We sought evidence about experiences in high-income host countries, preferably in non-insurance-based systems, as these most closely resemble the experiences of those residing and seeking asylum in Wales. However, conclusions may not all be generalisable to the Welsh context because of study heterogeneity and differences between geographical contexts.

We used key words (Appendix 1A, Table 2) to search the electronic databases CINAHL, Embase, MEDLINE, PsycINFO and Web of Science from 1st January 1998 until 24th May 2018. We selected and included evidence in a hierarchical manner (Appendix 1A, Table 2). We gave preference to systematic reviews which employed robust methods, as defined by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA).[27] Where no systematic review was available for a topic, we included other relevant secondary sources produced using a robust methodology, or in some cases, primary studies. We included more than one source for topics where this enhanced the map or gave additional insight.

We took a step-wise approach to screening citations and articles using inclusion and exclusion criteria based on the PICO acronym – Population, Intervention, Comparisons, and Outcomes (Appendix 1A, Table 1). Initially, one researcher screened all titles and abstracts. Then two reviewers independently screened each citation against the stated criteria. We resolved disagreements through consultation with a third reviewer. We obtained the full-text articles of remaining citations and two reviewers screened these for inclusion in the same way. While we selected the highest level of evidence available at each stage, we could not critically appraise all sources in the time available. Therefore, we do not consider this map a fully comprehensive synthesis of the evidence base.

2. Questionnaire survey of asylum seekers, refugees and those refused asylum across Wales

We surveyed 210 adults (aged at least 18 years) seeking sanctuary and currently living in Wales, whenever they arrived or however long they had lived in Wales. Data collection ran for 19 weeks with the first questionnaire completed on 19 April 2018 and the last on 31 August 2018. We trained a team of eight peer researchers to administer the questionnaires with those who required additional support to complete the questionnaire, particularly to overcome illiteracy. These were volunteers, who were a mixture of male and female with an age range of early 20 to 50 and spoke Kurdish, Urdu, Pushto and Farsi between them, recruited from communities of people seeking sanctuary in contact with Displaced People in Action (DPIA). They received training at Swansea University and then administered the survey at meetings and events in communities of people seeking sanctuary across Wales, working in small groups or with support from research team members. Some peer researchers completed questionnaires with eligible contacts outside the main data collection opportunities. Of those who responded to the question asking if they had completed the questionnaire with the help of a researcher or a support worker, 49% responded “yes” (100 of 204), demonstrating the value of providing this kind of support as part of the research team.

We based the questionnaire (Appendix 2) on a validated general population survey about use of health services[28] and adapted it for this study. The survey questions asked about the experiences of people seeking sanctuary in accessing health services, including what had helped or hindered their efforts to obtain care. To collect data we used closed-ended questions, Likert-type scales (three and five point) and open-ended questions. We also collected socio-demographic information about ethnic group, age, gender and when respondents had arrived in Wales. In order to cater as far as possible for the language needs of those seeking sanctuary in Wales, we translated the questionnaire into Amharic, Arabic, French, Kurdish Sorani and Tigrinya, and used community interpreters for other languages. The questionnaire was available online through a shared link and on paper; peer researchers were able to administer the questionnaire in both formats. Each respondent was provided with a participant information sheet explaining the purpose of the study and why we were collecting information from them. The information sheet was also translated into the above six languages.

We identified respondents through specialist primary care services, support workers linked to local authorities and voluntary sector organisations supporting people seeking sanctuary in Wales in nine ways:

- We visited English for Speakers of Other Languages (ESOL) classes at the Welsh Refugee Council (WRC) for both asylum seekers and refugees.
- The British Red Cross and WRC provided access to refused asylum seekers via drop in centres in Newport and Swansea.
- Displaced People in Action (DPIA) distributed questionnaires through Share Tawe, a voluntary housing scheme for destitute asylum seekers.
- DPIA, Ethnic Youth Support Team (EYST), and the British Red Cross provided access to Syrian refugees (who had come through the Vulnerable Persons Resettlement Scheme) from several Welsh local authority areas.
- Our website searches identified further pockets of refugees in rural areas, with whom voluntary sector agencies and local authorities facilitated contact.
- Questionnaires were distributed to EYST mother and toddler groups.
- The data collection team visited a voluntary sector centre in Cardiff, which supports people seeking sanctuary.
- DPIA distributed questionnaires to the Refugee and Asylum Seeker Advocacy Forum in Swansea, which is a mixed group of asylum seekers and refugees who work together to advocate on issues that affect them.

- We attended a Swansea City of Sanctuary Annual General Meeting, an Eid community party in Llanelli, and further drop-in groups in Swansea and Wrexham.

In surveys of populations with well-defined sampling frames or otherwise easy to recruit, it is good practice to report how many potential respondents one approaches both successfully and unsuccessfully, and to summarise this process by a flowchart modelled on the Consolidated Standard Of Reporting Trials (CONSORT) Statement. However this population is not easy to recruit, as shown by the disparate but effective sources listed above, and the tendency of participants to respond "Prefer not to say" rather than give valid responses. In these circumstances we eschewed the CONSORT approach, thus facilitating the work of the peer researchers.

Each questionnaire took about 30-40 minutes to complete. Although we shared the online link with third sector organisations and the peer researchers, the majority of survey responses were recorded on paper.

Analysis

We used the IBM SPSS Statistics for Windows Version 25 for descriptive analysis of the data, including basic frequencies for all questions (Appendix 3). We followed the general statistical principle of grouping responses to text questions into meaningful 'homogeneous' categories, that is similar to each other but different from those in other categories in order to allow for descriptive analysis. Where questions allowed respondents to tick "other" and elaborate, we reallocated them among existing categories whenever possible. Few questions yielded 200 valid responses. Given the nine basic sources of respondents listed above, we did not try to infer missing data. We used cross-tabulations and chi-squared tests to compare responses from different subgroups; and the non-parametric Mann-Whitney and Kruskal-Wallis tests for skewed continuous data.

We started by subdividing respondents into four subgroups – refugees on resettlement programmes, other refugees, current asylum seekers (Section 95) and refused asylum seekers (including Section 4) (Appendix 4). Judging that responses differing between these subgroups were both plausible and relevant to recommendations, we explored variations between them. If the first two did not differ significantly, we combined them as generic refugees; if the last two groups did not differ significantly, we combined them as generic asylum seekers. We included respondents coded 'Other' within the closest of these four groups whenever possible. We report all questions where responses differ significantly between groups: between generic refugees and generic asylum seekers when those two groups are both homogeneous; or between three or four groups when refugees or asylum seekers or both show significant internal differences. This enables us to report different conclusions for different groups whenever appropriate; but, more often, to report generic findings derived from all respondents.

We judged that gender was the only question other than asylum status worthy of analysis by cross-tabulation (Appendix 5). These tables enable us to report different conclusions for different genders whenever that is appropriate; but, more often, to report generic findings for both genders derived from all respondents. Owing to the sensitivity and difficulty of locating all people seeking sanctuary, random sampling was impossible. Using opportunistic rather than probabilistic sampling means that reporting effects as statistically significant assumes that the final sample of 210 was representative of those seeking sanctuary across Wales; and makes confidence intervals unreliable. If the final sample were indeed representative, it would have yielded 80% power to detect differences of at least 20% between refugees and asylum seekers, or males and females.

3. Focus groups and interviews

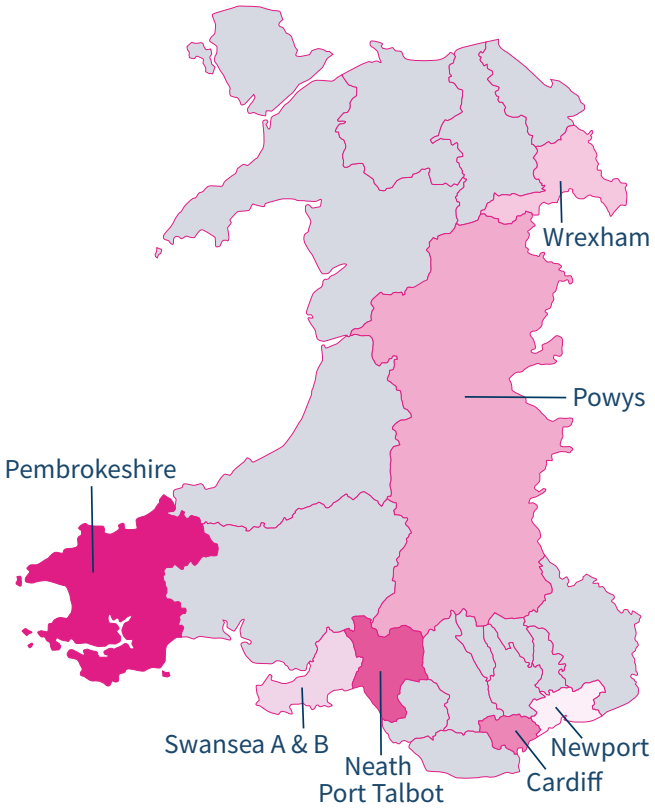
Focus groups

We conducted eight focus groups across Wales (see Figure 1). We recruited participants in a variety of ways. Survey respondents who had indicated a wish to take part in a focus group and provided their written contact details on the survey were contacted by telephone to attend a group. The response was surprisingly low however, with only six people attending focus groups through this method. The majority of focus group participants were identified through third sector support organisations (British Red Cross, DPIA, EYST and WRC), support workers or Croeso community sponsorship groups. We were invited to attend existing drop in sessions in Newport, Powys and Wrexham to carry out focus groups and also an ESOL class in Cardiff. In Pembrokeshire we arranged a focus group and invited participants to complete the survey.

In total there were 50 people seeking sanctuary and seven support workers and volunteers involved in the focus groups. The support workers and volunteers were there to assist their clients and three of them contributed to the discussion. We used a focus group question guide which included scenarios and semi-structured questions (Appendix 6). The focus group discussions allowed participants to describe their experiences and expectations of health services, in their own words[29]. An Arabic-speaking interpreter was present at five focus groups. The lead researcher interpreted for those speaking Urdu or Bengali. With participants' consent, we audio recorded and transcribed the discussions, as explained on the information sheet provided to participants prior to the focus group. Where the participants required an interpreter, we transcribed the interpreter's words, which is included in the transcripts, and not the language used (i.e. Arabic, Tigrinya and Urdu). One researcher led all eight focus groups with another observing, making written notes and helping with interpretation and translation. We based questions on hypothetical scenarios to invite views and capture understanding and expectations.

Focus group participation was voluntary with no financial incentives offered. At each focus group, we provided light refreshments and snacks. Participants who travelled to a location specifically to take part in a focus group were reimbursed for their travel.

Figure 1: Location of focus groups



Telephone Interviews - Professionals

We interviewed 32 health professionals across a range of professions by telephone. Our aim was to recruit respondents with experience of working with people seeking sanctuary and those without (Table 2). These respondents were based geographically across the whole of Wales. We selected respondents purposively from our previous contacts with health and care professionals and third sector organisations and in some instances respondents were able to refer colleagues through chain-referral sampling. Our third sector partners provided contact numbers and emails for Health Assessment services for newly arrived individuals in Cardiff, and Asylum Seeker Nurses in Wrexham, Newport and Swansea. These individuals made further suggestions of services that people seeking sanctuary were in regular contact with. Our research management group members signposted to other providers. One respondent (consultant in integrated sexual health) was suggested by one of the study interpreters and another two were recruited by the lead researcher through direct approach in a community setting (pharmacist and GP). We were provided with a list of GP practices and dentists used by people seeking sanctuary in some areas by the asylum seeker health services. We made telephone calls and sent out emails to several local GP surgeries from this list and also visited opticians, but this yielded a low response. We found chain-referral sampling to be most productive in securing a high response. Refusal to participate was due to time constraints or not wishing to take part.

We used semi structured questions to explore issues highlighted by the literature review and preliminary analysis of questionnaire data (Appendix 7) including the scope of healthcare provision, healthcare encounters, and training and guidance. We audio-recorded and transcribed these interviews with verbal consent.

Table 1: Professional roles of telephone respondents

Practitioners delivering dedicated asylum seeker services	Practitioners in services with dedicated slots for asylum seekers and refugees	Practitioners in services accessed by asylum seekers and refugees living in the catchment area	Practitioners in services delivered in areas with few or no asylum seekers and refugees
Asylum Seeker Nurse (n=3) Refugee Support Worker (Third sector) Community Support Worker (Third sector) Specialist (GP Locum) Health Support Worker (GP based) Specialist Health Visitor Specialist Midwife	Consultant/ Community Dentist (n=2) Trainee Dentist Dental Practice Manager Dental Practice Receptionist Clinical Director (Dental Services)	Paramedic Hospital Overseas Patient Officer GP Consultant in integrated sexual health Trainee GP GP Practice Manager GP Receptionist (n=2) Respiratory Nurse Community Pharmacist Optician's manager Palliative Care Nurse School Nurse Health Visitor (Flying Start)	Paramedic Psychiatrist (n=2)

Qualitative Analysis

We used framework analysis [29-31] to analyse focus group and telephone interviews. Framework analysis enables the researcher to explore data in-depth systematically, thus providing an audit trail and a rigorous analysis process. [29] This method is often used in the context of health policy research as it is suitable for limited timeframes and research with specific questions.[29, 32] We developed a thematic framework from our study aims and objectives, including research questions to form the basis of our analysis. An experienced qualitative researcher provided study oversight and guidance.

Most of the interview and focus group transcripts were transcribed by a professional transcription service. However, one focus group and one telephone interview were transcribed by the lead researcher, as the transcription service was unable to understand some of the accents. The lead researcher checked all transcripts against the audio recordings for accuracy before two researchers read through the interview and focus group transcripts twice along with the coding framework to familiarise themselves with the data. The data was coded (selecting text from transcripts) into relevant themes following the coding framework, using NVivo qualitative data analysis Software Version 12 (computer assisted qualitative data analysis software which allows codes to be mapped, compared and also recall of direct quotes). Within each theme the researchers created sub themes to code text in terms of barriers and enablers to healthcare access. The data was then summarised into a framework matrix to allow comparisons between themes and transcripts. The two researchers discussed the framework matrix and compared and further refined themes for inter-rater reliability. Discrepancies in interpretation were resolved by re-reading the original transcripts and field notes to agree results. For authenticity, all themes from the data are supported by anonymised direct quotes from interview and focus group transcripts. To maintain respondent anonymity pseudonyms are used. [32]

Results

Evidence map

We report the results by themes identified in the literature search focusing in particular on papers from the UK and systematic reviews which reference UK papers. To extend this limited literature, we also included evidence from insurance-based health systems in Australia and North America. We identified five themes: language and communication; cultural understanding and values; trusting relationships; structural obstacles; and health literacy. Appendix 1B shows a more detailed evidence map.

Language and communication

- Language barriers were consistently cited as one of the greatest challenges facing people seeking sanctuary, particularly difficulties with interpreting and translation. These include: lack of availability of interpreters and translators;[33-36] inappropriate use of family, friends or other non-professionals as interpreters;[33,34,37,38] differences in dialect between patients and interpreters;[38] and interpreters who were unsuitable in age or gender.[35] Other communication difficulties included refugees and asylum seekers being unable to read or write in the language of host countries, and thus unable to understand medical information or literature, and book appointments.[37,38]
- Facilitators for communication included: employing interpreters who spoke the dialect of patients;[38] offering health-related materials in the first language of refugees and asylum seekers;[38] and supporting GP clinics in providing more interpretation services.[37]

Health literacy

- Lack of knowledge of host countries' health systems was a barrier to services for most people seeking sanctuary.[35,37,38] One study reported several issues they had in accessing GP services, including not knowing where to find a practice, how to make an appointment, or how to register.[38] Some refugees and asylum seekers were also unaware of the potential to test for HIV and Sexually Transmitted Infections[35]. In another study they were not aware of services for mental illness, addiction or the harmful effects of drug and alcohol use.[36]
- Facilitators for refugees and asylum seekers in this area included: extending the length of time refugee assistance services were assigned to patients so that they had more time to understand the host country's healthcare system;[38] and conducting culturally appropriate education and outreach work.[39]

Cultural understanding and values

- Lack of cultural understanding was also frequently cited as a barrier for refugees and asylum seekers in accessing health services.[33,35,37,40,41] These included differences in cultural values, such as gender roles between practitioner and patient;[33] taboos surrounding the use or discussion of contraception (amongst both women and men);[35] and health professionals relying on assumptions made about patients, rather than establishing rapport and encouraging patients to talk about their concerns.[35]
- Ways in which to alleviate cultural barriers included: doctors being sensitive to patients' cultural beliefs and practices;[33,37] providing culturally appropriate education;[39] providing a culturally sensitive and personal service to patients (rather than standardised);[35] and assigning doctors of a similar cultural background to patients.[38]

Trusting relationships

- Reported challenges to building trust between health professionals and people seeking sanctuary included: the perceived racism or discrimination of practitioners towards patients;[34,37,41] the transient nature of people seeking sanctuary;[33] suspicion by patients that health professionals might contact immigration authorities;[33] and patients feeling that doctors were not interested in them or their experiences.[37]
- Facilitators in building a trusting relationship included: doctors who were friendly, compassionate, or empathetic to patients;[33,37] continuity of care;[33] doctors who showed an interested in patients' background and culture;[33] and clear explanation by doctors of their role and the concept of confidentiality.[33]

Structural barriers

- One of the structural barriers to accessing care in high income countries that was most frequently reported in the literature was the relatively high direct cost of out of pocket expenses to patients of accessing healthcare, for example for transport to and from services.[34,37,41]

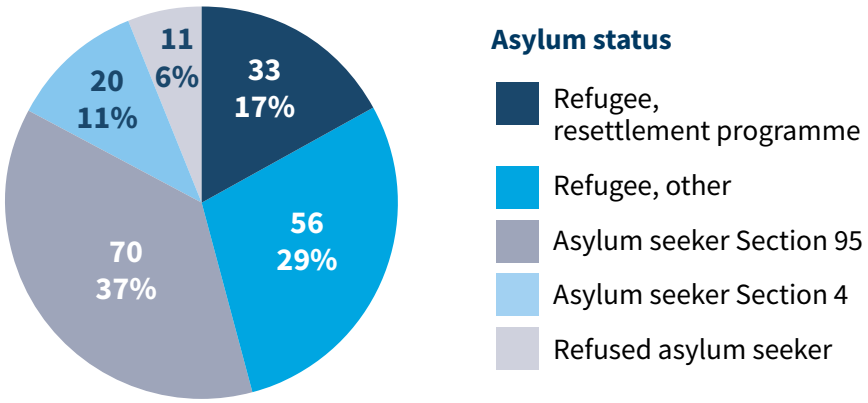
Survey results

Before we report our principal findings relating to the experiences of people seeking sanctuary in accessing health services, we summarise the characteristics of our heterogeneous sample. Of 217 questionnaires from across Wales entered into our database, we analysed 210 confirmed as eligible by audit. Of these, typically about 10% (20 of 210) did not give analysable responses to individual questions, often by choosing "Prefer not to say." Almost all respondents (97%; 204 of the 210) reported whether they had completed their questionnaires with the help of a researcher or support worker; of these, 49% (100 of 204) reported such help. Further details of the survey are available in appendices: Appendix 3 provides tabular summaries by question; Appendix 4 compares results by asylum status; and Appendix 5 compares results by gender.

Asylum and Refugee Status

Figure 1 summarises respondents' reported asylum or refugee status. Of the 190 (90%) valid responses, 37% (70 of 190) were seeking asylum under Section 95; 11% (20) were seeking asylum under Section 4; 6% (11) were refused asylum seekers; 17% (33) were refugees on resettlement schemes; and 29% (56) were refugees not on such schemes. Since asylum seekers under Section 4 have normally been refused asylum at least once, we grouped these together with refused asylum seekers for the rest of our analysis.

Figure 1: Asylum and refugee status of the 190 respondents giving valid replies



Demography

Figure 2 summarises respondents' self-reported nationalities. In summary, 35% (67 of 193) reported being from the Middle East, 35% (67) from Africa, 23% (45) from South and East Asia and 7% (14) came from Europe or the Americas. However, Figure 3 shows that refugees and asylum seekers had different distributions of nationalities. Syrians, the largest national group, were all refugees, mostly resettled refugees. Five people from other countries also said they were on resettlement programmes. Appendix 3 provides more detail about nationality.

Figure 2: Nationality of the 193 respondents giving valid replies

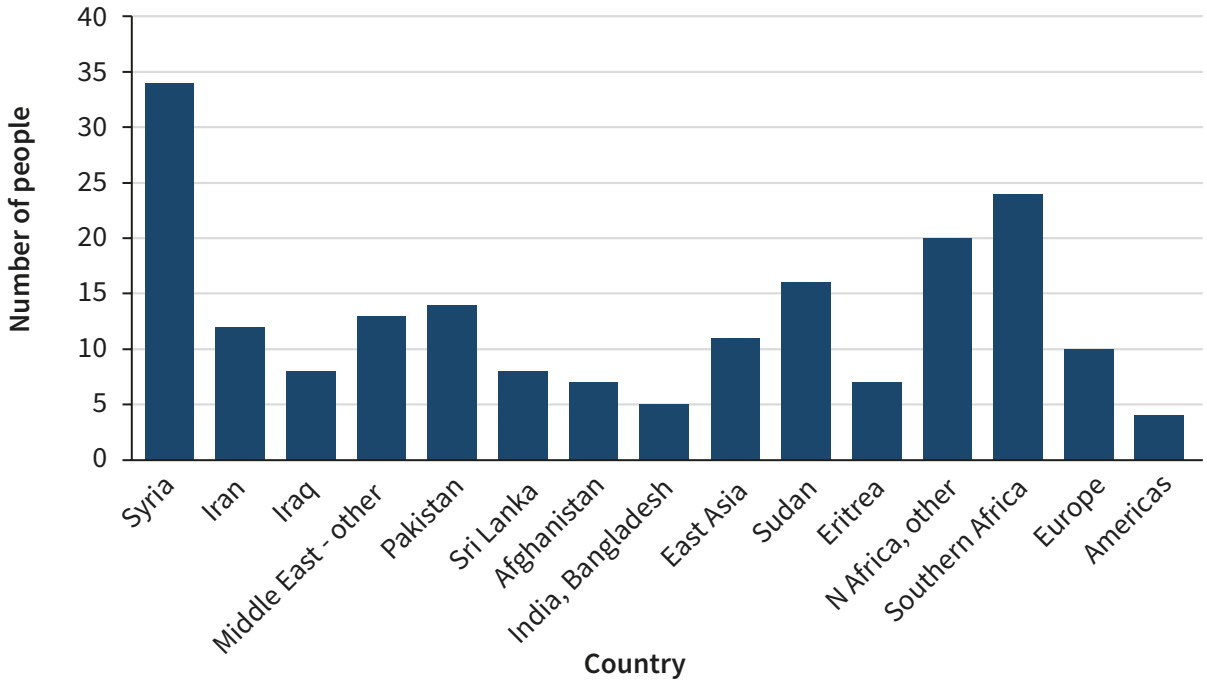
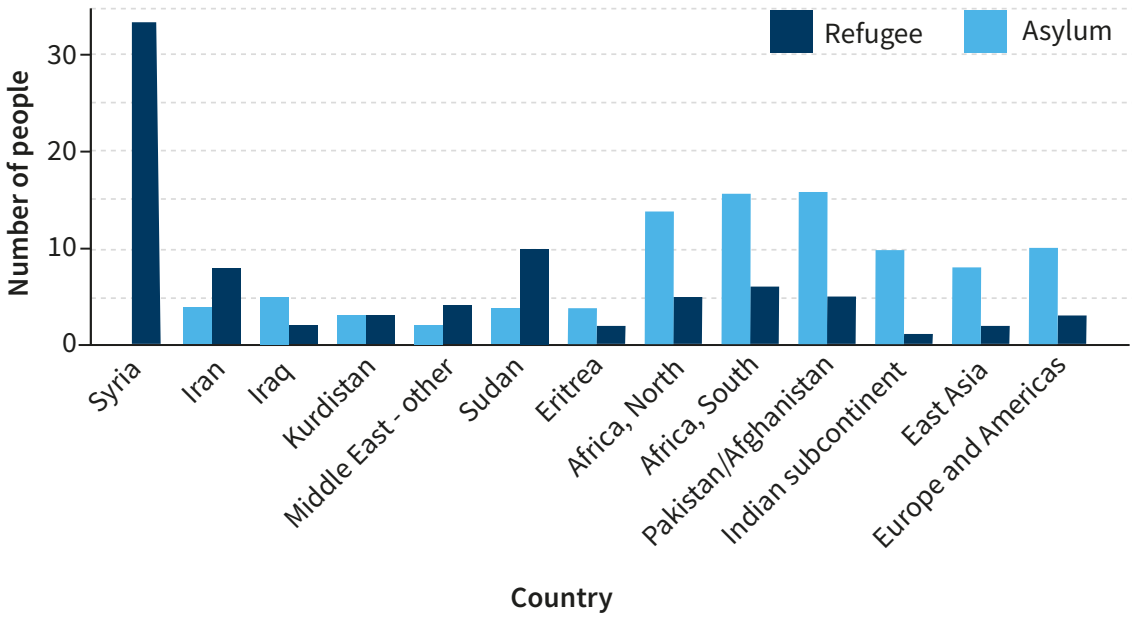
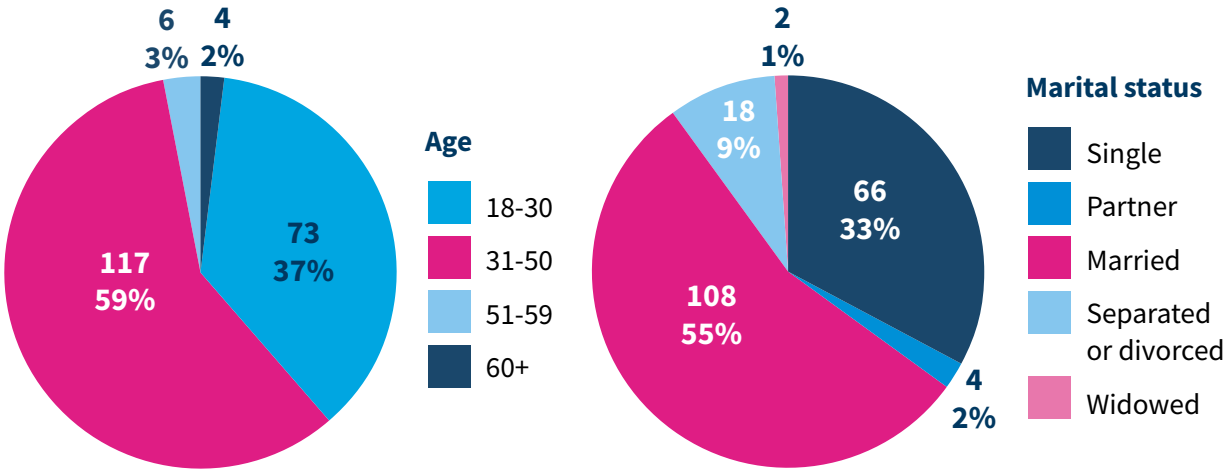


Figure 3: Nationality of 84 refugees and 96 asylum seekers giving valid replies to asylum status



82 respondents identified as males, 118 identified as females, and one respondent identified as 'other' gender. To ensure confidentiality, counts under 5 were not reported in the results tables in the appendices. Another nine respondents did not reply or preferred not to give their gender. So 41% of the 200 valid responses were male and 59% female. Gender balance did not vary significantly with asylum status (chi-squared with 2 df = 1.38; p = 0.50).

Figure 4: Age and marital status of respondents giving valid replies (200 and 198 respectively)



Of those who gave valid replies, 59% (120 of 200) were aged between 31 and 50; and 55% (108 of 198) were married or with a partner (Figure 4). There were no significant differences between refugees and asylum seekers in age, but resettled refugees were more likely than other respondents to be married or with a partner: 84% (26 of 31) resettled refugees compared with 52% (80 of 153) other respondents (chi-squared = 10.5 with 1df; p = 0.001).

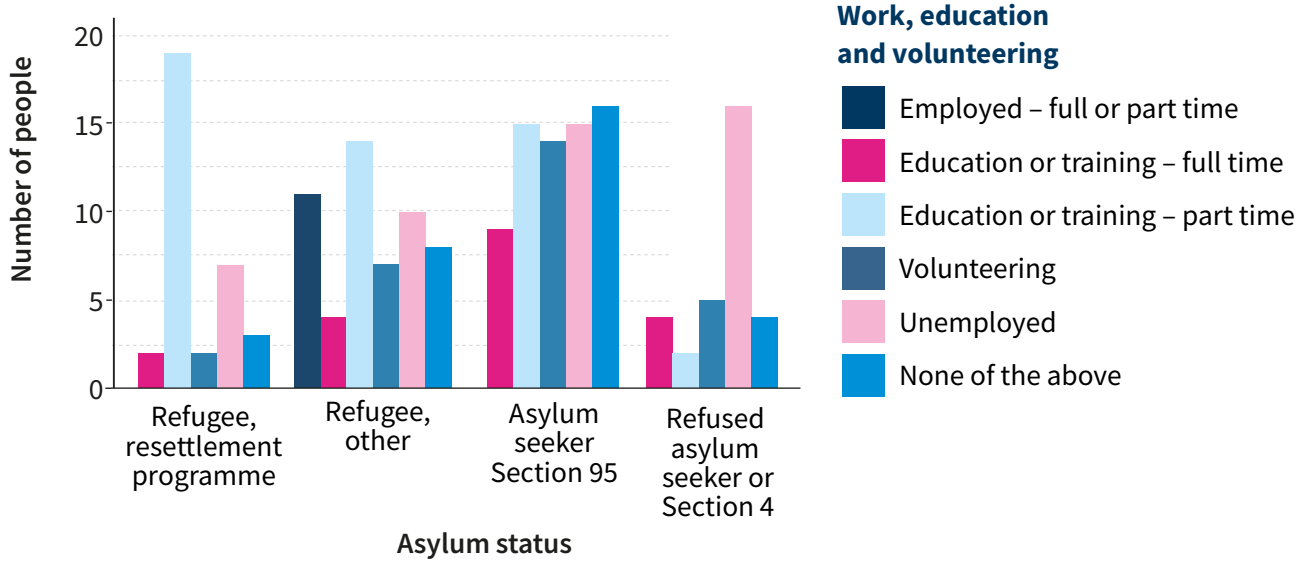
Table 3 summarises occupation (Appendix 3). Figure 5 shows that the occupation of the four asylum status groups differed highly significantly (chi-squared = 62.4 with 15 df; p < 0.001). All 11 employed respondents with known asylum status were non-resettled refugees; this is not surprising, as most asylum seekers are forbidden to work while their asylum claim is being decided. Resettled refugees were the most likely to be in part-time education, and Section 4 or refused asylum seekers the most likely to be unemployed (chi-squared = 31.8 with 12 df; p = 0.002). Refugees and asylum seekers were equally likely to volunteer.

Table 2: Employment status of 204 respondents giving valid replies

Employment status	Number (%)
Employed* (full or part time)	12 (6%)
Education or training full time (but not employed)	22 (11%)
Education or training part time (but not employed)	52 (25%)
Volunteering (but not employed or in education or training)	31 (15%)
Unemployed (but not in education or training or volunteering)	53 (26%)
None of these (including long-term sick or carer)	34 (17%)

* Two of whom were in education or training

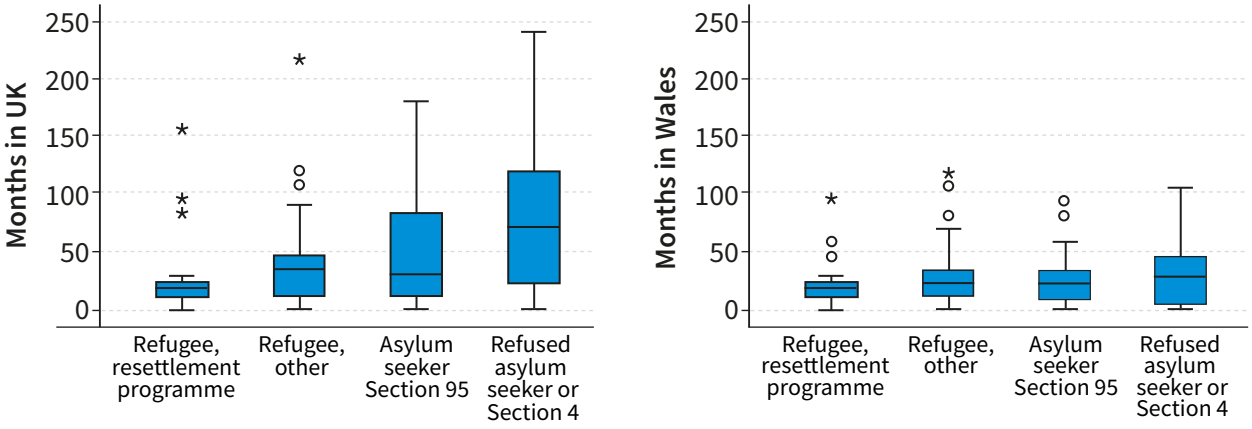
Figure 5: Occupation of 187 refugees and asylum seekers giving valid replies



Length of time in UK and Wales

The 196 participants providing valid durations in the UK reported that they had spent a mean 45 months and a median 26 months; the 197 providing valid durations in Wales reported a mean 27 months and a median 24 months. However individual lengths of stay varied, from 12 days to 20 years in the UK, and from 11 days to 13 years in Wales. These data are continuous rather than categorical. So Figure 6 uses 'boxplots' to display significant differences between the four types of refugee or asylum seeker in time spent in the UK (Kruskal-Wallis test; p = 0.002). More specifically resettled refugees had spent significantly less time than other refugees (Mann-Whitney test; p = 0.017) or Section 95 asylum seekers (Mann-Whitney test; p = 0.037). In turn, Section 95 asylum seekers had spent less time than other asylum seekers (Mann-Whitney test; p = 0.020). All groups had spent similar lengths of time in Wales (Kruskal-Wallis test; p=0.44).

Figure 6: Time in UK (196 valid replies) and Wales (197 valid replies) by asylum and refugee status

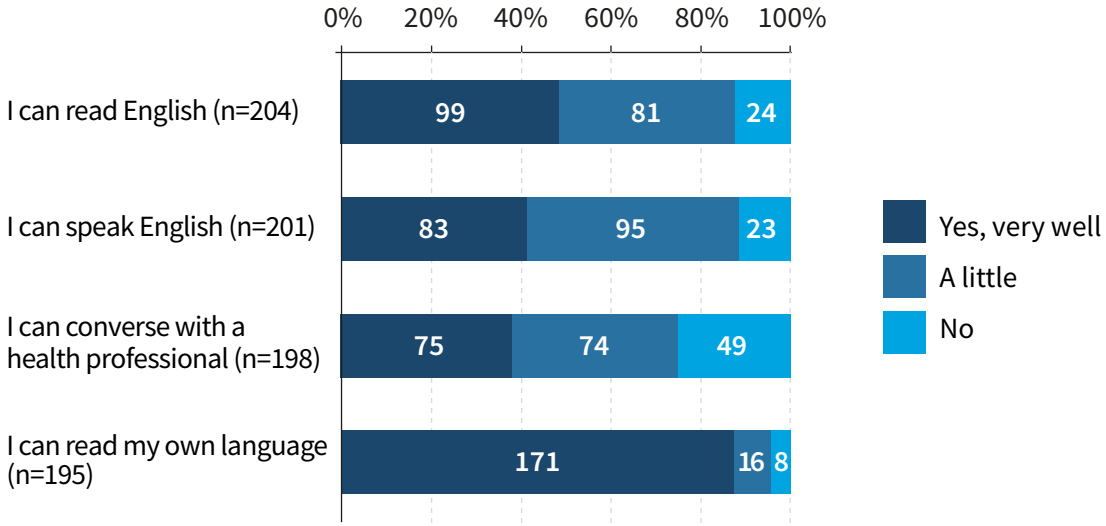


Note: Boxes show the median between the lower and upper quartiles. Whiskers extend to the highest data point within 1.5 interquartile ranges (IQR) from the upper quartile and the lowest data point within 1.5 IQRs from the lower quartile. Circles show data points between 1.5 and 3 IQRs from the nearer quartile, and asterisks show data points more than 3 IQRs from the nearer quartile.

Language and communications

Figure 7 shows that some 88% of respondents giving valid replies reported that they could read (180 of 204) and speak some English (178 of 201), but 25% (49 of 198) could not communicate in English with health professionals. Resettled refugees were much less confident than others (chi-squared = 37.9 with 4 df; $p < 0.001$). Twelve per cent of respondents (24 of 195 valid replies) could not read their own language well.

Figure 7: Respondents' language skills – reading and speaking (valid replies in brackets)



Health status

We asked "Do you consider yourself to have a disability?" and "Do you have a long-term illness not covered by Question 11?" as separate questions. Each then asked for details. We analysed them together because several answers appeared in both lists. Of 193 respondents giving valid replies to one or other question, 33% (64) reported a disability or long-term illness. Though descriptions of problems varied in interpretability, at least 7% (13 of 191 replies giving details) described mental health problems, which was the most frequently mentioned health problem (Appendix 3).

Access to services

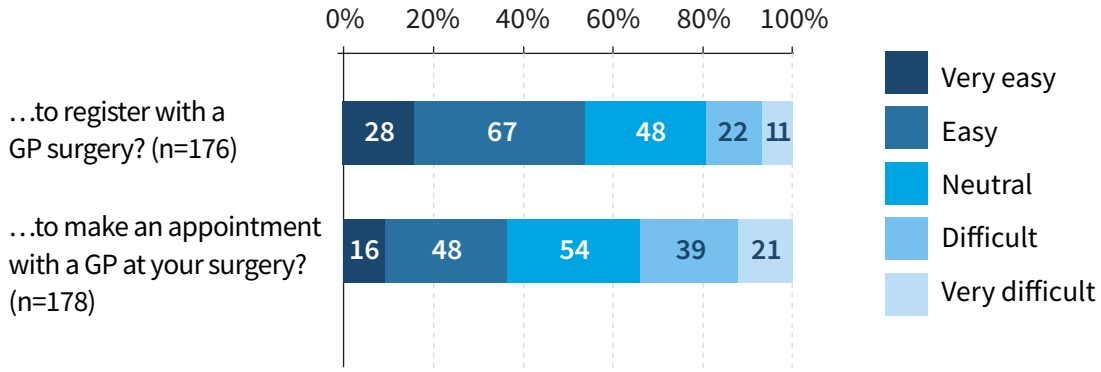
Initial health assessment

On arriving in Wales, 83% of respondents (162 of 196 valid replies) reported receiving an appointment to attend an initial health assessment; this differed significantly between 73% of refugees (60 of 82 valid replies) and 93% of asylum seekers (93 of 100 valid replies) [chi-squared = 13.2 with 1 df; $p = 0.001$]. Of 185 valid respondents, 82% (151, including 5 who were not invited) reported such an assessment (Appendix 3). Only three of those who had been invited but did not attend, provided an explanation.

General practice

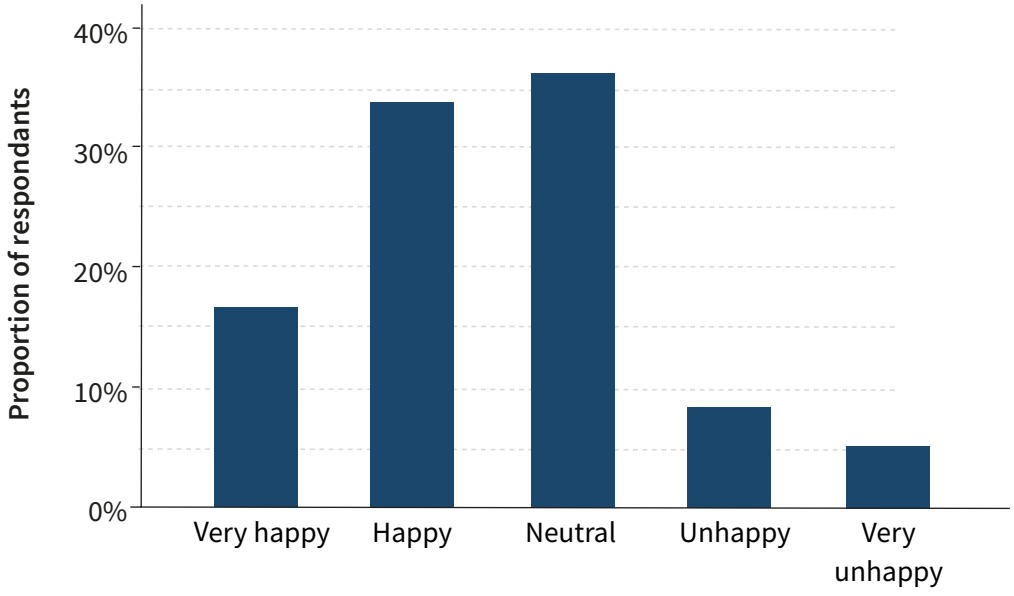
We asked respondents whether they were currently registered with a general practice. Of the 193 who gave valid replies, 94% (182) said they were registered. We asked them to reflect on how easy or difficult they found the process (Figure 8). Only 17% (5 of 29) resettled refugees found registration easy compared with 63% (84 of 134) other respondents – a highly significant difference (chi-squared for linear trend with 1 df = 21.8; $p < 0.001$). Similarly only 10% (3 of 29) resettled refugees found making appointments easy, compared with 43% (58 of 136) other respondents – also highly significant (chi-squared for linear trend with 1 df = 5.32; $p = 0.021$).

Figure 8: How easy to register and make appointments with your GP surgery? (valid replies in brackets)



51% of people seeking sanctuary (91 of 180 valid responses) were happy with the services they receive from their GP surgeries (Figure 9 and Appendix 3).

Figure 9: How happy are you with the service you receive from your GP surgery? (180 responses)



Awareness of services

Table 3 shows respondents' awareness of a range of primary and secondary care services, of which we highlight services out of hours. The best known services were the 999 ambulance service and daytime pharmacies; the drug and alcohol service was the least known (Appendix 3). Section 95 asylum seekers were significantly more likely than others to know how to contact pharmacists (chi-squared for linear trend with 1 df = 8.26; p = 0.004) or health visitors (chi-squared for linear trend = 5.54; p = 0.019), but there were no other significant differences.

Table 3: Ranked awareness of healthcare services available

Service	Heard of and know how to contact* Number (%)	Heard of but do not know how to contact Number (%)	Not heard of the service Number (%)
999 ambulance (185 valid replies)	142 (77%)	23 (12%)	20 (11%)
999 ambulance out of hours (186 valid replies)	134 (72%)	31 (17%)	21 (11%)
Pharmacist (173 valid replies)	114 (66%)	28 (16%)	31 (18%)
Dentist (182 valid replies)	104 (57%)	53 (29%)	25 (14%)
Emergency Department (180 valid replies)	102 (57%)	37 (20%)	41 (23%)
Optician (175 valid replies)	92 (53%)	55 (31%)	28 (16%)
Emergency Department out of hours (178 valid replies)	78 (44%)	38 (21%)	62 (35%)
Health visitor (174 valid replies)	74 (42%)	40 (23%)	60 (35%)
NHS 111 or NHS Direct (186 valid replies)	71 (38%)	26 (14%)	89 (48%)
NHS 111 or NHS Direct out of hours (185 respondents)	66 (36%)	42 (23%)	77 (41%)
Maternity services (175 valid replies)	54 (31%)	28 (16%)	93 (53%)
Family planning & sexual health (180 valid replies)	52 (29%)	32 (18%)	96 (53%)
GP out of hours (187 valid replies)	49 (26%)	33 (18%)	105 (56%)
Physiotherapist (183 valid replies)	45 (25%)	43 (23%)	95 (52%)
Screening, e.g. for cancer (181 valid replies)	41 (23%)	36 (20%)	104 (57%)
Delivery suite out of hours (175 valid replies)	39 (22%)	25 (14%)	111 (64%)
Minor injuries unit (176 valid replies)	35 (20%)	31 (18%)	110 (62%)
Pharmacist out of hours (182 valid replies)	35 (19%)	37 (20%)	110 (61%)
Drug and alcohol service (173 valid replies)	15 (9%)	25 (14%)	133 (77%)

*In descending order

Barriers and aids to accessing healthcare

Healthcare costs

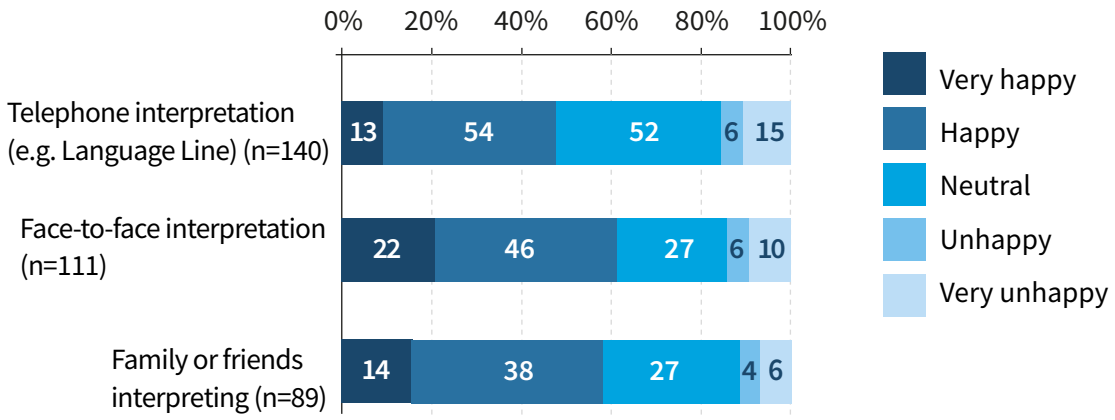
Of 208 giving valid replies, 81% (169) respondents knew that healthcare was free in Wales (Appendix 3). Of 116 respondents self-identifying as female giving valid replies, 87% (101) knew this; of 82 self-identified men, significantly fewer, at 73% (60), knew this (chi-squared with 1 df = 6.11; p = 0.013). But there was no significant difference between refugees and asylum seekers.

Of 201 giving valid replies 63% (126) knew that an HC2 certificate gives free access to NHS services. A significant difference was seen between refugees and asylum seekers, where 48% (41 of 86) refugees knew that a HC2 certificate gives free NHS access and; of 97 reported asylum seekers giving valid replies, significantly more, at 79% (77) knew this (chi-squared with 1 df = 20.0; p < 0.001).

Translation and Interpretation Services

Figure 10 shows satisfaction with three types of interpretation services: slightly more people were (very) happy with interpretation face to face, or by family or friends, than with telephone services such as Language Line. However, similar proportions were (very) unhappy with each method, suggesting that telephone translation is acceptable.

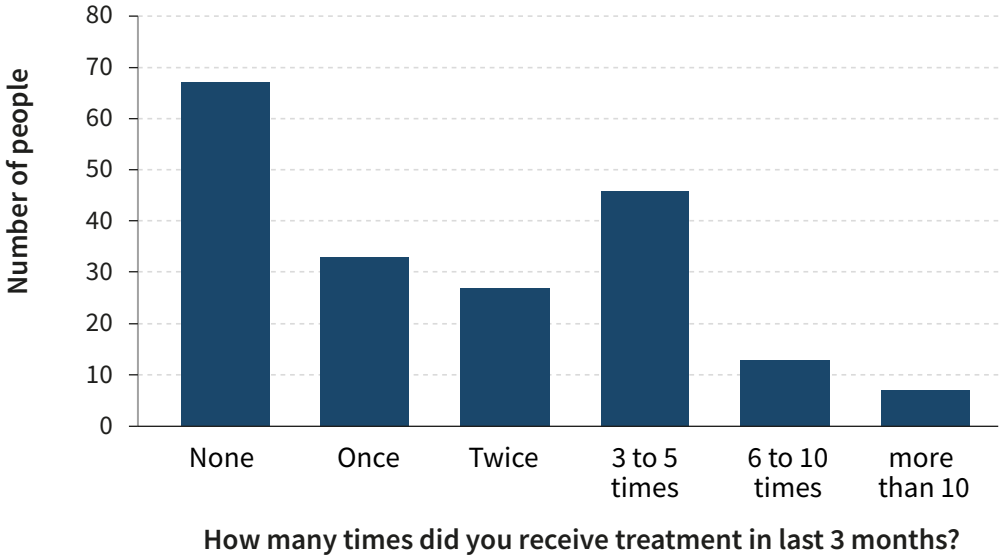
Figure 10: How happy were respondents with types of interpretation? (valid replies in brackets)



Experience of services: treatment and advice

Of 199 giving valid replies, 66% (132) had received treatment or advice for a health problem, however minor, or helped someone else to receive such care, during NHS working hours (between 8am and 6.30pm on weekdays) over the past three months. Figure 11 shows the frequency of such consultations. A higher proportion of Section 95 asylum seekers than refugees or refused asylum seekers had received such care (Appendix 4); and females more likely than males (Appendix 5). The majority of people had used services in hours for their health issues. Of 194 respondents only 28% (54) had received similar care (or helped others to receive it) outside these NHS working hours.

Figure 11: Frequency of accessing healthcare for self or others in working hours over previous three months (199 valid replies)



Qualitative findings

We begin this section with four stories told by people seeking sanctuary, volunteers and health practitioners about experiences of accessing healthcare. These stories have been selected as typical of experiences of our respondents. They describe some of the common barriers and facilitators affecting access to healthcare by people seeking sanctuary. Typical issues include difficulties in maintaining continuity of care, the effects of socio-economic issues on health and challenges to communication and information sharing. To maintain respondent anonymity pseudonyms are used.[32]

Joy's story (an asylum seeker), as told by a health visitor

"Joy says that she was trafficked into the country [as a child], she's now in her late 20s and was originally living in [city X]. When she was pregnant, the house in [X] wasn't suitable, so she was rehoused when her little one was about six months old, to Wales. So she'd been for a long time in [X], lots of friends, good network of friends, baby's father in [X] as well, who she's still in a relationship with. She was moved to [city Y] in an area where it's on quite a big hill. She was now a failed asylum seeker so she only had access to money on a card, so getting things like a bus was quite difficult. And she didn't have friends around here. Now, she's pregnant again by the same father as the first child, desperate to get back to [city X], she's got mental health problems and is on medication. She's desperate to go back to [X]. She's put in a request to go back to [X] but with no success. She recently got poorly with the pregnancy, ended up going into hospital. So that causes even more anxiety, more stress. She did have someone that she had known through a church group, somebody that she trusts, that her first child went to stay with. The staff in the hospital triggered a police welfare check. The child was seen, fine, and no concerns. However, the friend then said 'well I'm not willing to look after your child again because I don't want the police knocking at my door'. But now the baby's going to be born, there's no one to look after the older child when she goes into labour, so I'm currently in the process of sorting out a foster placement for the older child. But, you know, the stress… somebody who's suffering from mental health problems… thought to be suffering from post-traumatic stress disorder."

Michael's story (an asylum seeker)

There's one experience that I haven't liked with the NHS here, I think I understand the red book for the kids, but I understand the information is different, if you bring [it from elsewhere]. Before we came here we were in England, we had a baby there. We came here with the same red book from England. They said plainly, 'it's the same red book, but there in England the order [procedure] is different, so we can't find some of the information'. We're telling them she has received immunisations, we told them everything. Then they were like, 'No, those things that we can't see, we'd like to give your children like twice' and then I said, 'I don't think it's safe to give children a double dose just 'cause you can't find the information, it's not that I don't know what I'm talking, I know what I'm talking about, I know what my children got, I wouldn't allow my children to miss some of their vaccines'. They never gave any information… There was no explanation for it, but it was just an observation that only asylum seekers were getting this vaccine, they'll give you like the three injections, like one side, one side, and then they'll say, "Don't walk for five minutes, sit down," and then after that you can go [laughs].

Mr Singh's story (an asylum seeker), as told by a psychiatrist

"Because of the new system, you can't be in a place of your liking. You can be placed anywhere according to the Home Office. So, he has been put in [city A]. He's [religious]. He has more of a support network in [B] and he feels isolated in [A]. So that's actually affecting the whole mental health problem…But the issues with asylum seekers are not just limited to the mental health although the mental health is related to the whole other problems. Especially what's going on with the legal side of things. This man was placed in [A], he couldn't attend his [place of worship] in [B] which was a kind of a healer for him. So, he was feeling very lonely here. Resources are limited, we can't do anything about that because that comes from the Home Office. I don't know if they're going to be here next or not, if the Home Office moves them to another city. This continuity of care is a problem with this group of people. They are housed in small houses where they have one room and there's other people living in the same house. So there's a lack of privacy there. I think they are being given £20 per week and they are not allowed to work so I don't know how a person can survive on that kind of money in this day and age. So there's these kind of stresses as well. This money is so limited they find it difficult to come to my clinic when coming by bus. They have to report to the local police office after regular periods. So it's a multitude of issues which are concerning."

Fatima's story (a refugee) and the volunteer who supported her and her family

(told through a translator)
'Fatima said she think that they [the volunteers] are being with her very nice, taking to appointments and when she go to the doctor they are interested to help her...They are very helpful. At the night time, the volunteers came if the family asked for help. She said we feel really assured if they are around us… They [the volunteers] give them brochures in Arabic, any information for the baby also in Arabic.

She said they are really helpful, from the first day they arrived they took them to the GP and registered them, they took them to register with the dentist. She wouldn't know how to do this. They have a friendly neighbour to help them. She says they are very nice with them and they respect them and she even said they are looking to them in a kind way. She said if the people here saw them in street they ask them if they are good or bad. She said I want to learn English to communicate with my friends, the group. I cannot express everything that I want to them, I feel more sad. She said we are okay in help to overcome all the things that we have. The government is supporting but it is not good for us to just wait for them to help. We need, as they help us, to help ourselves so we will be more resilient.'

Volunteer
'So the week after she [Fatima's daughter] had the baby, she would have felt more vulnerable because she didn't have any English because whilst she was pregnant, she didn't go to English classes. Not being able to speak the language makes you feel very vulnerable. I think she was just frightened and that's why she wanted people who would speak the language near her.
We will always help them but the Home Office have said right from the start we've got to start to make them independent. We felt the first thing to do was the dentist. So now they can go on the bus to the dentist and also they have been making their own appointments for the dentist because they are there physically. Picking up a phone is much more difficult, to make an appointment. We've had a lot of one-to-one lessons. We pay for them or we've had grants for them… so that they can have one-to-one English which has helped. We are like friends. But in fairness, there is only probably six to eight of us left. We started with 12 to 14. But they are doing a lot themselves so things are definitely much easier.'

We now present the findings of focus groups with people seeking sanctuary, and interviews with practitioners, along five themes:

Theme 1a) Beliefs of people seeking sanctuary about what helps them to access services

Theme 1b) Beliefs of people seeking sanctuary about what hinders their access to services

Theme 2) Views of people seeking sanctuary of the role of primary and secondary care health services in enabling their health and well-being

Theme 3) Primary care professionals' views on enabling access to and use of health services by people seeking sanctuary

Theme 4) Level of awareness among health professionals of the care needs of people seeking sanctuary

Theme 5) Impact of social determinants on health of people seeking sanctuary

Quotations from participants are included. Where respondents contributed in their own language or through an interpreter, we report their words translated into English and note this. Respondents are identified as follows:

Focus groups

- FG1-8: Focus groups with people seeking sanctuary
- V1-3: Volunteers (unfunded)
- SW 1-4: Third sector support workers (funded roles)

Health service interviews

- HP1-29: Health practitioners
- ISW 1-3: Third sector and health service support workers (funded)

Theme 1a: Beliefs of people seeking sanctuary about what helps them to access services

Specialist and support workers

People seeking sanctuary described a range of specialist clinicians and support workers who directly provided them with healthcare and helped them to access services. These fell into four categories: statutory services such as asylum seeker nurses/health visitors/social workers employed by Health Boards or local authorities; a health support worker employed by a GP cluster from the voluntary sector; voluntary sector community support workers funded through short term funding grants; and volunteers (either independent or part of local community groups). All provided people seeking sanctuary with advice and support on accessing services when settling in a new community. Volunteers often bridged the gap where usual services were not able to accommodate the needs of people seeking sanctuary.

Most focus group respondents said they had been helped to register with a GP practice by one of these individuals. Many respondents who were asylum seekers stated that they did not retain all the information provided to them by the Asylum Seeker Nurse or other statutory services during the first appointment. They often asked within their communities for further clarification and support.

> *FG 7: [through an Interpreter] At the beginning the local council provided a lot of information about services in Arabic. If we needed more information we ask the people who have arrived before us. Sometimes we go to the Red Cross.*

Services or volunteers in some areas also provided support with transport, helped people access public health programmes and offered wider practical advice. Often they provided advice out of hours, sometimes even at night. They visited people at home, understood their situations and could maintain continuity at a time of enormous uncertainty. When people seeking sanctuary were moved to areas without this point of contact, it made them feel insecure and isolated.

> *FG 1: In X the Health Visitor come to your doorstep, they knock on your door, "Oh you have appointment today," and they will call you and follow up, come pick you in the morning and get you to your appointment and bring you back. 'Cause like everybody has one centre (drop in) where they meet twice a week and you can discuss all your appointments and so on and they follow up on everything. But there is nothing like that in Y. You have to start afresh on your own.*

Accessibility of care

People seeking sanctuary valued free access to healthcare in Wales. They were often surprised that they did not have to pay for prescriptions and most accepted the need to wait for a consultation. They also appreciated the quality of care and range of services to help them understand and manage matters related to health. Many sought advice from community pharmacists with varying responses or accessed information from websites such as the NHS or used NHS 111 telephone advice line. No one mentioned NHS Direct.

A number of times people said they were pleasantly surprised by the level of considerate care they received or the ease of access.

> *FG 8: [through an Interpreter] the service is very good and actually they are really thorough in the care that they provide. The staff here are kind and respectful. In Syria it takes a long time to get an appointment to see some of the doctors. The UK is safe and I'm happy that I can see a doctor quickly. Last Wednesday I told the doctor that I'm feeling drowsy and was afraid that I had anaemia. They did a test for bloods and ECG for the heart.*

Language support

Although some respondents could communicate in English, either fluently or in a limited way, we came across many who required an interpreter. Health services often used a telephone language service called Language Line which is commissioned and funded by the Health Boards. It is expected that when a person is unable to communicate in English they are offered this service.

> *HP 29: The use of Language Line is important. If you don't know what the problem is you can't solve it and then they keep coming back repeating the same thing.*

When translation was provided during healthcare consultations, either in person or via a telephone language service, this helped people feel reassured and understand the clinician's advice and treatment.

> *FG 7: [through an Interpreter] The British Red Cross have an interpreter who is available for us when we go to the GP or the dentist. We are very thankful that the Red Cross are here.*

> *FG 5: [through an Interpreter] When my wife was in labour the hospital provided me with information about induction of labour in Arabic. What is the procedure, what is the side effect and all these things in Arabic.*

Theme 1b: Beliefs of people seeking sanctuary about what hinders their access to services

Feeling their needs were not recognised by healthcare providers

Respondents described instances when they felt their health problems had not been acknowledged or were misinterpreted. They said their expectations of the service had not been met leaving them feeling confused and that their problems were not taken seriously. In some instances, respondents made repeated visits to the GP or accessed unscheduled services seeking the care they believed was needed. Some suggested that the service was poorer because it was free, recalling that paid-for healthcare in their home countries gave patients who could afford it a better experience. They cited instances where care providers' behaviour made them feel judged, or that their intellect was questioned. It was unclear whether these attitudes were due to a mismatch of expectations, to their immigration status or resulted from communication difficulties and unfamiliarity with the UK healthcare structure. Respondents also expressed fear of healthcare services as 'authorities' with unknown powers.

> *FG 2: I'm in pain but they don't believe. There is nothing. They just give me medicine. Nothing, you know. So by chance I found, oh my God, it's because of my feet. It's flat feet. I found myself.*

> *FG 6: [through an Interpreter] I had a bad experience. I called 111 because my child had injured his eye so they told me, it was three am in the morning, "If you don't bring her to the hospital we are going to have to call the police." So I got nervous and I called the neighbours because they have car to take me to hospital.*

Language barriers

We heard many stories of practitioners and patients relying on body language, limited English, Google Translate, or children and relatives to translate. In some cases people said they were sent home from hospital without treatment after making a difficult journey because the hospital was not able, or willing, to access Language Line or find an interpreter.

Although it was clear that these people seeking sanctuary were well informed about available services, a large number said they could not easily access what they needed due to language and communication barriers. This meant they lacked confidence and were easily confused about the best way to access care which they or family members needed. It also reinforced any sense of disempowerment associated with their arrival in Wales.

> *FG 6: [through an Interpreter] if I had an emergency I couldn't call 999, how would I speak to them, they wouldn't understand me in Arabic. I would have to speak to them in English, which I can't and that's not good.*

Feeling anxious and unwell made the language barrier greater, even for respondents with reasonable conversation skills. Several respondents recalled instances where they did not receive information or did not understand fully what was said resulting in errors in diagnosis or medication. Some also felt that health professionals who neglected to arrange an interpreter were signalling that they did not take the patient's needs seriously.

> *FG 6: [through an Interpreter] I would not rely on body language or Google Translate because most of the time it translates things and it doesn't translate what you want to say and I wouldn't risk it. You are not just buying a can of beans; you have to really communicate your message so that he/she knows what you are talking about. This issue must be taken more seriously. I spent two hours booking an appointment, got it eventually, went to see the doctor and he used Google Translate. The doctor thought the problem was with my throat but it was my foot.*

We came across one situation relayed in a focus group, about a 12-year old Syrian refugee who had been referred to hospital to repair damage caused by a bullet wound. Her parents had not been provided with a translator and were not aware what was going to happen during the visit. Consent to operate was taken from the child. The parent was very distressed about the incident.

> *FG 5: [through an Interpreter] I ask them for an interpreter but they [hospital] said your daughter knows English so there is no need for an interpreter. The doctors think that my daughter would understand the situation and they took her consent. I made a big mistake, next time I will not allow them to do anything, without an interpreter, I have to understand what is going on.*

Patients' access to services was further undermined by sparse use of interpreting services outside the consulting room. GP and hospital receptionists did not routinely have access to Language Line and places like opticians and pharmacies had never heard of or used telephone interpretation services, respondents suggested.

Out of pocket expenses

Asylum seekers (and to some extent refugees) had limited access to finance which meant that people had little or no money to pay for transport to travel to appointments. Some asylum seekers were aware they could claim back travel costs with the HC2 form, if they were eligible, but there were often delays in receiving the form. Reimbursements only covered the patient and not the parent or relative attending with them for support or interpretation. Some respondents who were asylum seekers wanted to register with a GP or dental practice nearer to their home, but some thought (erroneously) that this was not possible without a Home Office agreement letter for a change of GP. Also, dental surgeries were not always able to take on NHS patients.

> *FG 4: I was living in [X] now I am living in [Y], you know, so I wanted to change my GP […] but I haven't got any letter from Home Office.*

The money for non-prescription medicines could also be difficult to find when some people seeking sanctuary were asked to purchase basic medication such as infant paracetamol or hay fever tablets. Respondents said they often had to choose between healthcare costs and food costs when planning spending.

> *FG 5: [through an Interpreter] I don't have even have enough money to eat and provide essential things for my family, and I have to spend most of this money on travel going in and out of the hospital with my wife.*

We came across one respondent who was a destitute asylum seeker. He was under the impression that he would not have access to a GP or dentist and was reliant on the pharmacist for his care needs. At one time he was suffering from tooth pain and had paid £60 to a dentist to have the problem resolved; local church parishioners helped cover the cost.

Theme 2: Views of people seeking sanctuary of the role of primary and secondary care health services in enabling their health and well-being

Treating healthcare needs

Expectations about healthcare services among people seeking sanctuary in these focus groups were mixed. Some were satisfied with the care that they received and understood how to access care they needed. People from countries with poor health service provision generally viewed UK services as being of a good standard. Respondents understood that access was through their GP practice. Some were happy to do this whilst others were frustrated by this arrangement as in their home country access to specialists may have been direct. These respondents could not understand why they could not access specialist care directly, or why pharmacists could not prescribe medication, as often happened in their own countries where healthcare was usually private.

> *FG 1: We wanted to see a doctor but the nurse checked my wife and found the problem [thyroid condition] and gave her tablets. After two or three weeks the problem happened again and they gave her a course of more tablets. We ask for a specialist to resolve the problem and not just to give tablets. This is not good treatment as we need a [specialist] doctor to solve the problem with the blood test and find out what is the reason for the hormone decreasing.*

Others thought that they could get access to a specialist if they bypassed the GP and went straight to A&E. Many focus group participants when responding to a hypothetical scenario were not aware of the out of hours GP service.

> *FG 7: If he has high temperature in the night I would calling the hospital.*

Expectations around care varied among respondents. Some complained they were not given medication or given a generic medication instead of medication prescribed from a specialist, who they thought would have the solution for their problem and help them to recover quickly. There was a sense that some respondents from different cultures expected medication and felt it showed a proper level of care. These remarks suggested that some respondents' satisfaction was related to the care they were used to and expected, rather than indicate inadequate treatment actually received.

> *FG 8: [through an Interpreter] As Arabs, we like medication for any condition, we like medication. Medication is like sweets, people like to pop in their mouth. You look in any woman's handbag and it's full of tablets.*

Views on mental health needs

Respondents were happy to talk about mental health when it was presented in a hypothetical scenario. In this context, they could recognise behaviours and feelings associated with mental health problems and the links to stress caused by the isolation and uncertainty of their status.

Some were also willing to talk about their own experiences of needing help for mental health problems, for themselves or more often their family. Most tried to care for family members themselves at first, encouraging people to talk, trying to find good food or giving people comfort and a sense of security. Many reported seeking reassurance in their religion or religious community. They generally talked about feeling sad or unhappy rather than feeling mentally unwell. A few felt that mental health was less important than physical problems; the priority was to have food and security.

> *FG 2: mental health, actually they are just depressed but mostly if they can eat, they can walk, you know, nothing serious.*

Those that did seek GP support had experienced a long wait for counselling and psychiatric help, although this is likely to reflect the experiences of the general population. Respondents who had received counselling either through primary care or voluntary sector organisations felt it was too short and they continued to need support after it had ended. There were also those who were receiving mental healthcare but continuity of care could not be maintained due to Home Office policies around dispersal.

> *FG 3: When he'd [son] been in like England, he was seeing them [for mental healthcare], so afterwards when I come here [Wales] we told them from beginning time, many times [that he needs mental healthcare], but they didn't do anything. They said you've got to make a routine for him and then make it like a monthly and come to us then we can do it [make a referral]. But I, I can't do like this. I have shown him [GP] lots of like pictures, what he [son] doing, any time he can be angry or any time he can be like self-harming, slapping himself, ourselves, taking off all of the clothes sometimes, but they will not respond.*

Some felt there wasn't enough help for people whose poor mental health was linked to experiences of trauma and that services were unsure how to arrange that care.

Views on self-care

While respondents were mostly regular users of healthcare services, they also understood and practised self-care. They described remedies for treating minor ailments and injuries, such as bathing a red eye in cold tea or using herbs and vinegar to treat colds and fever. They said they took care to dress appropriately for the weather, eat fresh food when they could and take exercise. Women mainly walked but many of the male respondents were more active and visited local gyms to keep fit if they had free access or the cost was subsidised. Respondents in focus groups mentioned volunteering, dancing, music, talking to family and friends and keeping busy as ways to protect against mental health problems. Respondents appeared to understand they should only use healthcare services when they were genuinely ill and needed to take responsibility for their health where they could.

> *FG 2: You need to look after yourself because you cannot easily get access to the GP so you have to make sure that you stay healthy enough. You are taking care. Like say with food, you need to understand if you're sick...So I need to look after myself.*

Theme 3: Primary care professionals views on enabling access to and use of health services by people seeking sanctuary

Among primary care practitioners, there was a variety of experiences depending on whether their role was dedicated to supporting people seeking sanctuary or whether they treated them as a patient who was resident in their catchment area.

Specialist and support workers with access to specialist support services

This group had most knowledge and experience of people seeking sanctuary and provided clinical and support services which were delivered in places and at times to best meet clients' needs. As a result, their role was to help people seeking sanctuary navigate the system, to the benefit of patients and providers. These services would often work together and try and co-ordinate care.

> *HP 22: they'll [people seeking sanctuary] often go from organisation to organisation trying to seek help. [My role] is just trying to coordinate that, to make sure that they are getting the right help from the right people*

> *ISW 3: We've been running for quite a number of years this monthly Health and Well-being meeting. The asylum seeker nurse attends, we attend, Welsh Refugee Council, Red Cross, sometimes Clearsprings, Migrant Help, SEWREC who runs the housing, it is focused on their [people seeking sanctuary] well-being…so we're talking to each other and sharing information.*

A GP who provided care directly to people seeking sanctuary said the flexible arrangement within the specialist service she worked in allowed her to provide a service which matched their needs. She perceived her role as wider than a purely clinical one, incorporating support and counselling skills which the organisation facilitated. In her opinion it was very different from mainstream general practice because the resources there did not match the needs of people seeking sanctuary, she explained.

> *HP 25: we have more than one function. It would infinitely overwhelm any mainstream GP who's already overwhelmed already... e.g. missing appointments, appointment length, use of Big Word [interpreting service], the extra mile that you have to go to, to arrange same day investigations. All the letter writing and phone calls that we have to do with various third sector organisations. It's a very very different job, no doubt.*

At least one of the specialist services also had full time access to interpreters, which supported people seeking sanctuary to access to all the services they provided.

Support workers and voluntary groups, particularly those supporting Syrian families under the VPRS, made big efforts to enable better access to healthcare for people seeking sanctuary. They were often in very regular contact and arranged many of the healthcare contacts, along with looking after other social and practical needs. While these appeared to be very beneficial for the families affected, they took a lot of time and energy and in one area the number of volunteers declined over time. One respondent also suggested these specialist roles enabled commissioners not to provide improved asylum seeker and refugee services within mainstream provision.

> *ISW 1: Because we're supporting, they [Health Board] expect that's something that we're going to pick up, rather than them [Health Board] having to find a way of helping the refugees.*

Primary and community healthcare providers with limited or no specialist resources

Primary and community healthcare providers lacked resources and support to deliver care to people seeking sanctuary. Although their clinical skills matched the role they provided, many said they felt they needed more time or additional colleagues to deliver care to the numbers of people attending their clinics. They recognised that people seeking sanctuary had complex needs which, with the frequent language barriers, meant that appointment slots were too short. They also experienced cultural differences, such as men not being permitted to treat female patients, different parenting expectations and female genital mutilation (FGM). While not barriers to basic treatment in themselves, these issues made it difficult to manage resources because extra time or other staff were required.

Non-clinical staff, such as practice managers and receptionists, were usually the first staff to greet people seeking sanctuary and manage their entry to the healthcare system. Challenges they reported included supporting them with necessary paperwork, finding appointment slots they could attend using public transport and managing missed appointments. While some individuals said they felt a strong moral and humanitarian responsibility to help, they admitted they were under-informed and under resourced in many situations. One respondent mentioned that it was surprising that although people seeking sanctuary required time and resources they were often invisible in routine planning and review processes.

> ***HP 9: We have clinical meetings every Monday, where the doctors talk about certain cases, often complex cases and, you know, very, very rarely do asylum seekers get mentioned at those meetings or anything, and just perhaps they stand out a bit by their absence, which is a shame.***

Primary care providers who delivered specialist care, such as midwives or specialist nurses, spoke about the difficulties of maintaining continuity of care. One challenging area was reported in TB management, where language barriers often hindered patients' attendance or compliance with medication (necessary to receive full TB treatment). Staff reported different strategies to help them manage, sometimes alternating between kindness and sanctions in order to deliver necessary clinical care. They also tried to make transport arrangements and process expenses forms to enable patients to keep future appointments although this took time away from seeing more patients. Staff said they tried to maintain close working links with local specialist staff but often did not have the time to do this and cover all their appointments, especially since recent increases in numbers of people seeking sanctuary in parts of Wales. Often they did not know their patient would be an asylum seeker or refugee until they attended the appointment, which gave them no time to prepare. This usually meant interpreters were not quickly available or further appointments were needed because patients' needs were too complex. This was also the experience of GPs and the 999 emergency care service where patients were perceived to have been provided good care but not what was needed for the patient.

> ***HP 16: some patients definitely end up in hospital inappropriately because of difficulties in communication, either establishing exactly how severe their complaint is or just the timeframe of getting translators and things involved and trying to find an alternative pathway especially for patients who haven't registered with GPs. So though they don't always get the most appropriate care, they definitely still get the same good standard of care.***

Language was a widely reported barrier. Few non-specialist practitioners said they had access to high quality translation. Many admitted knowing little about how to access interpreters or make use of Language Line. Specialist support workers mentioned struggling with health services to ensure interpretation provision was available. Some providers said they asked family members to translate, even though they recognised this could compromise patient confidentiality.

> *ISW 1: We've made it clear to the GP that she needs Language Line over and over again. She [patient] doesn't have a clue what's going on and they asked her husband to interpret for her, which I don't think is right. She has the right to privacy if she doesn't want her husband to know what she's talking about. We've contacted the local Health Board and explained to them. They've been in touch with the surgery and outlined exactly how to use Language Line. They've [GP] then asked the patient to pay for it themselves. The Health Board has told them no. The Health Board is paying for it. The patient is not expected to pay for it. This went on for quite a few months, where they were still refusing to provide Language Line.*

Another support worker reported witnessing people being asked to wait for mental healthcare because they were not yet proficient in speaking English.

> *ISW 1: I have one family who have been through an extremely high level of torture and both adults, and I've been trying and trying to get them into the mental health services…The GP said there's no point referring to primary mental health because they wouldn't have a clue how to deal with this kind of thing. And there was a period where the psychiatrist kept passing the referral back to primary mental health. Primary mental health were saying we wouldn't know how to work with them and passed it back to the psychiatrist. This went on for a long period. And just recently the hospital said, oh, I feel they should improve their English before we can see them.*

Even those who used Language Line reported difficulties because it was slow and of unpredictable quality. They also found it difficult to read emotions and body language through interpreted conversations. It meant that consultations felt superficial for clinicians.

> *HP 10: You feel very detached from the patient and from the interpreter when you're using a telephone.*

Theme 4: Level of awareness among health professionals of the care needs of people seeking sanctuary

Awareness and understanding of the care needs of people seeking sanctuary appeared to be linked to the amount of experience that staff had of the patients they treated. Some had gained considerable insight into the past and present circumstances of individuals such as their lack of income or no right to work for asylum seekers, or for those who were refugees, the struggle to secure paid income or appropriate training. Some said they had sought informal training, usually through the specialist asylum seeker and refugee staff or the Health Board had commissioned training for certain staff. They asked for more information about the legal procedures and entitlements for asylum seekers and refugees and information about the backgrounds and experiences of cultural and national groups.

> *HP 20: Well, it's just the confusing element of it, so when people are coming in they're getting confused and I think sometimes it creates a problem where like for example, the woman that puts the registrations on, she handed me some back the other day because I'm the one that speaks to the Asylum--, there's like an asylum seeker nurse…so I'm the one that like emails X and stuff and the lady basically handed these forms back and said, "Oh these have ticked that they're refugees, they need proof--, they might need proof, or they might need to go through X." But then when I asked my manager, they're like, "No, it's not, they don't need any sort of proof, they don't need any sort of paperwork, we shouldn't not be registered them because of that." It's just--, I think it just confuses things a little bit.*

Many respondents recognised the mental health needs of patients', particularly those who had undergone traumatic experiences to reach the UK. Within normal primary care services, many respondents said people seeking sanctuary would not have routine access to mental health services. While some specialist services offered counselling (through interpreters if necessary) and group activities focused on well-being (gardening, painting, exercise in a safe place), these were often not accessible to respondents if they spoke little or no English in most primary care settings, nor were services such as exercise referral schemes or social prescribing opportunities utilised.

> *ISW 3: Yeah, and we did a bit of art for the winter, just painting. One afternoon, eight guys painted for two hours, silence, they all just painted and it was quite calm and soothing. I think the NHS is unable to deliver some of those things in reality. We're not necessarily client based here [centre supporting people seeking sanctuary], we're more relational.*

It appeared that primary health services understood they filled an important role, responding to the health needs of individuals which were shaped by their often traumatic previous lives and the challenges of settling in a new country and also determining their health experiences into the future.

> *HP 9: Once they are here, we have to make sure they get the services they need. Ultimately if they are not able to access primary care, then the burden will fall on secondary care and people are going to end up presenting to A&E very unwell.*

Theme 5: Impact of social determinants on health of people seeking sanctuary

Healthcare professionals suggested that the lack of adequate services, combined with socio-economic determinants such as social isolation and uncertain, and inadequate housing conditions for many asylum seekers, contributed to their poor mental and physical health. They would often present with insomnia, back pain and stomach complaints which resulted in missed appointments.

> *HP 25: They bring their trauma with them, that that usually manifests itself as PTSD symptoms, mild, moderate and severe. And that's from past experiences. And in addition to that, I think what happens when they arrive [here] is that they face two main problems. One is the social isolation that comes with being removed from your usual community and not being able to work. So the right to work is removed and therefore they don't have an awful lot to do to occupy themselves. So social isolation is a big factor that affects their health. And the other one I would say was the uncertainty and the hostile environment created by the Home Office around their housing stability and the uncertainty around their asylum, the time for their asylum case to be heard is a big deal. Those two factors obviously factor into their mental health but also their physical health so we see a lot of gastric upsets, a lot of physical manifestations of stress. From having those two issues some people don't eat well or sufficiently so we see people who are underweight or who have gastric problems from becoming quite hungry, many asylum seekers struggle with sleep so don't always turn up on time to their appointment.*

Challenges for clinicians delivering care were varied. They spoke of the difficulties in getting people to open up emotionally and talk about causes rather than symptoms. They perceived that some people seeking sanctuary were very demanding of the health service, not always attending promptly or requesting services which were not available. The circumstances of people seeking sanctuary presented the greatest challenge for practitioners though. For example, asylum seekers were liable to be moved without warning, which disrupted continuity of care. This combined with the complexity of people's situations and needs to create a very challenging situation, explained one respondent.

> *HP 28: The language barrier is the tip of the problem. Quite often there's a language barrier which is massive, so they're not sure where to go, who to speak to. They've been dispersed several times, they might have been denied asylum several times, and they're supposed to go back to their country and they're too frightened. So they become destitute and homeless and they just sofa surf or, you know, they've got lots of vulnerabilities haven't they. They're vulnerable because that's why they're seeking asylum in the first place, so there might have been lots of trauma. And then all these other vulnerabilities, in my case if they're pregnant, that's another one, they're homeless, they're scared, they might be fleeing domestic violence, honour-based violence, FGM. All these vulnerabilities makes them even more vulnerable and then they're just frightened to access healthcare 'cause they don't know where to go. If they've got really high-risk pregnancy and health issues, I write a letter to the Home Office explaining my concerns and can we keep them here but they don't always agree.*

Some people seeking sanctuary confirmed that they were stressed and frustrated by their situation in the UK – inadequate housing, split families, poor health, isolation and legal insecurity. These respondents recognised that the stress of their lifestyles was making them deeply unhappy and potentially very unwell. Very few talked about the journeys they had made to seek asylum, but their frustration about the many uncertainties in their lives did appear to take an emotional toll, as this respondent articulated.

> *FG 5: [through an interpreter] the experience that I have is killing me every day.*

Discussion

Summary

This mixed methods study sought to understand how people seeking sanctuary access and experience healthcare in Wales by exploring their views alongside those of health professionals, support workers and volunteers. We began by researching the literature and developing an evidence map. We also collected survey data from 210 people seeking sanctuary, and qualitative data from 32 health professionals and volunteers through semi-structured interviews, and 50 service users and seven support workers and volunteers through focus groups. This is a rare study reporting experiences from multiple perspectives and the largest of its kind in Wales.

People seeking sanctuary who took part in this study identified barriers and enablers to accessing healthcare. These were primarily language issues and social issues including low income, lack of family support, childcare issues, inadequate accommodation and asylum status. These also affected their quality of life.[33, 42-44]

Strengths and Limitations

This is the first study in Wales to collect the views of asylum seekers and refugees alongside those of health practitioners with experience of their needs. The resulting data from across Wales highlight the challenges of responding to these individuals and opportunities for improvement.

Although this was a mixed methods study, due to tight time constraints we were unable to take full advantage of the opportunity of using the results from each of the methods to inform the other. We conducted the mapping exercise in parallel to the survey, focus groups and interviews with health professionals. Survey data and interview and focus group data analysis followed after data collection was complete. We have synthesised the findings from all of the data collection methods in this discussion.

We successfully surveyed 210 people seeking sanctuary; focus groups included 50 people seeking sanctuary; and we interviewed 32 health professionals and volunteers. This report gives a broad and rich insight into the health of those who have sought sanctuary in Wales. As there is no accessible sampling frame for them, however, we recruited our samples opportunistically through our study partners. We cannot generalise our findings to all seeking sanctuary. In particular we recognise that we may underestimate barriers to accessing services, since those using services were more likely to participate.

We did not comprehensively seek the views of policy makers or commissioners due to resource limitations. This report has aimed to make feasible recommendations, but we acknowledge that ongoing work with policy makers and commissioners is required to implement these.

Below we present the themes drawn from the research

Themes arising from the research

Theme 1: Beliefs of people seeking sanctuary about what helps and hinders them to access services

Specialist Services and Role of Voluntary Sector Support

Asylum health services, support workers and volunteers were highly valued by asylum seekers and refugees. Their involvement smoothed the way to health provision and reduced pressure on already burdened services. They were on hand to deal with crisis situations, sometimes even out of hours when most people had little or no available support.

This also links to the issue of trust. Our success in gathering such a large sample is due to our collaboration with voluntary sector organisations, who have already been able to foster a high level of trust with their service users. In addition, the peer researchers were able to harness their existing links with the community to gather data. This reflects the importance of trust in access to services.

Survey respondents who had indicated a wish to take part in a focus group and provided their written contact details on the survey were contacted by telephone to attend a focus group. The response was surprisingly low however, with only 6 people attending focus groups through this method. The majority of focus group participants were identified through third sector support organisations (British Red Cross, EYST, WRC, DPIA), support workers or Croeso community sponsorship groups.

Access to Services

Asylum seeker and refugees also struggled to make appointments over the telephone.[15] The survey results showed less than 40% of respondents found it straightforward to make appointments. Some resolved this issue by making appointments in person and then waiting in the surgery until the appointment was due. This was an added burden for those having to juggle childcare responsibilities. For some it was a choice between taking children to school or seeing the GP. The study also provided evidence of out of pocket expenses – particularly transport and childcare costs - raising a barrier to health services.

There were differences in barriers to access between asylum seekers and refugees. While this is an area that warrants further investigation, this is likely due to the correlating differences in amount of time spent in the UK. Resettled refugees had spent significantly less time than other refugees or Section 95 asylum seekers, who had in turn spent less time in the UK than other asylum seekers. Far fewer resettled refugees reported finding registration, and booking an appointment with a GP easy, compared with other respondents, namely other refugees and all asylum seekers. This could be linked to levels of English language: while 25% of respondents to the questionnaire could not communicate in English with a health professional, the figure was much higher amongst resettled refugees (64%). The correlation of these findings with the amount of time spent in the UK suggests that efforts should be made to provide introductory information about what NHS services are available and how to access them as early as possible after the arrival of a person seeking sanctuary, in their own language wherever possible.

Language and Communication

People seeking sanctuary reported speaking a diverse range of languages, with least 24 different first languages identified by survey respondents. People seeking sanctuary in the focus groups strongly believed that using an interpreter during health consultations was paramount to ensure a correct diagnosis and treatment. A quarter of respondents to the survey could not communicate in English with health professionals, demonstrating the need for appropriate interpreting services, coupled with the need for access to English as a Second Language provision. Only some asylum seekers and refugees were readily offered Language Line or a face-to-face interpreter.

From our survey, over 80% of respondents received an adequate interpretation service, with similar proportions reporting dissatisfaction in both telephone and face-to-face interpreting services. Research has shown that despite formal interpretation services being provided to primary health practitioners, clinicians often do not use them.[45,46] We found that many health practitioners did not know if a patient was an asylum seeker or refugee ahead of their appointment and, more crucially, whether they needed interpretation services until the time of consultation, reducing their ability to make appropriate provision. Flagging up patients' needs in their notes, particularly for interpretation services, could reduce cancelled appointments or patients being turned away from services, and support appropriate service provision. Training for non-clinical staff such as receptionists and appointment managers would help improve and mainstream this practice.

Teams carrying out initial health assessments used language services but mainstream NHS services in primary, community or secondary care, found interpretation variable. There was concern about the quality of the interpretation service, particularly the professionalism of interpreters, accuracy of interpretation, and need to explain complex medical terms[15]. Access to appropriate and sound interpretation is crucial to gain informed consent and facilitate joint decision-making in care.

Professionals complained that using an intermediary when communicating with patients hindered the process and value of consultations. The accuracy and the quality of interpretation are important since nuance and tone are known to affect how a message is conveyed and advice taken.[47] Language services were also only limited to consultations and not available to all frontline staff such as primary care receptionists or community practitioners including pharmacists. These staff are often asylum seekers' and refugees' first contact with health services, when anxiety and illness can make them most confused and vulnerable. Trained and informed staff could potentially enable more effective and appropriate use of health services by asylum seekers and refugees.

Much of the available health literature and appointment letters were provided in English and Welsh, while information around maternity and pregnancy needs, flu vaccinations and diabetes were available in several languages. We found fewer than half of asylum seeker and refugee survey respondents said they could read English well and 14% said they could not read their own language very well. In asylum seeker and refugee focus groups, respondents suggested using technology to widen access to multilingual information. Ideas included: health information in all languages provided online, for people to download or print as required (also overcoming cost implications of producing leaflets in multiple languages); and adding an audio-link to information for those unable to read.[48] These ideas potentially widen access to information, particularly for older migrants and others used to an oral culture.[49]

Theme 2: Views of people seeking sanctuary of the role of primary and secondary care health services in enabling their health and well-being

Understanding of entitlements and awareness of available services

In general, the results portrayed appropriate and responsible use of health services in daytime hours. The majority of respondents to the questionnaire were registered with a GP, and the focus groups demonstrated an understanding of the need for self-care. However, less than two thirds of respondents were aware of the full range of entitlements provided by the HC2 certificate, with refugees significantly less likely to know about HC2 certificates than asylum seekers. Even amongst asylum seekers, 1 in 5 did not know about the HC2 certificate, despite all asylum seekers being eligible for it in Wales. This would serve to exacerbate the barrier to healthcare presented by out-of-pocket expenses. Day time NHS services had been used by 66% of respondents, compared with 28% having used out of hours services.

The drop in the levels of awareness regarding out of hours of services available is concerning, with almost three quarters of people seeking sanctuary not knowing how to access out of hours GP services. While the pharmacist ranked very highly in daytime hours, with 67% knowing how to contact, awareness of how to contact the pharmacist out of hours dropped to just 19%. Responses in the focus groups suggested that respondents used the 999 ambulance service or the Emergency Department for urgent out of hours care. The 999 emergency service topped the list of most well-known healthcare services selected by survey respondents, however 47% had not heard of 111/NHS Direct. This points to a need for information to be shared with people seeking sanctuary, particularly regarding out of hours services. Information about which health service to use and for which needs should be tailored to the asylum seeker and refugee population.

In addition, there were significant differences in the awareness and accessibility of services between men and women, demonstrating that sanctuary seeking women are generally more health literate than their male counterparts. For example, women were much more likely than men to know that healthcare is free in Wales and in general knew more about NHS services, particularly health visitors, maternity and antenatal services, and interestingly, out of hours GP services. Women were also more likely to have consulted in the last three months on behalf of their child. This may be linked to the finding that women were more likely to report that health visitors had helped them to access health services in Wales. Conversely, for women seeking sanctuary in Wales, caring for children or dependents also presented a barrier to healthcare for women more than men, indicating the impact of looking after dependents on their own healthcare access.

Theme 3: Primary Care Professionals' views on enabling access to and use of health services by people seeking sanctuary

Capacity of NHS Services

As noted above, specialist NHS services were greatly appreciated by people seeking sanctuary and health professionals themselves also recognised the opportunity for tailored person-centred care provided by these services. The majority of respondents to the questionnaire had attended an initial health assessment on arriving in Wales, suggesting that this service is essential as an entry point to wider health services in Wales. Furthermore, the asylum nursing service was the most popular response to the question 'what or who has helped you to access health services in Wales?', emphasising the value of specialist services. These services also have the opportunity to work together to try and co-ordinate care.

On the other hand, mainstream primary and secondary healthcare providers reported many challenges in adequately meeting the needs of people seeking sanctuary. While some of these challenges may be met through improved learning and development for staff (see below), there is also an issue of capacity, with providers reporting lack of resources to deliver longer appointments for example. In hospitals, multi-lingual staff were often sought from across departments and asked to interpret for patients. This proves inefficient for the NHS as a whole. This may be due to insufficient visibility of the needs of people seeking sanctuary in planning systems. Our findings point to the need for specialist services, working alongside existing mainstream services, that can meet the specific needs of people seeking sanctuary. Specialist services would allow for improved, specialist knowledge and more time per consultation to allow for the needs of the person seeking sanctuary. This should be accompanied by training to increase understanding of how mainstream services can be more inclusive and accessible.

Mental Health

Mental health issues were reported by a significant number of survey respondents (10%). Mental health and well-being was discussed openly by most asylum seeker and refugee participants in focus groups, which is contrary to previous work suggesting many asylum seekers and refugees come from cultures where mental health is seen as a taboo subject and not discussed.[50] Although there were some exceptions among more recent migrants, who suggested a belief in God or other religious belief, keeping busy, hobbies and talking to others would relieve symptoms, many did recognise that this may not be enough and medical help would need to be sought if the situation deteriorated. They also acknowledged that mental well-being was an important aspect of being healthy but found it difficult to access mental health services when needed.[51] As well as experiencing long waiting times when they sought help, additional barriers were encountered such as not being able to receive care through an interpreter.[16, 22] Good mental health is known to enable effective coping strategies during stress points and transition periods in people's lives[16, 52] and is likely to enable asylum seekers and refugees to integrate more successfully into new communities. In particular, there was evidence demonstrating the need for a clear referral route to Child and Adolescent Mental Health Services (CAMHS) for children displaying the effects of trauma, such as disturbed behaviour, to avoid potential escalation of need and the subsequent impact on resources. Examples of accessible mental health counselling were reported, such as group or one-to-one counselling through an interpreter. Community health initiatives facilitated by third sector organisations and volunteers were reported to reduce isolation, promote wider well-being and reduce the impact of trauma. Examples in Wales include the African Community Centre in Swansea.[53] Commissioners and service providers should look to support innovative ways of promoting mental well-being and preventing poor mental health by delivering care for mental health and well-being in asylum seeker and refugee communities, especially for children and young people as in Wales, third sector provision does not currently cater for this group.

Theme 4: Level of awareness among health professionals of the care needs of people seeking sanctuary

Visibility of the needs of people seeking sanctuary in health planning

It should be noted that this project found it difficult to engage health professionals in the collection of qualitative data. This points to a lack of visible champions of the cause of people seeking sanctuary within the health sector, which may in turn mean that people seeking sanctuary are not routinely considered in planning cycles. This issue was highlighted by one respondent.

Training

All health practitioners, support workers and volunteers recognised the need to understand the socio-legal context affecting asylum seekers and refugees in order to support their health and well-being. Whilst healthcare was reportedly being delivered on an equal basis and without discrimination, practitioners acknowledged lack of clarity around entitlements which affected their confidence and knowledge when treating patients and referring them to care such as social services or mental health services.[38, 40, 43] Lack of knowledge appeared to create de-facto barriers to care and support for asylum seekers and refugees and raises questions of resultant unintended discrimination in accessing healthcare for asylum seekers and refugees. Our findings echo other literature indicating the importance of widespread training for health and care staff.[33] As in other studies, we found few examples of training about seeking sanctuary and entitlements to healthcare as well as concerns about whether Health Boards could arrange such training. Often practitioners said they had gained knowledge 'on the job'.[43] We did find some imaginative steps to fill training gaps, such as specialist staff or the third sector organisations who came into regular contact with asylum seekers and refugees delivering ad-hoc sessions to NHS staff. Training for NHS staff should also be provided, to ensure they effectively redirect asylum seekers and refugees to the most relevant service for their needs. Equipping Health Board and primary care staff with clear guidance on entitlements and appropriate training would ensure that all practitioners and support workers are adequately prepared and confident and are able to take into consideration the particular needs and vulnerabilities of asylum seekers and refugees when providing care.

In a context of training, opportunities for sharing knowledge, experiences and resources across services seemed underutilised.[33] Health services, such as TB clinics or dental practices with close links with the local health assessment teams in dispersal areas, or voluntary sector organisations supporting asylum seekers and refugees, had knowledge and a better grasp of the changing situation at ground level than other staff. They were able to signpost people to services which could meet their needs or they used services they knew about as a resource for information and support. For example, school nurses in Swansea received training from a voluntary sector organisation EYST (Ethnic Minority Youth Support Team) to understand the needs of refugee children. This innovative practice has scope to be more widely applied. A number of practitioners mentioned that they had no exposure to asylum seekers and refugees, but were happy to receive training to increase their level of competency should they come across anyone in this situation.

Theme 5: Impact of Social Determinants of Health

Relocation

Both people seeking sanctuary and health professionals talked about the Home Office's dispersal policy, that often results in asylum seekers being moved, sometimes from where they have settled and started to access services, to somewhere completely new. The Home Office Statement of Requirements for the Asylum Accommodation and Support contracts awarded in January 2019 upholds that relocation should 'take into the account the general desirability of maintaining Service Users in an area in which they have become settled'. Under current guidance, pregnant women who are within six weeks of their due date, or who have given birth in the last six weeks must not be relocated unless there is clear benefit to doing so[54], although there are compelling calls for continuity of midwifery care to be maintained throughout pregnancy.[55] We found evidence that the dislocation and disorientation experienced by asylum seekers due to dispersal processes meant that people had to start over again, often repeatedly, and form new connections. In addition requests to relocate are at times made with very short/same day notice, leaving no time to inform new friends/community contacts, and leaving individuals feeling re-traumatised and dealing with new separation and loss without preparation. Safety needs are the foundation in care of any traumatised individual as identified by Skuse and Mathews in their Trauma Recovery Model.[56, 57] The policy also had substantial impact on continuity of care.[24, 58, 59] It contributed to complications, confusion and delays in treatment when medical notes were not read correctly and led to repeat visits. This is particularly challenging for people with chronic conditions, or for pregnant women, accessing maternity services. Health professionals reported having little influence over decisions made about dispersal and relocation. To protect continuity of care, essential for a streamlined and effective health and care service, the Home Office accommodation and dispersal services should give careful credence to letters from medical practitioners requesting a delay in dispersal to ensure treatment is completed before patients are dispersed.

Volunteering & Employment

Meaningful activity is well-known to impact on health and well-being of all groups.[61] Most asylum seekers do not currently have the right to work, so all of the respondents who responded that they were employed, either full- or part-time were refugees. However, this was just 11 out of 87 refugee respondents, pointing to the serious challenges faced by refugees in accessing the labour market. None of the respondents who were employed had come to the UK through a resettlement programme, although this likely tallies with the shorter length of time in the UK, and the lower levels of English language ability. While comparable proportions of all groups reported volunteering, resettled refugees were more likely, and refused asylum seekers less likely to be in education or training. The impact of opportunities to access meaningful activity such as education or volunteering, particularly for those excluded from employment warrants further study. However, the reduced access to education for refused asylum seekers is concerning as it points to further active social exclusion and a reduced ability to maintain resilience and good mental health.

Conclusions

People seeking sanctuary in Wales face barriers to accessing healthcare which lead to inefficient and inequitable provision. Language, resources and Home Office commissioned dispersal and accommodation for asylum seekers are the main concerns. Fortunately there is evidence of:

- A generally compassionate approach to providing care;
- Innovation by health professionals, support workers and volunteers to overcome challenges;
- Commitment to build on existing good practice; and
- Deployment of some additional resources to minimise healthcare inequities for refugees and asylum seekers in some areas of Wales.

This study adds to the evidence base on the health and care needs of asylum seekers and refugees and has led to robust insights into means by which improvements could be made which are listed in the recommendations section. Working with peer researchers from communities who are seldom heard increases the value of research such as that conducted for this study.

Recommendations arising from this research

In order to reduce barriers, improve access to services, and improve the experiences of people seeking sanctuary, we offer the following recommendations below.

We could support improved integration, health and well-being of people seeking sanctuary in Wales by:

Improving the ability of people seeking sanctuary to access health and well-being services by:

1. **Providing people seeking sanctuary in Wales with written introductory information (in their own language wherever possible) about their rights and entitlements to NHS services upon arrival.** This should aim to improve the awareness of the purpose and means of contacting NHS services, particularly out of hours primary care services and pharmacies.
2. **Improving health literacy of people seeking sanctuary, particularly through orientation support, advice, and translated literature.** Our study showed a high level of satisfaction with the voluntary sector as first point of contact for queries about services for people seeking sanctuary. This study notes the value of support workers in helping people seeking sanctuary navigate NHS systems. This benefits: patient well-being and safety (e.g. by encouraging preventative health, identifying chronic condition needs, avoiding potential medication errors, and explaining and encouraging treatment take up); promotion of healthy behaviours (e.g. smoking cessation); and reducing wasteful use of NHS resources such as emergency care. Innovative ways to raise health literacy through English language classes already offered (ESOL) could be explored**.** The NHS websites could offer translated material and an online query facility, for use on mobile phones or in libraries. As some people cannot read their own languages there is also scope for information available via videos and audio recordings.

Improving support for people seeking sanctuary in health and well-being settings by:

3. **Training health professionals on the social and legal issues affecting people seeking sanctuary, as well as cultural health issues and health status and infrastructure in countries from where people seek sanctuary.** Training should be aligned with the Welsh Government's 'Nation of Sanctuary' approach, to include equal care for people seeking sanctuary, regardless of whether they have arrived in Wales through the VPRS or through the asylum process, and care of refused asylum seekers. It should also include: Home Office policy and practice on dispersing and resettling people; differences between asylum seekers and refugees in legal status and entitlements and; financial constraints, e.g. on transport and childcare.
4. **Providing adequate and appropriate access to interpretation and translation services at all levels of interaction with health services, and training for health professionals to access this resource.** This includes assuring the quality and availability of teleconference interpretation services to ensure the safe and efficient delivery of healthcare. There is a need to provide clear guidance on the use of language services including the danger of relying on services such as Google Translate or children to interpret health issues. Flagging up patients' needs for interpretation services in their notes could reduce cancelled appointments or patients being turned away from services, and support appropriate service provision. Health Boards could explore innovative solutions to removing language barriers, such as interpretation via Skype call, or the use of appropriately supervised volunteer community interpreters face to face.

5. **Providing and promoting specialist services that meet the specific needs of people seeking sanctuary, especially in dispersal areas, including asylum nursing and designated health visiting services.**
6. **Providing accessible, foundation-level mental health promotion courses or resources, to encourage self-help and mental well-being and to prevent deterioration of mental health. This should be complemented by prompt access to adult primary mental health services or Child and Adolescent Mental Health Services where appropriate.** Mental health promotion should include supporting foundation level courses such as dealing with loss, trauma and resilience, parenting programmes and self-management or expert patient resources to support in available languages.

Employing a multi-agency approach to address the social determinants of health by:

7. **Liaison with the Home Office and the asylum accommodation provider to settle people seeking sanctuary in areas with diverse communities or explicitly committed to supporting people seeking sanctuary, where possible.** Those in welcoming communities have better access to, and experience of, primary and community health services and more opportunity to gain the skills and confidence to be independent. **Short-term, temporary placements should be avoided and the Home Office accommodation and dispersal services should give careful credence to letters from medical practitioners requesting a delay in dispersal to ensure treatment is completed before patients are dispersed. In particular, we recommend that no woman should be relocated in the last trimester of pregnancy unless that yields a clear advantage.** There is a need to address the instability caused by relocation at short notice, or at critical stages in a person's life e.g. pregnancy. Enabling continuity of care, in line with the Royal College of Midwives' 'Better Births' initiative, will allow mothers to build rapport with their midwives and gain crucial information, notably about the onset of labour and birth.
8. **Supporting initiatives to train people seeking sanctuary in legitimate volunteering roles such as peer supporters, interpreters or translators.** This will harness the skills of people seeking sanctuary to support new arrivals in a way that is culturally appropriate, benefiting both volunteers and service users. Such volunteering opportunities will also support access to the labour market for those granted leave to remain, and speed up integration.
9. **Continuing to ensure access to English for Speakers of Other Languages (ESOL) at the earliest opportunity, and Welsh when feasible, especially in areas with a high proportion of first language Welsh speakers.** Home Office funding available for the Vulnerable Persons Resettlement Scheme for this purpose is not available for asylum seekers or other refugees. Therefore we need to remove out of pocket financial barriers to attend language classes, particularly for asylum seekers, by providing crèche facilities or reimbursing transport costs, since the weekly allocation of £37.75 prohibits participation in many cases.
10. **Continuing to work with third sector partners to maximise support for those seeking sanctuary, including refused asylum seekers.** This should include providing information to enable effective signposting to health and related services, as well as legal advocacy and advice.

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Appendices

Appendix 1A: Evidence Map Search Strategy

Table 1: Eligibility Criteria

	Inclusion	Exclusion
Population	Adults or children who are: 1) Asylum seekers in high income countries (as defined by the World Bank) – persons who have claimed asylum yet to be awarded 2) Refugees in high income countries – persons who have made successful asylum claims 3) Refused asylum seekers awaiting deportation in high income countries	Adults or children who are: 1) Non-forced migrants – persons who have travelled to live for purposes other than asylum (e.g. primarily work or study) 2) Undocumented migrants 3) Persons seeking asylum or refugees residing in non-high income countries
Intervention (including face-to face, phone and online)	Any intervention provided by a healthcare service including: 1) Public sector: – Primary care and community services e.g. GP, dental care, psychological therapies, child health, family planning – Secondary care e.g. emergency care, in-patient hospital, outpatient care, genito-urinary/sexually transmitted disease services – Tertiary care e.g. in hospital surgical procedures or cancer management 2) Voluntary sector services e.g. counselling, drug misuse or rehabilitation services. 3) Private healthcare services	Interventions not provided by a healthcare service including the provision of practical, emotional or socio-legal support via social care or advocacy services).
Comparisons	Not applicable	Not applicable
Outcomes	Qualitative data regarding barriers and enablers to healthcare service usage. Quantitative data where appropriate e.g. numerical satisfaction scores, drop out or successful referral rates.	
Study Design/ Methods	Quantitative – any observational or experimental Qualitative – Ethnographic, phenomenological, narrative, grounded theory Mixed methods	Case studies, editorials, narrative or systematic literature reviews, or letters published in journals Abstracts Posters Thesis and dissertations
Limits	Full text peer reviewed articles published in scholarly journals English language only Published after 1st January 1998	

Table 2: Search strategy (adapted to specific requirements of data bases searched)

	Population		Services and personnel		Barriers/Enablers
Text terms	"asylum overstayer" OR "asylum seek*" OR asylum-seek* OR "Discretionary leave to remain" OR "Discretionary leave" OR "displaced people*" OR "displaced person*" OR evacuee OR "exile*" OR "failed asylum seeker" OR "Humanitarian protection" OR "Indefinite leave to remain" OR ILR OR "Person seeking asylum" OR "person seeking sanctuary" OR "Person with No Resource to Public Funds" OR NRPF OR "Person with refugee status" OR refugee* OR "Refugee status" OR "refused asylum seeker" OR "refused asylum-seeker" OR "stateless people*" OR "stateless person*" OR "unaccompanied asylum seeker child" OR "unaccompanied asylum seeker children" OR "uprooted people*" OR "uprooted person*" OR "victim of torture" OR "victim of trafficking" OR "war survivor*" OR "war victim*"	AND	health OR healthcare OR health-care OR "healthcare" OR "health service*" OR well-being OR "well being" OR well-being OR outpatient OR out-patient OR "general practi*" OR primary OR primary-care OR secondary OR tertiary OR emergenc* OR "emergency service*" OR EMS OR "emergency medical service*" OR support* OR "service prov*" OR "care prov*" OR acute* OR chronic* OR disab* OR "health personnel" OR medic* OR nurs* OR doctor* OR surg* OR physician* OR psychiatr* OR dental OR pharma* OR midwi* OR physiotherap* OR ambula* OR rehabilitat* OR occupational* OR "occupational therap*" OR charit* OR volunt* OR "voluntary sector" OR "third sector"	AND	access OR attitude* OR awareness OR barrier* OR challenge* OR dissatisfaction OR enabler* OR engagement OR experience* OR facilitat* OR "help seeking" OR help-seeking OR knowledge OR literacy OR motivat* OR obstacle* OR ongoing OR perception* OR perspective OR satisfaction OR understanding OR uptake OR usage OR use OR utilisation OR utilization

	Population		Services and personnel		Barriers/Enablers
Subject Headings	(MH "Refugees") OR (MH "Vulnerable Populations") OR (MH "Homeless Persons+") OR (MH "Medically Uninsured")	AND	(MM "Health Services+") OR (MH "Child Care+") OR (MH "Community Health Services+") OR (MH "Dental Health Services+") OR (MH "Dietary Services+") OR (MH "Emergency Medical Services+") OR (MH "Health Services Misuse+") OR (MH "Mental Health Services+") OR (MH "Preventive Health Services+") OR (MH "Rehabilitation+") OR (MH "Reproductive Health Services+") OR (MH "Women's Health Services+")	AND	(MH "Patient Acceptance of Healthcare+") OR (MH "Health Knowledge, Attitudes, Practice") OR "treatment adherence and compliance" OR (MH "Life Change Events") OR (MH "Health Literacy+") OR (MH "Patient Satisfaction+")

Appendix 1B: Results of Evidence Mapping – Sources and Summaries

Colour codes reflect the hierarchy of evidence described under Methods from highest to lowest:

Green: Systematic review Yellow: Literature review Red : Scoping review
Blue: Primary study

Primary care

Source	Summary of findings and authors' conclusions
Reference: Robertshaw L, Dhesi S, Jones LL. Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: A systematic review and thematic synthesis of qualitative research. BMJ Open. 2017;7(8):e015981. **Source type:** Systematic review: qualitative and mixed methods studies **Study population:** n = 357 healthcare professionals (194 nurses, 128 doctors and 35 midwives) **Outcomes summary:** Outcomes were based on the thematic analysis of interviews data. Interview formats included in-depth, semi-structured, structured and group. One study used qualitative questionnaires.	This study aimed to thematically synthesise primary qualitative studies that explore challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries. One barrier experienced by staff in building trusting relationships with service users included the inherently transient nature of refugees and asylum seekers. It was also found that refugees and asylum seekers sometimes suspected caregivers being involved with immigration authorities, which in turn compromised their trust in them. However, health professionals noted a number of facilitators to building trusting relationships including continuity of care, taking an active interest in service users' background and culture, and having a compassionate and empathetic disposition. Some caregivers also found that clear explanation of their role and confidentiality allayed suspicions. Language barriers were recognised as one of the main obstacles faced by professionals when giving care. While the use of interpreters was cited to facilitate communication, this itself also brought about its own unique set of challenges, including the additional time and expense required. Interpreters were found not always to be available, which led to delayed appointments, as well as family or other community members having to translate in place of professionals. Cultural understanding presented a large challenge for healthcare professionals. These included differences in cultural values such as gender roles and social taboos, often leaving professionals unsure of how to approach some tasks such as physical examinations. Refugees and asylum seekers understanding of host countries' health systems was also a big barrier for health professionals. Provision of care was

	often hampered by differing understandings of health and healthcare across cultures, with different terms being used for a single health condition, or some health concepts being unfamiliar to refugees and asylum seekers, such as preventative and mental healthcare. Health professionals reported that gaining knowledge about patients' cultures was an important facilitator in providing care, with the most important personal qualities to show deemed to be sensitivity, empathy and cultural humility. Health and social conditions of refugees and asylum seekers presented additional challenges to health professionals. Practitioners often felt unprepared to deal with the unique physical conditions and illnesses presented by refugees and asylum seekers, with some also expressing concern that this could lead to missed diagnoses. These included tropical conditions, such as malaria and schistosomiasis and physical injuries such as female genital mutilation. Professionals reported difficult psychological conditions, with the most challenging including trauma related to war, torture and other abuses. Care givers reported that the unique social problems of refugees and asylum seekers also presented difficulties, including postmigration stress, difficulty with the asylum and resettlement process, and social isolation. Facilitators cited as allaying some of the above problems were training in conditions common to refugees and asylum seekers, professional support from external organisations specialising in refugee healthcare, and careful history-taking of the medical, social, and migration backgrounds of patients.

Source	**Summary of findings and authors' conclusions**
Reference: Cheng IH, Drillich A, Schattner P. Refugee experiences of general practice in countries of resettlement: a literature review. British Journal of General Practice. 2015;65(632):e171-6. **Source type:** Literature review: qualitative studies only	This review aimed to describe the literature on the experiences of refugees and asylum seekers using general practice services in countries of resettlement. Access to services consistently emerged in the literature as something that refugees and asylum seekers struggle with. In particular, this was due to lack of knowledge about the health system with refugees and asylum seekers not knowing where to find a GP, how to make an appointment, how to access out-of-hours primary care, and how to register with GP services. Moreover, refugees and asylum seekers found the health system complicated and difficult to understand. Refugees and asylum seekers reported challenges with transport to and from services, as well as with the costs of medical care and medicines. Access was also hampered by visa entitlements or insurance programmes.

Study population: n = 864, both refugees and asylum seekers **Outcomes summary:** Responses to interviews with individuals, families or focus groups.	Language difficulties were commonly cited as a barrier experienced by refugees and asylum seekers. These included differences in spoken language, understanding written materials, completing paperwork and problems with the use of interpreters. Confusion was expressed about who is responsible for organising interpreters, with family members and friends frequently having to perform this role instead of a professional. The doctor-patient relationship was highlighted as something which refugees and asylum seekers frequently had concerns about. In particular, some felt that doctors were not interested in them and did not ask about their past experiences. Some also felt unfairly stereotyped or discriminated against and were afraid to go to a doctor as they felt unwanted or a burden on resources. However, refugees and asylum seekers also expressed preference of doctors who were friendly, welcoming and kind. They appreciated doctors who respected them as a whole person and were sensitive to gender, cultural beliefs and practices. Refugees and asylum seekers also expressed that they did not understand the nature of clinical assessment and that their pre-existing beliefs about health and expectations were not met. They were however welcoming of education and lifestyle advice but not at the exclusion of medicines or access to specialist doctors. The authors concluded by stating that more research should be conducted in each of the various countries of settlement, with an additional focus on specific ethnic groups. Support should be given to refugees and asylum seekers in how to access GP services, while GP clinics should also be supported in providing interpreting services for patients. GPs should be mindful in stereotyping patients and be sure to value them as individuals. GPs should endeavour to give clear explanations of unfamiliar clinical assessments and treatments that are consistent with patients' expectations.

Secondary care

Source	Summary of findings and authors' conclusions
Reference: Sheikh M, Nugus PI, Gao ZH, Holdgate A, Short AE, Al Haboub A, et al. Equity and access: understanding emergency health service use by newly arrived refugees. Medical Journal of Australia. 2011;195(2):74-6. **Source type:** Primary study: mixed methods **Study population:** n = 155, refugees (106 individuals of sub-Saharan African origin and 49 individuals of Middle Eastern origin) **Outcomes summary:** Responses to semi-structured telephone questionnaire.	This article examined the issues that affect newly resettled refugees in accessing an emergency health services. One of the major barriers identified in accessing emergency care was the perceived need by a large majority of participants (93%) for a doctor from their own ethnic group who could speak the same language. Qualitative data showed that a majority of participants would prefer to see a GP regarding a medical condition even if it was urgent, as they believed they would explain it in a more culturally relevant manner. While 92% of respondents knew how to call for an ambulance in an emergency, a large proportion were afraid to do so, even if it was required (21%). This was partly due to fear that police would come as well as, or instead of the ambulance, as they said happened in their home countries. Others explained that this was because they were worried that they would not understand, or be understood by, emergency staff. The authors suggested that to better facilitate access to emergency care, healthcare staff need to be trained to understand patient needs and how to explain procedures and diagnoses in ways they will understand. The authors also suggest that a more diverse workforce would aid in this regard. Finally, the authors recommend that policymakers should recognise the differences between ethnic groups, as refugees are often mistakenly considered as one homogeneous group. They state that identifying these differences will facilitate a better quality service and increase equity of access for refugees.

Maternity care

Source	Summary of findings and authors' conclusions
Reference: McLeish J. Maternity experiences of asylum seekers in England. British Journal of Midwifery. 2005;13(12):782-5. **Source type:** Primary study: qualitative **Study population:** n = 33, asylum seeking women only **Outcomes summary:** Responses to face-to-face interviews.	This study described the maternity experiences and problems encountered by 33 asylum seekers who were either pregnant or had a young baby in the UK. Several women had expressed difficulty in accessing maternity services, with no agency taking responsibility in directing them there, and some had been refused GP registration. Other obstacles included having no money for transportation to services and going hungry when the timing of an appointment meant missing set meal times at their hostels. Many women lacked information about maternity services and relied on word of mouth from other asylum seekers. The majority of women were not able to attend antenatal classes as they had not been made aware of them, because they had arrived in the UK too late during pregnancy, or because of a lack of interpreter services. Interpreters were also not available on the postnatal ward and for postnatal visits, and women had to rely on relatives, including children, to interpret. Most women reported positive experiences with the antenatal care they had received from midwives, however, labour and postnatal experiences were mixed. Negative experiences included indifference, rudeness and racism, describing some midwives as acting with disrespect for their individuality and disregard for their feelings. The authors conclude by suggesting that the challenges for maternity services are to ensure that discrimination is eliminated from the system and to work with asylum agencies to meet women's needs for information, interpreting and support.

Dental and oral health

Source	Summary of findings and authors' conclusions
Reference: Keboa MT, Hiles N, Macdonald ME. The oral health of refugees and asylum seekers: a scoping review. Globalization & Health. 2016;12:59-. **Source type:** Scoping review: qualitative, quantitative, and mixed method studies **Study population:** Refugees and asylum seekers **Outcomes summary:** Thematic analysis by review authors	This scoping review sought to synthesize the available evidence on the oral health of, and access to oral healthcare of asylum seekers and refugees. The review found a number of barriers for asylum seekers and refugees in accessing dental and oral healthcare. These included the healthcare policy of the host country, with some granting healthcare to all asylum seekers and refugees, but others limiting healthcare to only those who have been granted refugee status before arrival. Other factors which contribute to oral hygiene and practice included previous oral care experiences, while the process of migration and adapting to a new culture can influence the use of services. The authors concluded by stating that socioeconomic and cultural backgrounds are factors which can influence access to healthcare, with the literature showing limited access for refugees and asylum seekers. The authors recommend that these concepts are investigated further so that targeted interventions can be designed. Other barriers which affected refugees and asylum seekers in host countries included long wait times, high cost of dental treatment, lack of dental insurance and language barriers. The authors emphasise the urgent need for host countries to design and implement sustainable strategies to improve access to and reduce inequity in oral healthcare for refugees and asylum seekers.

Screening

Source	Summary of findings and authors' conclusions
Reference: Saadi A, Bond B, Percac-Lima S. Perspectives on preventive healthcare and barriers to breast cancer screening among Iraqi women refugees. Journal of Immigrant and Minority Health. 2012;14(4):633-9. **Source type:** Primary study: qualitative **Study population:** n = 20, refugees only **Outcomes summary:** Responses to one-on-one 30-minute semi-structured interviews.	This study sought to determine the perspectives of Iraqi refugee women on preventive care and perceived barriers to breast cancer screening. Some of the main barriers described by the women were psychosocial barriers such as fear of pain during mammography and fear of receiving a cancer diagnosis. Health consequences of war were also a factor in women not seeking help as early as they should. They described this as being due to the fact that they were so used to living in constant fear of death and violence that they do not consider their own personal health, even after relocating to the United States. Other common barriers included religious concerns relating to modesty, with women stating that they preferred female doctors. This however was not the main concern, with some women even stating that their faith compelled them to undergo any procedures that were beneficial to their health. The study acknowledged several limitations including its small sample size of only 20 women and the fact that it was conducted using a convenience sample in a health centre. Both of these limitations will affect the study's generalisability to the wider population. Other limitations were that participants' socioeconomic status were not considered and subgroup variations were not explored. The authors recommend that future research seeks a deeper understanding of women refugees' emotional trauma and mental health status, which could give insight into their motivation to seek screening. They also emphasise the importance of culturally appropriate education and need for outreach work to address the health needs of undeserved communities.

Immunisation and vaccination

Source	Summary of findings and authors' conclusions
Reference: Mahimbo A, Seale H, Smith M, Heywood A. Challenges in immunisation service delivery for refugees in Australia: A health system perspective. Vaccine. 2017;35(38):5148-55. **Source type:** Primary study: qualitative **Study population:** N = 30, stakeholders with an interest in immunisation service delivery, including, general practitioners, paediatricians, nurses, policy advisors, and health service managers. **Outcomes summary:** Responses to 40-minute semi-structured telephone interviews.	This study's objective was to examine the challenges in the provision of immunisation services in Australia to refugees by consulting with key stakeholders to inform strategies to improve vaccine coverage. Stakeholders included general practitioners, paediatricians, nurses, policy advisors, and health service managers. Five main themes emerged of challenges affecting immunisation service delivery. The first of these was variability in accessing funded vaccines outside of Australia's National Immunisation Program with different states having different levels of funding for vaccination. In particular, this put older children and adults at risk, as they might not have been vaccinated in their countries of origin. Similarly, a lack of a national policy for catch-up immunisation for refugees put this group at risk further. This was exacerbated by the fact that there was uncertainty amongst stakeholders on who is responsible for providing catch-up vaccines to refugees, with many experiencing frustration with inadequate referral pathways in this area. Another barrier to imminusation service delivery was the lack of a central register meaning that service providers were unable to check the immunisation status of refugees over the age of seven years old. This was also limiting for those in policy and planning roles as they were unable to measure the coverage rates at practice or health district level. Finally, there was an indication amongst some GPs that there was a lack of necessary training and expertise in the provision of catch-up immunisation in their profession. This was echoed by other stakeholders, such as those involved in policy and planning for refugee immunisation services, who felt that GPs often lacked the experience required to manage refugee-specific health issues. It was felt that this had resulted in incomplete refugee health assessments and deficiencies in the development and implementation of catch-up plans.

Mental health

Source	Summary of findings and authors' conclusions
Reference: Wong EC, Marshall GN, Schell TL, Elliott MN, Hambarsoomians K, Chun CA, et al. Barriers to mental healthcare utilization for US Cambodian refugees. Journal of Consulting and Clinical Psychology. 2006;74(6):1116-20. **Source type:** Primary study: qualitative **Study population:** N = 490, refugees only **Outcomes summary:** Responses to face-to-face semi-structured interviews averaging 2 hours in length	This study assessed the extent to which structural and cultural barriers to mental healthcare were experienced by using a probability sample drawn from the largest Cambodian refugee community in the United States. Of the structural barriers, it was found that a 80% of respondents cited the high cost of services as the main reason for not seeking Western mental healthcare. The next most commonly endorsed barriers by respondents were language problems (66%), difficulty not knowing where to obtain services (25%), and transportation (24%). Cultural barriers were less common with 15% of the sample saying that they anticipated racial discrimination, 5% saying they were afraid what others would think, and 5% saying that they thought Asian healthcare is better. The study's results run counter to those of some previous studies which say that cultural barriers to mental healthcare such as stigma and distrust in Western care are the most important obstacles to care. The authors recommend that further research into the structural barriers of mental healthcare are explored, as these have been previously overlooked and could provide further insight into this group's utilisation of services.

Sexual and reproductive health

Source	Summary of findings and authors' conclusions
Reference: Sudbury H, Robinson A. Barriers to sexual and reproductive healthcare for refugee and asylum-seeking women. British Journal of Midwifery. 2016;24(4):275-81. **Source type:** Literature review: qualitative and quantitative studies **Study population:** Refugee and asylum-seeking women **Outcomes summary:** Perceived knowledge of and barriers to sexual and reproductive health	Examined the barriers to sexual and reproductive healthcare for refugee and asylum-seeking women in the UK, as well as how related issues can be ameliorated by healthcare professionals. Health literacy was found to be one of the main barriers to sexual and reproductive health. This was due to both a lack of knowledge of services available, as well as in health education. This resulted in unfamiliarity in the importance of screening as well as incorrect knowledge regarding HIV and STIs. Cultural norms and expectations were also found to represent barriers to sexual and reproductive health for refugee and asylum-seeking women. Some women were found to have good knowledge of contraception, yet still reported a taboo in discussing this with their family or partners. Other cultural barriers included lack of contraceptive knowledge among male partners and health professionals making assumptions regarding refugee and asylum-seeking women, such as that they will refuse contraception. Communication and language problems were identified as another major barrier to sexual and reproductive health. Evidence found that interpreters had often failed to be booked, despite obligations for health-care providers to do so. Even in instances in which interpreters had been booked, these were often unsuitable due to gender, age or ability to articulate sensitive topics. This was shown to cause problems in appropriately seeking consent. The authors conclude by highlighting the fact that refugee and asylum-seeking women are not a homogenous group and are differentiated by cultural norms, education and past experiences. Barriers to receiving appropriate care include socioeconomic position and poor health literacy. The authors stress that health professionals have a unique choice to promote access to culturally sensitive services, including the coordination of interpreter services. They suggest that the needs of refugee and asylum-seeking women should be addressed by an individualised, rather than, standardised approach.

Substance use

Source	Summary of findings and authors' conclusions
Reference: Posselt M, McDonald K, Procter N, de Crespigny C, Galletly C. Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: addressing the barriers. BMC Public Health. 2017;17:1-17. **Source type:** Primary study: mixed methods **Study population:** n = 86, (15 refugee youth, 15 service providers, and 56 service managers) **Outcomes summary:** Responses to interviews with refugee youth and service providers and survey of service managers.	This study investigated the barriers and facilitators to care for refugee youth with alcohol and other drug (AOD) problems and mental health problems, and whether services were equipped to provide support. Refugee youth reported that they were often not aware of services available to them and that they had little knowledge of addiction or mental illness, nor the potentially harmful consequences of drug and alcohol use. This lack of information, compounded with the fear and mistrust of services resulted in a lack of help-seeking. Refugee youth also expressed that information they had encountered was rarely delivered in a way that was meaningful to them. Language barriers were reported to be a common obstacle in accessing services, with interpreters not always being available. Refugee youth suggested that they would be willing to seek assistance if they thought it would be beneficial. They suggested one way to facilitate this would be for healthcare staff to promote services and give more information directly to refugee communities. This was considered important not only to educate, but also to foster trust and familiarity. Refugee youth also suggested that offering appointments in non-traditional locations (e.g. such as going for a walk in a park) could facilitate deeper communication between practitioner and patient.

Child health

Source	Summary of findings and authors' conclusions
Reference: Vermette D, Shetgiri R, Al Zuheiri H, Flores G. Healthcare access for Iraqi refugee children in Texas: Persistent barriers, potential solutions, and policy implications. Journal of Immigrant and Minority Health. 2015;17(5):1526-36. **Source type:** Primary study: qualitative **Study population:** N = 24 parents of refugee children and N = 8 key-informant interviewees **Outcomes summary:** Responses to four focus groups of the parents of refugee children and eight semi-structured interviews with key-informants	This study examined the persistent barriers to healthcare access for Iraqi refugee children in the United States from the perspectives of parents and refugee service providers. Parents reported insurance-related barriers in acquiring healthcare for their children, with delays of up to five months until their policies were reactivated. Miscommunications between parents and insurance companies were also reported, while some refugee children were deemed ineligible for cover. Some parents were unable to find treatment for their children due to lack of knowledge and exhibited confusion about obtaining insurance and the distinction between generalist and specialist doctors. The financial burden of medical visits also prevented some parents from taking their children to the doctor. Language barriers for many mothers taking their children to appointments, leading to communication difficulties. Parents reported interpreters using unfamiliar Arabic dialects, meaning they were difficult to understand. The children themselves were frequently used as interpreters which sometimes led to problems as they were not able to articulate their health problems adequately. Health education and clinic-related materials were frequently found not to be in Arabic. Parents suggested a number of solutions to facilitate access to child healthcare. These were to extend the length of time refugee-assistance services were assigned to families in order to give parents time to understand the healthcare system. Parents also suggested that interpreting services also employ interpreters who speak more Iraqi dialects and that more clinics provide Arabic health education materials. They also suggested that doctors with a similar cultural background be assigned.

Appendix 2: Quantitative survey questionnaire

Public Health Wales & Swansea University: Using the National Health Service in Wales: Please tell us about your experience

This survey is being carried out by Public Health Wales, Swansea University and Wales based charities to help us understand your experience with using the National Health Service (NHS) in Wales. It asks you about how easy or difficult it is to use different services or to get help, interact with staff and understand the system.

Your experience and views will be valuable in helping health services in Wales to work better for everyone in the future. Please answer as many questions as you can, except where the questions does not apply.

Your data will be held by the research team at Swansea University and kept in accordance with their data policy, respecting the current data regulations.

Completing the survey will probably take about 30 minutes. All responses are confidential and will only be seen by the research team. No one will be identifiable in any way to anyone outside of the research team. We do not need full personal details.

An envelope has been provided for your reply. No stamp is required. If you are completing the survey online, your answers will still be private as we will not know where they came from. If you complete the survey with a research/support worker, please leave the survey with them and they will return it to Swansea University.

If you have any questions about the survey or the study please contact:

Dr Ashra Khanom (Project Manager), Swansea University, tel. 01792 606649; email. A.khanom@swansea.ac.uk

Dr Victoria Williams (Research Officer), Swansea University, tel. 01792 606464; email. v.a.williams@swansea.ac.uk

Section A: About you

1. What is your country of nationality? (if you like, you can write **'Prefer not to say'**)

2. How long have you been living in the UK?

3. How long have you been living in Wales?

4. Gender: Are you?

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say

5. How old are you?

- ☐ 18-30
- ☐ 31-50
- ☐ 51-60
- ☐ 60+
- ☐ Prefer not to say

6. Marital situation: Are you?

- ☐ Single
- ☐ Living with a partner (not married)
- ☐ Married
- ☐ Separated or divorced
- ☐ Widowed
- ☐ Prefer not to say

7. Which of these describes your situation?

☐ Refugee	☐ Asylum seeker Section 95	☐ Asylum seeker Section 4
☐ Refused Asylum Seeker	☐ Prefer not to say	☐ Don't know
☐ Other		

a. If you ticked **Other**, please describe in the box below.

8. Did you move to Wales as part of a resettlement programme? (e g. Syrian. Afghan or unaccompanied child programmes)

☐ Yes	☐ No	☐ Don't know
☐ Prefer not to say		

9. Tell us about your work and/or educational situation. (Tick all those that apply)

☐ Employed full-time	☐ Employed part-time	☐ Volunteering
☐ In Education or training part-time	☐ In Education or training full-time	☐ Unemployed
☐ None of the above		

10. Let us know about your understanding and use of both English and your own language.

	Please answer below			
	Yes. very well	A little	No	Prefer not say
I can read English	☐	☐	☐	☐
I can speak English	☐	☐	☐	☐
I can hold a conversation in English with a health professional	☐	☐	☐	☐
I can read my own language	☐	☐	☐	☐
I can communicate using sign language	☐	☐	☐	☐

a. What is your own language?

11. Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Prefer not to say

If you chose **No** or **Prefer not to say**, go to question 12.

a. If you chose **Yes**, how would you describe your disability?

☐ Deaf or severe hearing difficulty ☐ Blind or severe sight difficulty ☐ Learning difficulty
☐ Mental health problems ☐ Physical difficulty ☐ Other

i. If you ticked **Other**, please describe in the box below.

12. Do you have a long-term illness not covered by question 11?

☐ Yes ☐ No ☐ Prefer not to say

If you chose **No** or **Prefer not to say**, go to Section B.

a. If you chose **Yes**, please describe this condition or state '**Prefer not to say**'.

b. Also, If you chose **Yes**, have you received treatment for this condition in Wales?

☐ Yes
☐ No
☐ Prefer not to say

Section B: Health Assessment/Check on arrival to Wales

13. When you arrived in Wales, were you sent an appointment to attend an initial health assessment?

☐ Yes ☐ No ☐ Prefer not to say

If you chose **No** or **Prefer not to say**, go to Section C.

a. Please tell us the name of the town/city where you were offered your initial health assessment or if you cannot remember, please state 'can't remember'.

14. Did you attend the initial health assessment?

☐ Yes ☐ No

If you chose **Yes**, go straight to Section C.

15. If you chose not to attend this assessment please let us know the reason(s) why. (Tick all that apply)

☐ I was frightened ☐ I was unwell ☐ I was unable to attend due to caring responsibilities

☐ I moved to another area before I could attend ☐ I did not feel the need to attend a health assessment check ☐ Other

☐ Prefer not to say

a. If you ticked **Other**, please describe in the box below.

Section C: About your GP, Dentist, Optician and Pharmacist

16. Do you know how to register with a GP surgery?

☐ Yes ☐ No

If you chose **No**, go to question 18.

17. Are you currently registered with a GP surgery?

☐ Yes ☐ No ☐ Don't know
☐ Prefer not to say

If you chose **No**, **Don't know** or **Prefer not to say**, go to question 18.

a. How difficult or easy was it to register with a GP surgery?

☐ Very difficult
☐ Difficult
☐ Neutral
☐ Easy
☐ Very Easy

b. Do you know how to make an appointment with a GP at your surgery?

☐ Yes ☐ No

If you chose **No**, go to question C.

i. How difficult or easy is it to make an appointment with your GP surgery?

☐ Very difficult
☐ Difficult
☐ Neutral
☐ Easy
☐ Very Easy

c. In general, how happy are you with the quality of service you receive from your GP surgery?

- ☐ Very unhappy
- ☐ Unhappy
- ☐ Neutral
- ☐ Happy
- ☐ Very happy
- ☐ I haven't been to see a GP at my practice yet

18. What do you know about the following services available during daytime hours? Daytime means 8:00am-6:30pm. Monday-Friday and does not include night time, bank/public holidays and weekends.

	Please select one option for each of the services listed.		
	Not heard of the service	Heard of the service but don't know how to contact	Have heard of and would know how to contact the service
Dentist	☐	☐	☐
Optician	☐	☐	☐
Pharmacist	☐	☐	☐
Health Visitor	☐	☐	☐

19. Do you know that healthcare is free in Wales?

☐ Yes ☐ No ☐ Don’t know

20. Did you know that a HC2 certificate can help you to access NHS dental treatment, sight tests, cost of glasses or contact lenses and the cost of travelling to receive NHS treatment?

☐ Yes ☐ No

Section D: Factors that help or prevent you accessing healthcare

21. What or who has helped you to access health services in Wales? (Tick all that apply)

☐ Asylum nursing services	☐ Information leaflets	☐ The 'Welcome to Wales' pack
☐ Friends & family	☐ Health Visitor	☐ Community support workers
☐ Religious communities	☐ Charities	☐ Positive attitudes on the part of healthcare staff
☐ Accommodation Manager	☐ Help with transport costs	☐ Neighbours
☐ Do not need any support	☐ Other	

a. If you ticked **Other**, please describe in the box below.

22. What issues, if any, have been a barrier to you accessing and receiving healthcare in Wales? (Tick all that apply)

☐ No issues that I can think of	☐ Transport costs	☐ I cannot speak English
☐ Not having language support at GP surgery, hospital or dentist	☐ Childcare or caring for other dependants	☐ Difficulties booking an appointment
☐ Negative attitudes of healthcare staff (clinicians/administrators /receptionists)	☐ Distance to healthcare facility	☐ Other

a. If you ticked **Other**, please describe in the box below.

23. Please describe how happy you were when accessing the following assistance. Select NA (Not applicable), if you have not accessed this type of assistance.

	Describe					
	Very unhappy	Unhappy	Neutral	Happy	Very happy	NA
Telephone interpretation (e.g. Language Line)	☐	☐	☐	☐	☐	☐
Face to face interpretation service	☐	☐	☐	☐	☐	☐
Family & friends interpreting	☐	☐	☐	☐	☐	☐

a. Please make comments here if you have anything more you would like to say about interpretation services.

Section E: Accessing healthcare in daytime hours

This section is about healthcare services that you might access in **daytime hours**: 8:00am to 6:30pm, Monday - Friday and therefore does not include night time, bank/public holidays and weekends.

24. In the past 3 months, have you received treatment/advice or helped someone else receive treatment/advice for any health problem(s), however minor, during daytime hours?

☐ Yes ☐ No ☐ Prefer not to say

If you chose **No** or **Prefer not to say**, go to question 25.

a. Please tell us about the person you were seeking treatment or advice for? I was seeking help for: (Tick all that apply)

☐ Myself ☐ My child or baby (age 0-16) ☐ Another family member that lives with me

☐ Another family member that lives in a different home from me ☐ Other

i. If you ticked **Other**, please describe in the box below.

b. How many times during the last 3 months have you received treatment/advice for any health problem, for yourself or someone else, during daytime hours?

☐ None	☐ 1	☐ 2
☐ 3-5	☐ 6-10	☐ more than 10

i. Thinking of your most recent contact for yourself or someone else, what sort of health problem(s) was it for? Some examples include sore throat, accident, back pain, worry, sadness, maternity, dental. State if you **Prefer not to say**.

ii. Thinking of your most recent contact for yourself or someone else, who or which services did you contact? Some examples might include family, friends, internet, GP, dentist, hospital?

25. What do you know about the following services available during daytime hours?

	Please select one option for each of the services listed		
	Not heard of the service	Heard of the service but don't know how to contact	Have heard of and would know how to access the service
Maternity and Antenatal services	☐	☐	☐
Family planning and sexual health	☐	☐	☐
Physiotherapist	☐	☐	☐
Screening services (e.g. cancer or diabetic screening)	☐	☐	☐
Drug and alcohol service	☐	☐	☐
NHS 111/NHS Direct telephone advice	☐	☐	☐
Minor Injuries Unit	☐	☐	☐
999 Ambulance service	☐	☐	☐
Accident and Emergency	☐	☐	☐

Section F: Accessing healthcare at night time, weekends and on public holidays

This section is about healthcare services that you might access **outside of daytime hours.** This means healthcare accessed between 6:30pm in the evening and 8:00am in the morning during the week, as well as during weekends and bank or public holidays.

26. In the past 3 months, have you received treatment/advice or helped anyone else receive treatment/advice for any health problem(s), however minor, **outside of daytime hours**?

☐ Yes ☐ No ☐ Prefer not to say

If you chose **No** or **Prefer not to say**, go to question 27.

a. Please tell us about the person you were seeking treatment or advice for? I was seeking help for: (Tick all that apply)

☐ Myself ☐ My child or baby (age 0-16) ☐ Another family member that lives with me

☐ Another family member that lives in a different home from me ☐ Other

i. If you ticked **Other**, please describe in the box below.

b. If you chose **Yes**, how many times during the last 3 months have you received treatment or advice for any health problem, for yourself or someone else, outside of daytime hours?

☐ None ☐ 1 ☐ 2
☐ 3-5 ☐ 6-10 ☐ more than 10

i. Thinking of your most recent contact for yourself or someone else, what sort of health problem(s) was it for? For example, sore throat, accident, back pain, worry, sadness, maternity, dental. State if you **Prefer not to say**.

ii. Thinking of your most recent contact for yourself or someone else, who or which services did you contact? For example, family, friends, internet, GP, dentist, hospital?

27. What do you know about the following services available outside of daytime hours?

	Please select one option for each of the services listed		
	Not heard of the service	Heard of the service but don't know how to contact	Have heard of and would know how to contact the service
GP out of hours service	☐	☐	☐
Out of hours pharmacist	☐	☐	☐
Hospital A&E Department	☐	☐	☐
NHS 111/NHS Direct telephone advice	☐	☐	☐
999 Ambulance Service	☐	☐	☐
Pregnancy delivery suite telephone number	☐	☐	☐

Final administrative questions & thank you

28. Please enter today's date:

29. Did you complete this questionnaire with the help of a researcher/support worker?

☐ Yes ☐ No

a. If you answered **Yes** to the above question, please provide their name or signature here:

30. Having completed the questionnaire, can you confirm that you are happy that your feedback and comments provided here can be included anonymously by the research team in a report to Public Health Wales and any associated publications?

☐ Yes ☐ No

If you answer **No**, your questionnaire responses will not be included in the study.

Focus group participation

31. Would you like to participate in a focus group to discuss your views on access to health services in Wales? If so, please write your name, telephone number/email and your location (e.g. Wrexham, Swansea, Cardiff etc) in the box below? **If not, please leave blank**.

Thank you very much for your help.

If you are submitting electronically, PLEASE PRESS THE FINISH BUTTON BELOW.
If returning by post, please send your completed questionnaire in the accompanying freepost envelope or leave with the charity you obtained the questionnaire from, for collection by the research team.

Appendix 3: Frequency tables from quantitative survey

Prologue – data management

In consultation with the HEAR research team, we have removed 7 rows from the Excel data file that we received:

A The rows of 3 participants who answered "No" to Q30 – "Having completed the questionnaire, can you confirm that you are happy that your feedback and comments provided here can be included anonymously by the research team in a report to Public Health Wales and any associated publications?" This is because Q30 concludes "If you answer No, your questionnaire responses will not be included in the study". However we included the responses of 8 participants who did not answer Q30 at all, but none of their comments.

B The row of a participant who reported that he was a "citizen" and thus outside the scope of the survey; he had been in UK for 13 years and spoke English "very well".

C Three of 4 rows which mirrored each other so precisely as to establish that they reported the same person; further scrutiny confirmed that these rows arose from a questionnaire extracted 4 times into the data file.

Thus each table included at most 210 respondents. Moreover each question had at least 4 non-responders who left the question blank, often many more. Some questions allowed respondents to reply 'Prefer not to say' or 'Don't know', which we typically treated as missing data. A few questions explicitly allowed 'Not applicable'; we also used this label when a question asked respondents who made a specific reply to skip subsequent questions.

We converted the Excel data file to SPSS and edited to make it suitable for quantitative analysis. Though we commend the research team for recruiting 210 valid respondents in short time, errors and inconsistent responses are inevitable in this sample. We resolved these wherever we could, but retrospective data cleaning was subject to time constraints, language problems, and lack of access to the field workers and their records. Hence we are less confident about the validity of survey findings than usual. Nevertheless we believe this report gives a broadly accurate picture.

This Appendix includes frequency tables for all substantive variables, and short explanations of these frequencies. Appendix 4 presents selected crosstabulations of these variables against asylum status, and Appendix 5 presents selected crosstabulations of these variables against gender.

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Section A: About you

Q1 Country of nationality

The 193 people who replied to this question specified 86 separate countries. We have combined countries into seven continental groupings in descending size: Middle East, Africa North, Indian subcontinent, Africa South, East Asia, Europe, and the Americas.

One third of respondents were from the Middle East, and a further fifth from North African countries. We have retained 6 respondents who said they were from Kurdistan as a separate category, because several neighbouring countries include parts of Kurdistan.

When investigating associations with gender and asylum status (Appendices 4 and 5), we combined Europe and America; the only country we retained as a separate category was Syria, which is distinctive because of special government measures.

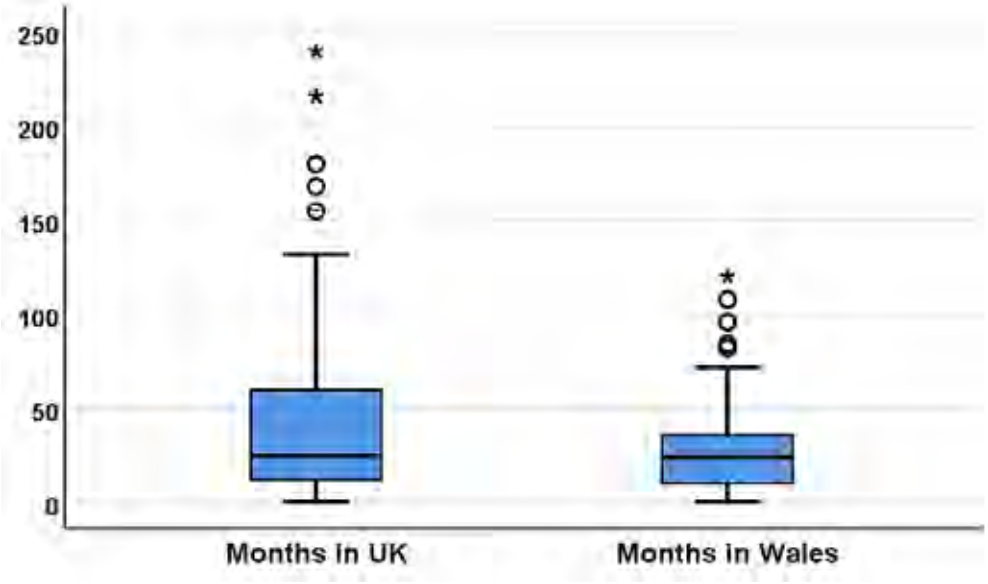
		Number	%	Valid %
Valid	Syria	34	16	18
	Iran	12	6	6
	Iraq	8	4	4
	Kurdistan	6	3	3
	Middle East (other)	7	3	4
	Middle East (all)	67	32	35
	Sudan	16	8	8
	Eritrea	7	3.	4
	Africa North (other)	20	10	10
	Africa North (all)	43	21	22
	Pakistan	14	7	7
	Sri Lanka	8	4	4
	Afghanistan	7	3	4
	India, Bangladesh	5	2	3
	Indian subcontinent (all)	34	16	18
	Africa South	24	11	12
	East Asia	11	5	6
	Europe	10	5	5
	Americas	4	2	2
	Total valid	193	92	100
Missing	Prefer not to say	3	1	
	No response	14	7	
	Total missing	17	8	
Total		210	100	

Q2 How long have you been living in UK?
Q3 How long have you been living in Wales?

Because these are continuous rather than categorical variables, this table shows summary statistics. A boxplot (sometimes called a box-and-whisker plot) provides a visual summary below the table. Additional boxplots in Appendix 4 contrast refugees with different types of asylum seekers.

	Months in UK (n=196)	Months in Wales (n=197)
Mean	45.3	27.2
Median	25.5	24.0
Std. Deviation	45.9	23.9
Minimum	0.4	0.4
Maximum	240.0	120.0
Lower quartile	12.0	10.0
Upper quartile	64.5	36.0
Interquartile Range	52.5	26.0

Boxplots of length of time in the UK and in Wales



Note: Boxes show the median between the lower and upper quartiles. Whiskers extend to the highest data point within 1.5 interquartile ranges (IQR) from the upper quartile and the lowest data point within 1.5 IQRs from the lower quartile. Circles show data points between 1.5 and 3 IQRs from the nearer quartile, and asterisks show data points more than 3 IQRs from the nearer quartile.

Q4 Gender

The sample included 82 reported males and 118 reported females. We treated the person reported as 'other' gender (pre-specified response) as missing in subsequent analyses. A further 9 people preferred not to give their gender or did not reply. So 41% of the 200 valid respondents were male and 59% female. Gender balance did not vary with asylum status (Appendix 4). Appendix 5 examines other differences between males and females.

Q5 Age

		Number	%	Valid %
Valid	18-30	70	35	36
	31-50	120	56	59
	51-59	6	3	3
	Over 60	4	2	2
	Total valid	200	95	100.0
Missing	Prefer not to say	5	2	
	No response	5	2	
	Total missing	10	5	
Total		210	100	

More than half the respondents were aged between 31 and 50. As only 5% were over 51, we combined the two oldest groups for further analyses. Neither asylum status nor gender varied by age.

Q6 Marital status

		Number	%	Valid %
Valid	Single	66	31	33
	Partner	4	2	2
	Married	108	51	55
	Separated or divorced	18	9	9
	Widowed	2	1	1
	Total valid	198	94	100
Missing	Prefer not to say	4	2	
	No response	8	4	
	Total missing	12	6	
Total		210	100	

More than half the respondents were married, and one third were single. For further analyses, we combined "partner" with "married" and "widowed" with "separated or divorced"; and sometimes with "single" to compare single and married respondents. Resettled refugees were more likely to be married than other refugees or asylum seekers. Although equal proportions of men and women were married, 19 of the 20 separated, divorced or widowed were female.

Q7 Asylum status

		Number	%	Valid %
Valid	Refugee*	89	42	47
	Asylum seeker Section 95	70	33	37
	Asylum seeker Section 4	20	10	10
	Refused asylum seeker	11	5	6
	Total valid	190	90	100
Missing	Don't know	8	4	
	Prefer not to say	7	3	
	No response	5	2.	
	Total missing	20	10	
Total		210	100	

* Including 3 people who reported their status as "family reunion".

This includes the few 'Other' responses in Q7a in the most appropriate category; this process was usually straightforward, but sometimes used responses to other questions. Appendix 4 reports associations between asylum status and all other questions. Initially we combined Section 4 and refused asylum seekers; if this combined group did not differ from Section 95 asylum seekers, we contrasted refugees and asylum seekers.

Q8 Did you move to Wales as part of a resettlement programme (e.g. Syrian, Afghan or unaccompanied child programme)?

One tenth of respondents either did not know or preferred not to answer this question; another tenth made no response. Of the remaining 169, 49 (29%) replied yes; more than half of these were

Syrian. Refugees from other countries were no more likely than asylum seekers to report being on a resettlement programme (Appendix 4); and nearly two thirds of those on resettlement programmes were female (Appendix 5).

Q9 Occupation (tick all that apply)

Like other questions stating "Tick all that apply", this needs several variables to define responses. Yet 4 provide an adequate summary, as employment and education need only one ordinal variable each:

Q9.1 Work, education and volunteering: separate responses to each category

	Number	Valid %
Employed full-time	4	2
Employed part-time	8	4
In education or training full-time	23	11
In education or training part-time	53	26
Volunteering	50	24
Unemployed	67	33
None of the above	34	17
Total ticking at least one box	204	

Six people (3% of 210) did not reply to this question. Because respondents could tick more than one box, numbers add to 239, and percentages to 117%. Most multiple ticks were consistent; for example employed people may also volunteer or be in education. But we assumed that two people who ticked both "unemployed" and "none of the above" were unemployed. We combined all responses into a single hierarchical variable putting each of the 204 respondents into one of 7 categories:

- Employed full time 4 (2%)
- Employed part time 8 (4%)
- Education or training full time (but not employed) 22 (11%)
- Education or training part time (but not employed) 52 (25%)
- Volunteering (but not employed or in education or training) 31 (15%)
- Unemployed (but not in education or training and not volunteering) 53 (26%)
- None of these (includes long term sickness/caring responsibilities) 34 (17%)

All 12 employed people were refugees, as asylum seekers are not allowed to work. Asylum seekers and males were less likely to be in part time education than refugees and females respectively; only the first of these differences was significant (Appendices 4 and 5).

Q10 Your understanding and use of English and your own language

Can you: Number (%)	No	A little	Yes, very well
Q10a Read English (n=204)	24 (12%)	81 (40%)	99 (48%)
Q10b Speak English (n=201)	23 (11%)	95 (47%)	83 (41%)
Q10c Converse with a health professional in English (n=198)	49 (25%)	74 (37%)	75 (38%)
Q10d Read own language (n=195)	8 (4%)	16 (8%)	171 (88%)
Q10e Use sign language (n=167)	101 (60%)	40 (24%)	26 (16%)

Nearly 90% of respondents could read and speak at least a little English; but were less confident about conversing with health professionals in English. Refugees felt significantly less able to do so than asylum seekers but this was largely due to those arriving on resettlement programmes (Appendix 4). There were no other associations with asylum status or gender.

Q10a What is your own language?

		Number	%	Valid %
Valid	Albanian	6	3	3
	Amharic	5	2	3
	Arabic	62	30	35
	Bangladeshi, Bengali	3	1	2
	Chichewa	4	2	2
	Chinese, Mandarin	9	4	5
	English	4	2	2
	Farsi	10	5	5
	French	6	3	3
	Hindu, Punjabi, Gujerati	7	3	4
	Kurdish	13	6	7
	Lingala	2	1	1
	Pashto	4	2	2
	Russian	2	1	1
	Shona	2	1	1
	Sinhalese, Tamil	7	3	4
	Somali	2	1	1
	Spanish	2	1	1
	Swahali	3	1	2
	Tigrinya	3	1	2
	Urdu	10	5	5
	Vietnamese	2	1	1
	Yoruba	5	2	3
	Other single language	11	5	6
	Total valid	184	88	100
Missing	Prefer not to say	2	1	
	No response	24	11	
	Total missing	26	12	
Total		210	100	

Arabic was the most common language, with 62 people reporting it as their own language. Of the remainder only Kurdish, Farsi and Urdu had ten or more reported speakers. Farsi and Urdu were spoken by members of the research team; and we translated our questionnaire into Arabic and Kurdish Sorani.

Q11 Do you consider yourself to have a disability?
Q12 Do you have a long-term illness not covered by Q11?

These two questions each have sub-questions asking for details of disability or illness. We consider them together because several answers appeared in both lists.

Q11 and Q12 Disability and long-term illness

		Number	%	Valid %
Valid	Neither	129	61	66.8
	Disability	16	8	8.3
	Long term illness	29	14	15.0
	Both	13	6	6.7
	At least one*	6	3	3.1
	Total	193	92	100.0
Missing	Prefer not to say	5	2	
	No response‡	12	6	
	Total	17	8	
Total		210	100	100.0

* Either Q11 or Q12 answered 'yes', but no response to the other.

‡ Both Q11 & Q12 omitted, or one answered 'no' with no response to the other.

Q11 and Q12 Types of disability and long-term illness

		Number	%	Valid %
Valid	None	129	61	67
	Learning difficulty	7	3	4
	Mental health problem	13	6	7
	Deafness or hearing problem	3	1	2
	Back pain	5	2	3
	Other	22	11	11
	Multiple problems	8	4	4
	Unspecified	4	2	2
	Total valid	191	91	100
Missing	Prefer not to say	7	3	
	No response to either question	12	6	
	Total missing	19	9	
Total		210	100	

The 'Other' problems were diverse and not easy to classify or group but included diabetes, gynaecological problems, kidney problems and other chronic conditions.

Section B: Health Assessment on arrival in Wales

Q13 When you arrived in Wales, did you receive an appointment to attend an initial health assessment?

		Number	%	Valid %
Valid	Yes	162	77	83
	No	34	16	17
	Total valid	196	93	100
Missing	Prefer not to say	8	4	
	No response	6	3	
	Total missing	14	7	
Total		210	100	

Almost all asylum seekers, but fewer than three quarters of refugees, had received an IHA appointment; those coming on resettlement programmes were more likely than other refugees to have received an appointment (Appendix 4). Over half of respondents did not state where the appointment was offered; responding refugees reported appointments across Wales, but asylum seekers mentioned the three main cities.

Q13a Where were you offered your initial health assessment

		Number	%	Valid %
Valid	Cardiff*	39	19	38
	Swansea	29	14	28
	Newport	13	6	12
	Other in Wales	18	9	17
	Not in Wales	5	2	5
	Total valid	104	50	100
Missing	Cannot remember	6	3	
	No response	100	48	
	Total missing	106	51	
Total		210	100	

* Including two “Cardiff & Swansea” and one “Cardiff & Newport”

Q14 Did you attend an initial health assessment?

		Number	%	Valid %
Valid	Yes	159	76	79
	No*	42	20	21
	Total	201	96	100
Missing	No response	9	4	
Total		210	100	

* Including 20 who did not receive an invitation, so skipped Q14 and Q15.

Q15 If you chose not to attend this assessment please let us know why (tick all that apply)
Q15a If you ticked "Other" in Q15, please describe in the box below.

I did not need to attend a health assessment	2
I was frightened	2
I was unwell	2
I moved to another area before I could attend	1
I was unable to attend due to caring responsibilities	1
I had just arrived	1
Prefer not to say	2
No-one told me	1
I can't remember	1
Total	13

Several who had attended an IHA answered this question; and most of those who reported that they had not attended an IHA did not give any reason for not attending, despite getting explicit options. Only three of the ten people who gave a reason said they had been invited to an assessment.

Section C: About your GP, Dentist, Optician and Pharmacist

Q16 Do you know how to register with a general practice?

		Number	%	Valid %
Valid	Yes	145	69	70
	No	61	29	30
	Total valid	206	98	100
Missing	No response	4	2	
Total		210	100	

Q17 Are you currently registered with a general practice?

		Number	%	Valid %
Valid	Yes	182	87	94
	No	11	5	6
	Total valid	193	92	100
Missing	Don't know	5	2	
	Prefer not to say	1	0.5	
	No response	11	5	
	Total missing	17	8	
Total		210	100	

Only 6% of respondents reported ***not*** being registered. There is no association between registration and asylum status, but women are more likely to be registered than men (Appendix 5). Nevertheless men and women gave similar answers to questions 17a to 17c.
As we asked respondents ***not*** registered to skip to Q18, there are more missing responses than usual to the next 4 tables. Even so the number of non-responders to Q17b is surprising.

Q17a How difficult or easy was it to register with a general practice?

		Number	%	Valid %
Valid	Very easy	28	13	16
	Easy	67	32	38
	Neutral	48	23	27
	Difficult	22	11	13
	Very difficult	11	5	6
	Total valid	176	84	100.0
Missing	No response	34	16	
Total		210	100	

Nearly one fifth of respondents had found registration difficult or very difficult. Refugees had found this significantly more difficult than asylum seekers, but different types of asylum seekers did not differ (Appendix 4). Almost half of those on resettlement programmes found this difficult or very difficult and this accounted for most of the difference between asylum seekers and refugees.

Q17b Do you know how to make an appointment with a GP at your surgery?

		Number	%	Valid %
Valid	Yes	128	61	94
	No	8	4	6
	Total valid	136	65	100
Missing	No response	74	35	
Total		210	100	

Almost all valid responders replied yes, but this was only 65% of the entire sample.

Q17b1 How easy is it to make an appointment with your GP?

		Number	%	Valid %
Valid	Very easy	16	8	9
	Easy	48	23	27
	Neutral	54	26	30
	Difficult	39	19	22
	Very difficult	21	10	12
	Total valid	178	85	100
Missing	No response	32	15	
Total		210	100	

More than a third of respondents found it difficult or very difficult to make an appointment, and less than a tenth found it very easy. But there was no association with asylum status or gender.

Q17c How happy are you with the quality of service you receive from your GP surgery?

		Number	%	Valid %
Valid	Very happy	30	14	17
	Happy	61	29	34
	Neutral	65	31	36
	Unhappy	15	7	8
	Very unhappy	9	4	5
	Total valid	180	86	100
Missing	Have not seen GP	5	2	
	No response	25	12	
	Total missing	30	14	
Total		210	100.0	

Only 13% of respondents were unhappy or very unhappy with their general practice. Refugees are significantly less happy than asylum seekers (Appendix 4). A smaller proportion of those on resettlement programmes were very happy or happy.

Q18 What do you know about the following services available during daytime hours?

	Heard of & know how to contact	Heard of; don't know how to contact	Not heard of this service
Service	Number (%)	Number (%)	Number (%)
Pharmacist (n=173)	114 (66%)	28 (16%)	31 (18%)
Dentist (n=182)	104 (57%)	53 (29%)	25 (14%)
Optician (n=175)	92 (53%)	55 (31%)	28 (16%)
Health visitor (n=174)	74 (42%)	40 (23%)	60 (35%)

Q19 Do you know that healthcare is free in Wales?

Excluding the only two who did not reply, 169 (81%) answered "Yes" while 39 (19%) replied "No" or ""Don't know", equivalent in this question. Women were significantly more likely than men to know that health care is free (87% v 74%, Appendix 5), but there were no differences between refugees and asylum seekers.

Q20 Did you know that an HC2 certificate can access NHS dental care, sight tests, the cost of glasses or contact lenses, & the cost of travel to NHS treatment?

Of 201 responses, 126 (63%) replied yes. Refugees were significantly less likely to know about HC2 certificates than asylum seekers (48% v 79% – Appendix 4); more women than men knew about them but this difference was not significant (67% v 56% – Appendix 5).

Section D: Factors that help or prevent you accessing healthcare

Q21 What or who has helped you to access health services in Wales? (tick all that apply)

Percentages for Q21 & Q22 do not sum to 100%, because we asked respondents to tick all applicable.

	Number	% of sample	Valid %
No help needed	5	2	2
Asylum nursing service	77	37	38
Friends and family	44	21	22
Charities	36	17	18
Community support worker	34	16	17
Health visitor	31	15	15
Accommodation manager	28	14	14
Information leaflets	24	11	12
Religious communities	18	9	9
Positive attitude of health staff	15	7	7
'Welcome to Wales' leaflet	14	7	7
Help with transport costs	11	5	5
Neighbours	8	4	4
Red Cross*	7	3	3
Other	16	8	8.
Total for each row	201	96	
No response to any part of Q21	9	4	
Total	210	100	

* = Not pre-specified response.

The asylum nursing service was most popular, especially among asylum seekers, nearly half of whom selected that (Appendix 4). Women were more likely to have been helped by a health visitor, and by the positive attitude of health staff, but otherwise males and females made similar choices (Appendix 5).

Q22 What has been a barrier to you accessing and receiving healthcare in Wales?

	Number	% of sample	Valid %
No issues	58	28	30
Cannot speak English	64	30	33
Transport costs	55	26	28
Difficulty booking appt	50	24	26
No language support	33	16	17
Distance to travel	21	10	11
Negative attitude of staff	19	9	10
Childcare or carer	17	8	9
Other*	3	2	2
Total (for each row)	196	93	
No response	14	7	
Total	210	100	

* Though ten respondents ticked this box, we could assign the other 7 to other pre-specified categories.

Section 95 asylum seekers are significantly more likely to find childcare a barrier than refugees or refused asylum seekers. While the difference is not significant, more refugees than asylum seekers found not speaking language a barrier, but this difference was completely accounted for by those refugees on resettlement programmes. Women were more likely to find caring (statistically significant) and distance as barriers to access. There were no other associations with gender or asylum status (Appendices 4 and 5).

Q23 Please describe how happy you were when accessing the following assistance

Number (%)		How happy were you in accessing this type of interpretation?		
		Telephone	Face to face	By family or friends
Valid	Very happy	13 (9%)	22 (20%)	14 (16%)
	Happy	54 (39%)	46 (41%)	38 (43%)
	Neutral	52 (37%)	27 (24%)	27 (30%)
	Unhappy	6 (4%)	6 (5%)	4 (4%)
	Very unhappy	5 (11%)	10 (9%)	6 (7%)
	Total valid	140 (100%)	114 (100%)	89 (100%)
Missing	Not applicable	57	76	90
	No response	13	23	31
	Total missing	70	99	121
Total		210	210	210

Telephone interpretation was slightly less popular than interpretation face to face.

Q23a 32 comments in response to Q23 about interpretation services

All the charities and voluntary sector were very supportive.
Always people hesitant to call ***interpreter***.
Asked for ***Language Line***, but GP says they have no time.
Child was ill, could not make appointment immediately. Appointment was booked for a week later. Sometimes lady has headaches, requires tablets, but can't get them in time. Child makes appointment for her to visit dentist. GP not provide ***interpreters***. Has to wait for her son aged 10 to be available or not in school to ***interpret*** for her. Dentist used ***Language Line*** for child.
Different accents are difficult, so ***interpreter*** needs to be face to face.
Does the ***translator*** have to tick or colour the circle?
Face-to-face ***interpretation*** is best but sometimes I feel embarrassed to speak about my health problems.
GP need to have an ***interpreting*** service available; GP doesn't even want to try to help us.
GP not provide medicines for children's hayfever. Told to go to pharmacist. If you have some knowledge about your condition, more likely to listen to you.
GP not provided ***interpretation services***.
Having an ***interpreter*** really helps.
I am happy.
I am happy for this service.
I asked for an ***interpreter*** and they didn't help in that till 7pm.
I don't have any ID to receive the health service treatment.
I have a problem on telephone because of hearing aid. So I don't understand on phone properly.
I never had to use this service as I can speak and understand English.
I will suggest the ***interpreter*** need to know more about the language; should learn more.
I would like to say, this service very interesting for me because most people didn't understand and explain their own problem.
I would like to see dentist.
I would prefer it if I could explain my condition myself and not rely on others. ***Language line*** is OK but sometimes it can be difficult to convey the message. Can't speak the language so need to visit the GP surgery to make appointment.
If I need an ***interpreter*** I prefer face to face or on same table. It is good to be good in language, special education persons' interpreters are very important, with the same accent.
Just that on that side it's OK, it works well. I was satisfied with the service. Cool.
My family and I did not get any ***translator*** since we came here in Wales, but we asked to have translator, sometimes is available and sometimes not, in the beginning of our arrival the administrator went with us to the GP and helped in registering and then nobody helps us at all, we really need help in this issue.
My friends say they find it difficult with ***interpretation services***, Wondered if some languages are hard to find e.g. Tingrinya. There are so many young Tingryinya refugees – train them!
Never had an ***interpreter*** even though we felt we needed it.
No comments; happy to help.
Not asked for an ***interpreter*** but sometimes difficult to understand English.
Not for health but for some interview I would like some male ***interpreter***.
Should have help from different nationalities. I can communicate better with people from his own country. Sometimes the ***translator*** becomes busy.
They are not good enough. They need to be more trained for very specific health issue.
Used ***Language Line*** once when pregnant, and the midwife used LL.

Not surprisingly these comments from 15% of respondents cover the range from very positive to very negative. They suggest that a detailed study of interpretation services would be helpful.

Section E: Accessing health care in working hours

Q24 In the past 3 months have you received treatment or advice during working hours?

		Number	%	Valid %
Valid	Yes	132	63	66
	No	67	32	34
	Total valid	199	95	100
Missing	Prefer not to say	5	2	
	No response	6	3	
	Total missing	11	5	
Total		210	100	

Section 95 asylum seekers were more likely than refugees or refused asylum seekers to have received treatment (Appendix 4); and females more likely than males (Appendix 5).

Q24a For whom were you seeking treatment or advice? (tick all that apply)

We summarise answers to this question in two ways. The first table reports on 4 main categories; these percentages do not sum to 100% because we asked respondents to tick all applicable boxes. The second table splits the 135 valid responses into three broad mutually exclusive groups:

	Number	% of sample	Valid %
Myself	95	45	70
My child under 16	51	24	38
Other family member*	21	10	16
Other (not family member)	7	3	5
Total for each row	135	64	
Not applicable	61	29	
Prefer not to say	2	1	
No response	12	6	
Total missing	75	36	
Total	210	100	

* "Other family member living with me" or ditto "not living with me"; no respondent ticked both boxes.

	Number	% of sample	Valid %
Only for myself	64	30.0	46.4
Only for one or more other people	41	19.5	30.4
For myself and at least one other person	30	14.3	22.2
Total for each row	135	64.3	
Not applicable	61	29.0	
Prefer not to say	2	1.0	
No response	12	5.7	
Total missing	75	35.7	
Total	**210**	**100.0**	

Refugees were significantly more likely to have asked only about someone else (Appendix 4). Females were nearly twice as likely as males to have consulted about their own child (Appendix 5).

Q24b How often during last 3 months have you received treatment or advice during daytime hours for a health problem of yours or someone else?

	Number	%	Valid %
None	67	32	35
1	33	16	17
2	27	13	14
3-5	46	22	24
6-10	13	6	7
More than 10	7	3	4
Total valid	193	92	100
No response	17	8	
Total	210	100	

One third of respondents had not consulted; one third had consulted either once or twice in the previous 3 months; and one third had consulted three or more times.

Q24bi Thinking of your most recent contact for yourself or someone else, what sort of health problem(s) was it? For example sore throat, accident, back pain, worry, sadness, maternity, dental.

Seven people preferred not to say, and another 99 did not reply, leaving 104 valid respondents. As 28 of these mentioned at least two problems. Percentages in this table do not add to 100%:

	Number	% of sample	Valid %
Dental problem	30	14	29
Back pain	15	7	14
Sore throat	12	6	12
Depression or sadness	9	4	9
Respiratory e.g. asthma	7	3	7
Routine or preventive	7	3	7
Anxiety, stress or worry	7	3	7
Reproductive, maternity or gynaecological	6	3	6
Digestive system	5	2	5
Headache	5	2	5
Sleeplessness or tiredness or	5	2	5
Unspecified mental problem	2	1	2
Other	33	16	32
Total for each row	104	50	
Prefer not to say	7	3	
No response	99	47	
Total missing	106	50	
Total	**210**	**100**	

The most common type of problem was dental (in Q24d these 30 people all said they had consulted a dentist), followed by back pain and sore throat. Twenty people, including 3 who mentioned both anxiety and depression, consulted for a mental health problem, sleeplessness or tiredness. While the 'Other' category is large, it does not contain any problem mentioned more than three times. As many respondents used one of the words suggested in the question, this was probably helpful. Asylum seekers were more likely to report anxiety, depression, sleeplessness and unspecified mental health problems.

Q24bii Thinking of your most recent contact for yourself or someone else, who or which services did you contact? For examples, family, friends, internet, GP, dentist, hospital.

As several respondents mentioned at least two contacts, percentages in this table do not add to 100%.

	Frequency	% of sample	Valid %
GP	53	25	56
Dentist	30	14	32
Hospital	29	14	31
Family or friends	7	3	7
Other*	11	5	12
Total for each row	94	45	
No response to Q24d	116	55	
Total	210	100	

* 2 each used internet, nurse & 999; others used fertility clinic, health visitor, psychiatrist, Specsavers & 111.

More than half those who replied had contacted or attempted to contact a GP. Asylum seekers and females were more likely to contact a GP than refugees and males respectively; and all seven people who consulted family and friends were female.

Q25 What do you know about the following services available during daytime hours?

	Heard of & know how to contact	Heard of; don't know how to contact	Not heard of the service
Service	Number (%)	Number (%)	Number (%)
999 ambulance service (n=185)	142 (77%)	23 (12%)	20 (11%)
Accident and Emergency (n=180)	102 (57%)	37 (21%)	41 (23%)
NHS 111 or Direct (n=186)	71 (38%)	26 (14%)	89 (48%)
Maternity and antenatal (n=175)	54 (31%)	28 (16%)	93 (53%)
Family planning & sexual health (n=180)	52 (29%)	32 (18%)	96 (53%)
Physiotherapist (n=180)	45 (25%)	43 (24%)	95 (52%)
Screening services, e.g. cancer (n=181)	41 (23%)	36 (20%)	104 (57%)
Minor injuries unit (n=176)	35 (20%)	31 (18%)	110 (62%)
Drug and alcohol services (n=173)	15 (9%)	25 (14%)	133 (77%)

Section F: Accessing health care at night time, weekends or public holidays

Q26 In past 3 months, have you received (or helped anyone else receive) treatment or advice for any health problem, however minor, outside daytime hours?

		Number	%	Valid %
Valid	Yes	54	26	28
	No	140	66	72
	Total valid	194	92	100
Missing	Prefer not to say	8	4	
	No response	8	4	
	Total missing	16	8	
Total		210	100	

Q26a For whom were you seeking treatment or advice?

		Number	%	Valid %
Valid	Myself	21	10	40
	My child	12	6	23
	Me and my child	2	1	4
	Other family	10	5	19
	Me and other family	1	0.5	2
	My child & other family	2	1	4
	Non-family	3	1	6
	Me and non-family	1	0.5	2
	Total valid	52	25	100
Missing	Not applicable	140	67	
	Prefer not to say	4	2	
	No response	14	7	
	Total missing	158	75	
Total		210	100	

Q26b How many times during the last 3 months have you received treatment or advice for any health problem, for yourself or someone else, outside daytime hours?

		Number	%	Valid %
Valid	None	140	67	75
	1	22	10	12
	2	12	6	6
	3-5	9	4	5
	6-10	3	1	2
	Total valid	186	89	100
Missing	No response	24	11	
Total		210	100	

Q26bi Thinking of your most recent contact for yourself or someone else, what sort of health problem(s) was it? For example, sore throat, accident, back pain, worry, sadness, maternity, dental.

Because few respondents mentioned more than one problem or contact (in contrast to Q24, the daytime equivalent), we summarise this question and the next by one variable each. Of the 33 respondents to Q26bi: 6 mentioned back pain, 5 dental issues, 4 heart issues, 4 fever, 2 blood pressure, 2 gynaecological issues, 2 mental issues, 2 respiratory issues, 2 skin issues, 1 accident, 1 diarrhoea, 1 hypoglycaemia and 1 sore throat.

Q26bii Thinking of your most recent contact for yourself or someone else, who or which services did you contact? For example, family, friends, internet, GP, dentist, hospital?

Of the 39 respondents: nine had contacted a GP, eight a hospital, eight the 999 service, five only family or friends, four a dentist (two of whom also contacted hospital), two both GP and hospital, two the NHS 111 service and one a social worker.

Q27 What do you know about the following services available outside daytime hours?

	Heard of & know how to contact	Heard of; don't know how to contact	Not heard of this service
Service	Frequency (%)	Frequency (%)	Frequency (%)
27e. 999 ambulance service (n=186)	134 (72%)	31 (17%)	21 (11%)
27c. Accident and Emergency (n=178)	78 (44%)	38 (21%)	62 (35%)
27d. NHS 111/NHS Direct (n=185)	66 (36%)	42 (23%)	77 (42%)
27a. GP out of hours (n=187)	49 (26%)	33 (18%)	105 (56%)
27f. Pregnancy delivery suite (n=175)	39 (22%)	25 (14%)	111 (63%)
27b. Pharmacist (n=182)	35 (19%)	37 (20%)	110 (60%)

Nearly three quarters of respondents knew how to contact 999, more than two fifths knew how to contact Accident and Emergency. The other four services, including GP out of hours, were less well known. Women had more knowledge than men about all these services except 999 (Appendix 5); and asylum seekers knew more than refugees about NHS direct and 999 (Appendix 4).

Final administrative questions

(Q28 is the administrative question seeking the date of completion)

Q29 Did you complete this questionnaire with help of a researcher or support worker?

		Frequency	%	Valid %
Valid	No	104	49	51
	Yes	100	48	49
	Total valid	204	97	100
Missing	No response	6	3	
Total		210	100	

(Q30 is the administrative question seeking consent to quote feedback or comments)
(Q31 is the administrative question seeking consent to participate in a focus group)

Appendix 4: Associations between asylum status and survey responses

Prologue – asylum status

This appendix investigates whether the main recommendations of HEAR should vary by asylum status. Our main approach is to test statistically whether the responses to the survey questions differ by asylum status. However Question 7 offered 5 valid responses – refugee, asylum seeker (Section 95, Section 4 or refused), and other.

Furthermore Question 8 asked whether respondents moved to Wales as part of a resettlement programme – for example Syrian. Of the total sample of 210, only 169 gave valid responses to Q8, of whom 49 (29%) replied yes. Though people on resettlement programmes must be refugees rather than asylum seekers, 10 of those who answered yes to Q8 were asylum seekers, and a further 23 asylum seekers did not give a valid response. Thus Q8 was not well understood. To resolve these inconsistencies we give precedence to Q7, and recode Q8 where necessary. Among the 89 known refugees, this yields 33 who said they were on a resettlement programme, 46 who said they were not, and 10 who did not give a valid answer. This appendix combines these last two categories for analysis. When this combined group does not differ significantly from resettled refugees, we can analyse all refugees as a single group.

Similarly to combine the asylum seekers into fewer, generally homogeneous groups for analysis, we first reallocate the few 'Other' responses among the remaining four categories. Then we combine Section 4 and refused asylum seekers, because both small groups had had asylum applications rejected. If this combined group does not differ significantly from Section 95 asylum seekers, we analyse asylum seekers as a single group. If both refugees and asylum seekers thus form single groups, then our main comparison is between these two groups.

Section A: About you

Q1 Country

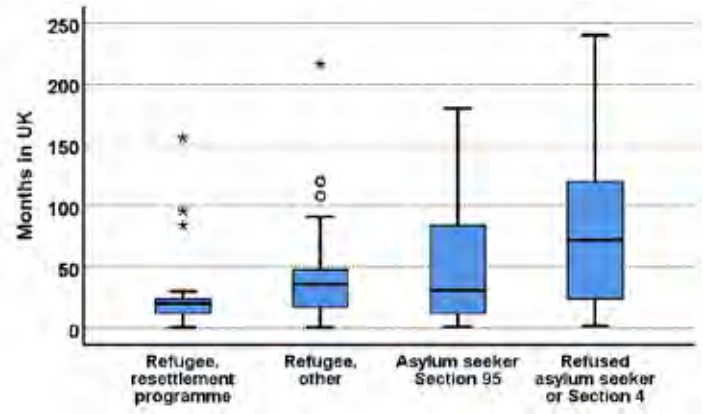
Number (% within asylum status)		Q7 & Q8 Asylum status			
		Resettled refugee	Other refugee	Asylum seeker	Total
Country	Syria	26 (84%)	7 (13%)	0 (0%)	33 (18%)
	Middle East (other)	1 (3%)	16 (30%)	14 (15%)	31 (17%)
	Africa North	1 (3%)	16 (30%)	22 (23%)	39 (22%)
	Africa South	0 (0%)	6 (11%)	16 (17%)	22 (12%)
	Indian subcontinent	2 (6%)	4 (8%)	26 (27%)	32 (18%)
	East Asia	1 (3%)	1 (2%)	8 (8%)	10 (6%)
	Europe and Americas	0 (0%)	3 (6%)	10 (10%)	13 (7%)
	Total	**31**	**53**	**96**	**180**

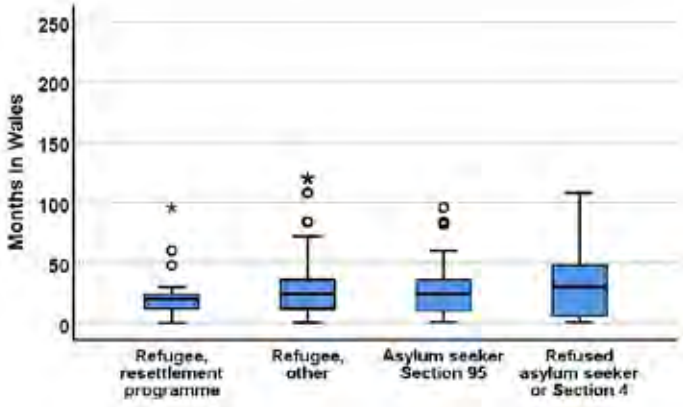
Refugees and asylum seekers differed highly significantly [chi-squared = 57.8 with 6 degrees of freedom (df); $p < 0.001$]. All 33 Syrians who replied to Q7 were refugees, of whom 26 (79%) were on a resettlement programme. Among the rest, refugees were more likely than asylum seekers to come from the Middle East or North Africa (chi-squared = 12.8 with 5df; p=0.026). The two types of asylum seeker did not differ significantly.

Q2 How long have you been living in the UK?
Q3 How long have you been living in Wales?

Because these are continuous rather than categorical variables, this table shows summary statistics. A boxplot (sometimes called a box-and-whisker plot) provides a visual summary below the table, contrasting the four types of refugee or asylum seeker.

	Resettled refugee	Other refugee	Section 95 asylum seeker	Refused asylum seeker
Months in UK (n=180)	**(n=31)**	**(n=53)**	**(n=68)**	**(n=28)**
Mean	26.4	38.8	44.2	80.7
Median	20.0	36.0	31.0	72.0
Std. Deviation	31.1	36.8	40.5	66.7
Minimum	0.4	0.5	1.0	2.0
Maximum	156.0	216.0	180.0	240.0
Interquartile Range	12.0	32.5	72.0	102.0
Months in Wales (n=182)	**(n=31)**	**(n=53)**	**(n=69)**	**(n=29)**
Mean	21.7	30.4	26.3	34.1
Median	20.0	24.0	24.0	30.0
Std. Deviation	18.3	26.1	22.5	30.3
Minimum	0.35	0.5	0.7	2.0
Maximum	96.0	120.0	96.0	108.0
Interquartile Range	12.0	24.0	25.5	41.5





Note: Boxes show the median between the lower and upper quartiles. Whiskers extend to the highest data point within 1.5 interquartile ranges (IQR) from the upper quartile and the lowest data point within 1.5 IQRs from the lower quartile. Circles show data points between 1.5 and 3 IQRs from the nearer quartile, and asterisks show data points more than 3 IQRs from the nearer quartile.

As both times had skewed distributions with a few very large values, we used non-parametric tests to compare groups of respondents. The Kruskal-Wallis test showed major differences in time spent in the UK among the four groups with significance level of 0.2%. More specifically resettled refugees

had spent significantly less time than other refugees (Mann-Whitney test; p = 0.017) or Section 95 asylum seekers (Mann-Whitney test; p = 0.037). In turn Section 95 asylum seekers had spent less time than other asylum seekers (Mann-Whitney test; p = 0.020). However the difference between other refugees and Section 95 asylum seekers was not significant (Mann-Whitney test; p = 0.78). In contrast time spent in Wales was similar for all four groups (Kruskal-Wallis test; p=0.44).

Q4 Gender

There was no significant difference by asylum status (chi-squared with 2 df = 1.38; p = 0.50).

Number (% within asylum status)		Refugee	Asylum seeker Section 95	Refused asylum seeker or Section 4	Total
Gender	Male	35 (41%)	24 (35%)	14 (47%)	73 (40%)
	Female	50 (59%)	45 (65%)	16 (53%)	111 (60%)
Total		**85**	**69**	**30**	**184**

This table excludes one respondent with 'Other' gender and 25 respondents who preferred not to reply, or did not know, or did not respond, to Q4 or Q7 or both.

Q5 Age

There was no significant age difference by asylum status.

Q6 Marital status

Number (% within asylum status group)	Q7&Q8 Asylum status			
	Resettled refugee	Other refugee	Asylum seeker	Total
Single, divorced, separated, widowed	5 (16%)	23 (42%)	50 (51%)	78 (42%)
Married or with partner	26 (84%)	32 (58%)	48 (49%)	106 (58%)
Total	**31**	**55**	**98**	**184**

Resettled refugees were more likely to be married or partnered than other refugees or asylum seekers (chi-squared = 10.5 with 1df; p=0.001). But there was no difference in marital status between other refugees and asylum seekers, or between the two types of asylum seeker.

Q9 Employment, education and volunteering

This question asked respondents to 'tick all that apply'. In the following table, Employed includes those who also ticked Education or Volunteer; Education includes those who also ticked Volunteer or Unemployed; and Volunteer includes those who also ticked Unemployed. The 4 groups differed significantly (chi-squared = 62.4 with 15 df; p < 0.001) mainly because all the employed were other refugees. Among those not employed there were still significant differences (chi-squared = 31.8 with 12 df; p=0.002): resettled refugees (64%) were more likely, and refused asylum seekers (19%) less likely, to be in education or training than the other two groups (34%). Most refused asylum seekers said they were unemployed. There were no significant differences between groups in the proportion volunteering.

Number (% within asylum status group)	Q7 and Q8 Asylum status				Total
	Resettled refugee	Other refugee	Asylum seeker Section 95	Refused asylum seeker or Section 4	
Employed full or part time	0 (0%)	11 (20%)	0 (0%)	0 (0%)	11 (6%)
Education or training full time	2 (6%)	4 (7%)	9 (13%)	4(13%)	22 (12%)
Education or training part time	19 (58%)	14 (26%)	15 (22%)	2 (6%)	50 (26%)
Volunteering	2 (6%)	7 (13%)	14 (20%)	5 (18%)	28 (15%)
Unemployed	7 (21%)	10 (19%)	15 (22%)	16 (52%)	48 (25%)
None of the above	3 (9%)	8 (15%)	16 (23%)	4 (13%)	31 (16%)
Total	**33**	**54**	**69**	**31**	**187**

Q10 Understanding of English and own language

This question comprised 5 x 3-point Likert scales and an extra option 'prefer not to say', which we treated as missing in crosstabulations. There is a highly significant pattern across the first three questions: those on refugee resettlement programmes considered themselves much less proficient at speaking and writing English, and conversing with health professionals than all other respondents. Though other refugees reported greater proficiency in all three aspects of English than asylum seekers, they did not differ significantly from them.

Q10a: Can you read English?

Number (% within asylum status group)		Q7 & Q8 Asylum status			Total
		Resettled refugee	Other refugee	Asylum seeker	
Can you read English?	No	7 (21%)	5 (9%)	9 (9%)	21 (11%)
	A little	22 (67%)	14 (26%)	44 (44%)	80 (43%)
	Yes, very well	4 (12%)	35 (65%)	48 (48%)	87 (46%)
Total		**33**	**54**	**101**	**188**

Chi-squared with 4 degrees of freedom is 24.0 ($p<0.001$)

Q10b: Can you speak English?

Number (% within asylum status group)		Q7 & Q8 Asylum status			Total
		Resettled refugee	Other refugee	Asylum seeker	
Can you speak English?	No	8 (24%)	6 (11%)	7 (7%)	21 (11%)
	A little	24 (73%)	17 (31%)	49 (50%)	90 (49%)
	Yes, very well	1 (3%)	31 (57%)	42 (43%)	74 (40%)
Total		**33**	**54**	**98**	**185**

Chi-squared with 4 degrees of freedom is 29.2 ($p<0.001$)

Q10c: Can you converse with a health professional in English?

Number (% within asylum status group)		Q7 & Q8 Asylum status			
		Resettled refugee	Other refugee	Asylum seeker	Total
Can you converse with a health professional in English?	No	21 (64%)	11 (21%)	16 (16%)	48 (26%)
	A little	12 (36%)	16 (31%)	42 (43%)	70 (38%)
	Yes, very well	0 (0%)	25 (48%)	40 (41%)	65 (36%)
Total		**33**	**52**	**98**	**183**

Chi-squared with 4 degrees of freedom is 37.9 ($p<0.001$)

Q11 Do you consider yourself to have a disability?
Q12 Do you have a long-term illness not covered by Q11?

These questions both asked for details of the disability or illness. We consider them together because several answers appeared in both (Appendix 3). About one third of both groups answered yes to at least one of these two questions. However refugees on resettlement programmes were significantly more likely than other refugees or asylum seekers to label their condition as disability rather than long-term illness (chi-squared = 14.2 with 2 df; $p=0.001$). There was no significant difference between the two types of asylum seeker.

Q11 and Q12: Disability and long-term illness

Number (% within asylum status group)		Q7 and Q8 Asylum status			
		Resettled refugee	Other refugee	Asylum seeker	Total
Disability and illness	Neither	21 (66%)	37 (66%)	60 (65%)	118 (66%)
	Disability	7 (22%)	5 (9%)	3 (3%)	15 (8%)
	Long term illness	1 (3%)	8 (14%)	19 (21%)	28 (16%)
	Both	3 (9%)	3 (5%)	7 (8%)	13 (7%)
	At least one*	0 (0%)	3 (5%)	3 (3%)	6 (3%)
Total		**32**	**56**	**92**	**180**

* Either Q11 or Q12 answered 'yes', but no response to the other.

Despite small expected numbers, the type of illness or disability varied between refugees and asylum seekers (chi-squared = 16.7 with 7df; $p=0.019$). Refugees were more likely to have learning difficulties or hearing problems (9 refugees but 1 asylum seeker) and less likely to have mental health problems or back pain (3 refugees but 13 asylum seekers).

Section B: Health Assessment on arrival in Wales

Q13 Were you sent an IHA appointment?

Number (% within asylum status group)		Q7 Asylum status			
		Refugee	Asylum seeker Section 95	Refused asylum seeker or Section 4	Total
Were you sent an IHA appointment?	No	22 (27%)	3 (4%)	4 (13%)	29 (16%)
	Yes	60 (73%)	66 (96%)	27 (87%)	153 (84%)
Total		82	69	31	182

Refugees were significantly less likely (73%) than asylum seekers (93%) to report receiving an appointment (chi-squared = 13.2 with 1 df; p = 0.001). The difference between types of asylum seeker was not significant (chi-squared = 2.41 with 1 df; p = 0.10).

Q14 Did you attend an IHA?

Number (% within asylum status group)		Q7 Asylum status			
		Refugee	Asylum seeker Section 95	Refused asylum seeker or Section 4	Total
Attended IHA?	No*	23 (27%)	6 (9%)	5 (16%)	34 (18%)
	Yes	61 (73%)	64 (91%)	26 (84%)	151 (82%)
Total		84	70	31	185

* No to Q14 or Q14 missing and No to Q13.

Refugees were also significantly less likely (73%) than asylum seekers (89%) to report attending an IHA (chi-squared = 8.31, 1df, p=0.004). Only 6 people reporting an IHA appointment said they did not attend it; and only 5 not reporting an appointment nevertheless said they did attend. Q15 asked for reasons for non-attendance; despite receiving explicit options, only 10 of the 34 non-attenders gave a reason and only 3 of these said they had been sent an appointment.

Section C: About your GP, Dentist, Optician and Pharmacist

Q16 Do you know how to register with a GP surgery?

Only 13 (42%) resettled refugees knew how to register – highly significantly fewer than 46 (82%) other refugees or 75 (74%) asylum seekers (chi-squared with 2df = 16.7; p<0.001).

Q17 Are you currently registered with a GP surgery?

Only 5 refugees and 3 asylum seekers said they were not registered with a GP.

Q17a How difficult was it to register with a GP?

Resettled refugees reported more difficulty in registering than other respondents (chi-squared for linear trend with 1 df = 21.8; p<0.001). However there was no difference between other refugees and asylum seekers of either type.

Number (% within asylum status group)		Q7 Asylum status			Total
		Resettled refugee	Other refugee	Asylum seeker	
Q17a How difficult was it to register with a GP?	Very easy	1 (3%)	7 (15%)	17 (20%)	25 (15%)
	Easy	4 (14%)	24 (50%)	36 (42%)	64 (40%)
	Neutral	12 (41%)	10 (21%)	22 (26%)	44 (27%)
	Difficult	6 (21%)	4 (8%)	9 (10%)	19 (12%)
	Very difficult	6 (21%)	3 (6%)	2 (2%)	11 (7%)
Total		**29**	**48**	**86**	**163**

Q17b Do you know how to make an appointment with a GP at your surgery?

Fifty (98%) of the 51 responding refugees and 67 (90%) of the 74 responding asylum seekers replied 'Yes'; this difference was not significant (chi-squared with 1 df = 2.83; p = 0.09). As there were many non-responses to this question, it is likely that both proportions are overestimates.

Q17bi How difficult is it to make an appointment with your GP surgery?

Number (% within asylum status group)		Q7 Asylum status			Total
		Resettled refugee	Other refugee	Asylum seeker	
Q17bi How difficult is it to make an appointment with your GP surgery?	Very easy	0 (0%)	6 (13%)	8 (9%)	14 (8%)
	Easy	3 (10%)	15 (32%)	29 (33%)	47 (28%)
	Neutral	15 (52%)	15 (32%)	19 (21%)	49 (30%)
	Difficult	6 (21%)	7 (15%)	22 (25%)	35 (21%)
	Very difficult	5 (17%)	4 (9%)	11 (12%)	20 (12%)
Total		**29**	**47**	**89**	**165**

Resettled refugees reported more difficulty than other groups in making GP appointments (chi-squared for linear trend with 1 df = 5.32; p = 0.021). There was no difference between other refugees and the two types of asylum seeker.

Q17c How happy are you with the quality of service you receive from your GP surgery?

Number (% within asylum status group)		Q7 Asylum status		Total
		Refugee	Asylum seeker	
Q17c Happy with GP quality of service?	Very happy	9 (12%)	18 (20%)	27 (16%)
	Happy	17 (23%)	38 (41%)	55 (33%)
	Neutral	34 (47%)	28 (30%)	62 (38%)
	Unhappy	8 (11%)	4 (4%)	12 (7%)
	Very unhappy	5 (7%)	4 (4%)	9 (5%)
Total		**73**	**92**	**165**

Asylum seekers were happier than refugees with the quality of service they received from their GP surgery (chi-squared for linear trend with 1 df = 7.50; p = 0.006), but the two types of asylum seeker were similar, as were the two types of refugee.

Q18 What do you know about these services available during daytime hours?

Knowledge about dentists or opticians was not associated with asylum status. Section 95 asylum seekers were more likely than other asylum seekers or refugees to know how to contact a pharmacist (chi-squared for linear trend with 1 df = 8.26; p=0.004) or health visitor (chi-squared for linear trend = 5.54, p=0.019).

Number (% within asylum status group)		Q7 Asylum status			Total
		Refugee	Asylum seeker Section 95	Refused asylum seeker or Section 4	
Q18c Pharmacist	Not heard of this	16 (22%)	5 (8%)	4 (15%)	25 (16%)
	Heard; don't know how to contact	14 (19%)	5 (8%)	6 (23%)	25 (16%)
	Heard & know how to contact	42 (58%)	49 (83%)	16 (62%)	107 (68%)
Total		**72**	**59**	**26**	**157**

Number (% within asylum status group)		Q7 Asylum status			Total
		Refugee	Asylum seeker Section 95	Refused asylum seeker or Section 4	
Q18d Health Visitor	Not heard of this	28 (37%)	14 (24%)	12 (46%)	54 (34%)
	Heard; don't know how to contact	21 (28%)	12 (21%)	3 (11%)	36 (23%)
	Heard & know how to contact	26 (35%)	32 (55%)	11 (42%)	69 (43%)
Total		**75**	**58**	**26**	**159**

Q19 Do you know that healthcare is free in Wales?

For this question there was no difference by asylum status.

Q20 Did you know an HC2 certificate can help to access NHS dental treatment, sight tests, glasses or contact lenses & cost of travelling to NHS treatment?

Number (% within asylum status group)		Q7 Asylum status		Total
		Refugee	Asylum seeker	
Did you know about HC2 certificate?	No	45 (52%)	20 (21%)	65 (36%)
	Yes	41 (48%)	77 (79%)	118 (64%)
Total		**86**	**97**	**183**

Asylum seekers were more likely to know than refugees (chi-squared with 1 df= 20.0; p<0.001). Resettled refugees (39%) were less likely to know than other refugees (53%), but this difference was not significant.

Section D: Factors that help or prevent you accessing healthcare

Q21 What or who has helped you to access health services in Wales?

Although many responses were equally likely across groups, there were significant differences by asylum status. Significantly more asylum seekers (48%; 47 out of 98) than refugees (28%; 24 out of 86) reported that asylum nursing services had helped them (chi-squared with 1 df = 7.78; p = 0.005). But refugees were more likely than asylum seekers to report that 'others' had helped; 6 of the 7 respondents who specified the Red Cross were resettled refugees. None of the 31 refused asylum seekers reported help from religious groups or 'staff with a positive attitude', but this was not significantly different from the other two groups. A higher proportion of refugees (9%) than asylum seekers (3%) were helped by the 'Welcome to Wales' leaflet, but more asylum seekers (16%) than refugees (7%) chose the general 'information leaflets' category. Again neither comparison was significant.

Q22 What have been barriers to you accessing and receiving healthcare in Wales?

Answers to this question came from 178 people with known asylum status: 81 refugees, 66 section 95 asylum seekers and 31 other asylum seekers. Only one difference was statistically significant: Section 95 asylum seekers (18%) were significantly more likely to find childcare or dependants a barrier than refugees (5%) or refused asylum seekers (0%) [chi-squared = 11.5 with 2 df; p = 0.003].

Splitting refugees by resettlement status revealed more differences. The negative attitude of staff was a barrier for 11 (17%) section 95 asylum seekers and 7 (14%) other refugees, compared with only one (3%) refused asylum seeker and no resettled refugee (chi-squared with 3 df = 8.37; p = 0.039). Resettled refugees were more likely (64%; 19) to find English a barrier to accessing health care than other refugees (25%; 13) or asylum seekers (27%; 26) [chi-squared with 2 df = 15.6; p < 0.001]. However equal proportions of all groups mentioned lack of language support.

Q23 Please describe how happy you were when accessing the following assistance

Number (% within asylum status group)		Q7 Asylum status		Total
		Refugee	Asylum seeker	
Q23a Language line	Very happy	2 (3%)	18 (12%)	10 (8%)
	Happy	17 (29%)	30 (45%)	47 (37%)
	Neutral	30 (51%)	18 (27%)	48 (38%)
	Unhappy	2 (3%)	4 (6%)	6 (5%)
	Very unhappy	8 (14%)	7 (10%)	15 (12%)
Total		59	67	126

Though 57% of asylum seekers and 32% of refugees were 'happy' or 'very happy' with the language line, the difference was not significant (chi-squared for linear trend with 1 df = 3.64; p=0.057). However asylum status did not affect opinions about interpretation face to face or by family and friends.

Section E: Accessing health care in daytime hours

Q24 In the past 3 months have you received treatment or helped someone else receive treatment for health problems, however minor, during daytime hours?

Section 95 asylum seekers were more likely (79%) to have received care than refugees or refused asylum seekers (60%) (chi-squared with 1df = 6.9; p = 0.008).

Number (% within asylum status group)		Q7 Asylum status			Total
		Refugee	Section 95 asylum seeker	Refused asylum seeker	
Treatment in last 3 months?	No	32 (39%)	14 (21%)	13 (42%)	59 (32%)
	Yes	51 (61%)	54 (79%)	18 (58%)	123 (66%)
Total		**83**	**68**	**31**	**182**

Q24a Please tell us about the person you were seeking treatment or advice for?

Number (% within asylum status group)		Q7 Asylum status		Total
		Refugee	Asylum seeker	
Seeking help for	Myself	24 (45%)	37 (51%)	61 (48%)
	Other person or people	22 (42%)	14 (19%)	36 (29%)
	Myself and others	7 (13%)	22 (30%)	29 (23%)
Total		**53**	**73**	**126**

Refugees were significantly more likely to have asked only about someone other than themselves (chi-squared with 2 df = 9.37; p = 0.009)

Q24b How many times during the last 3 months have you received treatment for any health problem, for yourself or someone else, during daytime hours?

Section 95 asylum seekers consulted more often than the other 2 groups (chi-squared for linear trend with 1 df = 3.99; p=0.048). However this difference was significant only because more of them did not consult at all; there was no difference between groups among those who consulted at least once.

Q24bi For what sort of health problem was your most recent contact?

Dental problems, the most common, did not differ between groups. However asylum seekers (31%) were significantly more likely than refugees (7%) to contact about a mental health issue, sleeplessness or tiredness (chi-squared with 1 df = 8.8; p = 0.003).

Q24bii Who or which services did you contact?

Among those who replied to this question, 3 (21%) of 14 resettled refugees, 12 (52%) of 23 other refugees, 24 (65%) of 37 Section 95 asylum seekers, and 12 (80%) of 15 other asylum seekers contacted a GP (chi-squared with 3 df = 11.6; p=0.009). More resettled refugees (8 out of 14, 57%) than other respondents (21 out of 75, 28%) contacted a dentist (chi-squared = 4.56; p = 0.033). More resettled refugees (7 out of 14, 50%) than other respondents (20 out of 75, 27%) contacted a hospital, but this difference was not statistically significant (chi-squared with 1 df = 3.04; p = 0.081). There were no other differences between groups.

Q25 What do you know about the following services during daytime hours?

Only two of nine services listed differed by asylum status: the NHS 111 telephone line was better known among Section 95 asylum seekers than refugees and refused asylum seekers (chi-squared for linear trend with 2 df = 10.81; p = 0.001); and refugees knew significantly more about the Minor Injuries Unit than asylum seekers of either type (chi-squared for linear trend with 2 df = 5.40; p = 0.020). Asylum seekers knew more, but not significantly more, than refugees about the 999 ambulance service (chi-squared for trend with 1 df = 3.39; p=0.061)

Number (% within asylum status group)		Q7 Asylum status			Total
		Refugee	Section 95 asylum seeker	Refused asylum seeker	
NHS 111 line	Not heard of it	42 (56%)	21 (32%)	17 (59%)	80 (47%)
	Heard, don't know how to contact	13 (17%)	10 (15%)	2 (7%)	25 (15%)
	Heard, know how to contact	20 (27%)	34 (52%)	10 (34%)	64 (38%)
Total		**75**	**65**	**29**	**169**
Minor injuries unit	Not heard of it	35 (51%)	40 (64%)	24 (83%)	99 (62%)
	Heard, don't know how to contact	16 (23%)	11 (18%)	3 (10%)	30 (19%)
	Heard, know how to contact	18 (26%)	12 (19%)	2 (7%)	32 (20%)
Total		**69**	**63**	**29**	**161**

Number (% within asylum status group)		Q7 Asylum status		Total
		Refugee	Asylum seeker	
999 ambulance	Not heard of it	9 (12%)	6 (6%)	15 (9%)
	Heard, don't know how to contact	13 (17%)	10 (11%)	23 (14%)
	Heard, know how to contact	53 (71%)	78 (83%)	131 (78%)
Total		**75**	**94**	**169**

Section F: Accessing health care at night, weekends and public holidays

Q26 In the past 3 months, have you received, or helped anyone else receive, treatment for any health problems, however minor, outside daytime hours?

There were no significant differences between groups for this question or any sub-question.

Q27 What do you know about the following services outside daytime hours?

Of the six services listed, knowledge about five was not related to asylum status. However asylum seekers knew more than refugees about the 999 ambulance service (chi-squared for linear trend with 1 df = 4.48; p = 0.034).

Q27.5 What do you know about the 999 ambulance service outside daytime hours?

Number (% within asylum status group)		Q7 Asylum status		Total
		Refugee	Asylum seeker	
Q27.5 999 ambulance service	Not heard of this	10 (13%)	9 (10%)	19 (11%)
	Heard of; don't know how to contact	19 (24%)	8 (9%)	27 (16%)
	Heard of & know how to contact	49 (63%)	76 (82%)	125 (73%)
Total		**78**	**93**	**171**

Q29 Did you complete this with the help of a researcher or support worker?

Only 36% of 88 refugees but 65% of 97 asylum seekers reported help with the survey (chi-squared = 15.1 with 1 df; p < 0.001). But there was no difference between types of asylum seeker or of refugee.

Appendix 5: Associations between gender and survey responses

Section A: About you

Q1 Country

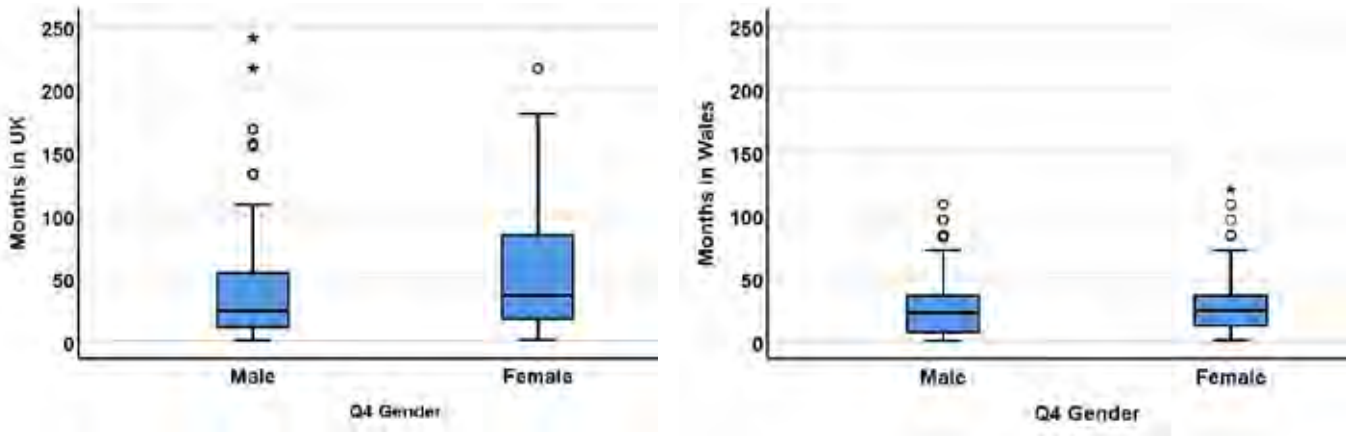
Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q1 Country (grouped)	Syria	12 (16%)	20 (18%)	32 (17%)
	Middle East (other)	21 (27%)	12(11%)	33 (17%)
	Africa North	19 (25%)	23 (20%)	42 (22%)
	Africa South	9 (12%)	15 (13%)	24 (13%)
	Indian subcontinent	11 (14%)	23 (20%)	34 (18%)
	East Asia	2 (3%)	9 (8%)	11 (6%)
	Europe and Americas	3 (4%)	11 (10%)	14 (7%)
Total		**77**	**113**	**190**

Men were more likely to be from the Middle East; women more likely to be from the Indian subcontinent, East Asia and Europe and America, but the difference was only just significant [chi-squared with 6 degrees of freedom (df) = 13.3; p = 0.039].

Q2 How long have you been living in the UK?
Q3 How long have you been living in Wales?

Because these are continuous rather than categorical variables, this table shows summary measures (e.g. averages, minimum, maximum). A boxplot (sometimes called a box-and-whisker plot) provides a visual summary below the table, contrasting males with females.

	Male (n=78)	Female (n=112)
Months in UK (n=190)		
Mean	43.2	47.4
Median	24.0	36.0
Std. Deviation	51.9	42.2
Minimum	0.4	1.0
Maximum	240.0	216.0
Interquartile Range	26.0	66.8
Months in Wales (n=190)		
Mean	25.3	29.1
Median	22.5	24.0
Std. Deviation	24.9	23.4
Minimum	0.35	0.7
Maximum	108.0	120.0
Interquartile Range	29.0	24.0



Men had spent significantly less time in the UK than women (p=0.048, Mann-Whitney non-parametric test). Men had spent less, but not significantly less, time in Wales than women (p=0.068, Mann-Whitney test).

Q5 Age

There is no age difference between men and women.

Q6 Marital status

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q6 Marital status (3 groups)	Single	33 (42%)	31 (27%)	64 (33%)
	Married or with partner	45 (57%)	66 (57%)	111 (57%)
	Separated, divorced, widow	1 (1%)	19 (16%)	20 (10%)
Total		**79**	**116**	**195**

The marital status of males and females differed significantly (chi-squared with 2 df = 13.7; p = 0.001). Although equal proportions (57%) of men and women were married, 19 of the 20 separated, divorced or widowed were female.

Q7 Asylum status

There is no significant gender difference between the 4 asylum status groups (Appendix 4).

Q8 Did you move to Wales as part of a resettlement programme?

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q8 Resettlement programme?	No	56 (79%)	62 (69%)	118 (73%)
	Yes	15 (21%)	28 (31%)	43 (27%)
Total		**71**	**90**	**161**

31% of women and 21% of men were in a resettlement programme (chi-squared with 1 df = 2.02; p = 0.155). However more than half of these were from Syria. 85% (17/20) of Syrian women and 67% (8/12) of Syrian men were in a resettlement programme. Among non-Syrians only 11% of women and 9% of men were part of a resettlement programme. None of these differences were significant.

Q9 Occupation (employment, education, volunteering)

Although there were no significant gender differences in employment status, men were less likely than women to be in part-time education but more likely to be in full-time education (chi-squared with 2 df = 4.41; p = 0.11).

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q9 Education or training	No, but other response	49 (60%)	72 (63%)	121 (62%)
	Part time	18 (22%)	33 (29%)	51 (26%)
	Full time	14 (17%)	9 (8%)	23 (12%)
Total		**81**	**114**	**195**

Q10 Understanding and use of English and own language
Q11 Do you consider yourself to have a disability?
Q12 Do you have a long-term illness not covered by Q11?

Male and female answers to these questions did not differ.

Section B: Health Assessment/Check on arrival to Wales

Q13 Did you receive an appointment to attend an initial health assessment?
Q14 Did you attend an initial health assessment?
Q16 Do you know how to register with a GP surgery?

Male and female answers to these questions did not differ.

Section C: About your GP, Dentist, Optician and Pharmacist

Q17 Are you currently registered with a GP surgery?

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q17 Registered with GP now?	No	9 (12%)	2 (2%)	11 (6%)
	Yes	64 (88%)	110 (98%)	174 (94%)
Total		**73**	**112**	**185**

Women were more likely to be registered than men (chi-squared with 1 df = 8.78; p = 0.003).

Q17a How difficult or easy was it to register with a GP surgery?
Q17b Do you know how to make an appointment with a GP at your surgery?

Male and female answers to these two questions did not differ.

Q17c How difficult is it to make a GP appointment?

Women found it more difficult to make an appointment than men, but the difference was not quite significant (trend chi-squared with 1 df = 3.58; p = 0.058)

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q17b How difficult or easy is it to make a GP appointment?	Very easy	6 (9%)	10 (9%)	16 (9%)
	Easy	24 (36%)	22 (21%)	46 (27%)
	Neutral	18 (27%)	35 (33%)	53 (31%)
	Difficult	14 (21%)	22 (21%)	36 (21%)
	Very difficult	4 (6%)	17 (16%)	21 (12%)
Total		**66**	**106**	**172**

Q17d How happy are you with the quality of service you receive from your GP surgery?

Male and female answers did not differ.

Q18 What do you know about following services available during daytime hours?

Women knew more about all 4 types of service, but only the difference in knowledge about Health Visitors was significant (trend chi-squared with 2 df =10.9; p = 0.005):

Q18d What do you know about the Health Visitor service?

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q18d Health Visitor	Not heard of it	29 (43%)	29 (30%)	58 (35%)
	Heard, don't know how to contact	21 (31%)	18 (18%)	39 (23%)
	Heard, know how to contact	18 (26%)	51 (52%)	69 (42%)
Total		**68**	**98**	**166**

Q19 Do you know that healthcare is free in Wales?

Women were much more likely to know this than men (chi-squared with 1 df = 6.11; p = 0.013):

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q19 Do you know healthcare is free?	No	22 (27%)	15 (13%)	37 (19%)
	Yes	60 (73%)	101 (87%)	161 (81%)
Total		**82**	**116**	**198**

Q20 Did you know that an HC2 certificate can access NHS dental care, sight tests, the cost of glasses or contact lenses, & the cost of travel to NHS treatment?

Women were more likely to know this, but the difference was not significant (chi-squared with 1 df = 2.65; p = 0.103):

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q20 HC2 Certificate	No	35 (44%)	37(33%)	72 (38%)
	Yes	44 (56%)	76 (67%)	120 (62%)
Total		**79**	**113**	**192**

Section D: Factors that help or prevent you accessing healthcare

Q21 What or who has helped you to access health services in Wales (Tick all that apply)?

Number (% within gender)	Q4 Gender		
	Male	Female	Total
Q21 Health Visitor	5 (6%)	25 (22%)	30 (16%)
Q21 Information leaflets	13 (16%)	9 (8%)	22 (11%)
Q21 Religious communities	11 (14%)	7 (6%)	18 (9%)
Q21 Positive attitude of staff	2 (3%)	13 (12%)	15 (8%)
Total answering Q21	**79**	**113**	**192**

Among 14 potential sources of help, women were significantly more likely than men to have been helped by health visitors (chi-squared with 1 df = 8.80; p = 0.003) or positive attitudes of health service staff (chi-squared with 1 df = 5.20, p = 0.023). Men were non-significantly more likely than women to have been helped by religious communities (chi-squared with 1df = 3.27; p = 0.071) or by information leaflets (chi-squared with 1 df = 3.30; p=0.069). Other sources did not differ between men and women.

Q22 What issues, if any, have been a barrier to you accessing and receiving healthcare in Wales? (Tick all that apply)

Of nine issues, all but one were similar for males and females: women were more likely than men to find caring for children or dependents a barrier (chi-squared with 1 df = 5.74; p= 0.017). They were also more likely to find distance a barrier (14% of women versus 7% of men), but this difference was not statistically significant (chi-squared with 1 df = 2.78; p= 0.10).

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q22 Childcare or dependents	No	74 (97%)	97(87%)	171 (91%)
	Yes	2 (3%)	14 (13%)	16 (9%)
Total		76	111	187

Q23 Please describe how happy you were when accessing the following assistance

Men and women gave similar responses to this question.

Section E: Accessing healthcare in daytime hours

Q24 In the past 3 months, have you received treatment or advice, or helped someone else do so, for any health problem, however minor, in daytime hours?

Women were more likely (81/111 = 73%) than men (46/79 = 58%) to answer 'yes' (chi-squared with 1 df = 4.53; p = 0.033).

Q24a Please tell us who you were seeking treatment or advice for (Tick all that apply)

More women (79) than men (45) ticked at least one box. Despite small numbers, there were 2 significant differences: 38 women (49%) but only 11 men (24%) selected 'My child' (chi-squared with 1 df = 6.71; p = 0.010); and six men (13%) and one woman (1%) selected 'Other than family' (chi-squared with 1 df = 7.84; p = 0.005).

Q24b How many times during the last 3 months have you received treatment or advice for any health problem, for yourself or someone else, during daytime hours?

Women consulted more frequently than men (trend chi-squared with 1 df = 4.76; p=0.029).

Number (% within gender)		Q4 Gender		
		Male	Female	Total
Q24b Number of times received treatment or advice	None	34 (44%)	28 (27%)	62 (34%)
	1	13 (17%)	17 (16%)	30 (16%)
	2	11 (14%)	15 (14%)	26 (14%)
	3-5	13 (17%)	32 (30%)	45 (25%)
	6 or more	7 (9%)	13 (12%)	20 (11%)
Total		78	105	183

Q24c What sort of health problem was your most recent contact for?

Similar proportions of men and women mentioned dental or mental health problems; other answers were too rare for useful comparison.

Q24d In your most recent contact, who or which services did you contact?

As we specified no options for this sub-question, we grouped replies as other questions about types of services. Only 28 men and 66 women responded. Seven women (10%) but no men consulted 'family and friends', but this was not significant (chi-squared with 1 df = 2.98; p = 0.084). Otherwise men and women answered similarly.

Q25 What do you know about following services available during daytime hours?

Of nine services, all reported on the same 3-point scale, only three had significant gender differences: women knew significantly more than men about maternity and antenatal services (trend chi-squared with 1 df = 7.37; p = 0.007) and NHS 111 telephone line (trend chi-squared with 1 df = 10.8; p = 0.001). Though women were also more likely to know how to contact the family planning service, both genders were equally likely not to have heard of it at all (chi-squared with 2 df = 9.77; p = 0.008).

Number (% within gender)		What do you know about this service?			Total
		Not heard of it	Heard, don't know how to contact	Heard, and know how to contact	
Q25a Maternity and antenatal	Male	44 (63%)	15 (21%)	11 (16%0	**70**
	Female	47 (49%)	11 (11%)	38 (40%)	**96**
Q25b Family planning	Male	41 (57%)	18 (25%)	13 (18%)	**72**
	Female	52 (53%)	11 (11%)	36 (36%)	**99**
Q25f NHS 111 telephone	Male	48 (62%)	10 (13%)	20 (26%)	**78**
	Female	37 (37%)	15 (15%)	47 (47%)	**99**

Section F: Accessing healthcare at night or weekends & on public holidays

Q26 In past 3 months, have you received or helped anyone else receive, treatment or advice for any health problem, however minor, outside daytime hours?

There were no significant differences for this question or any sub-question.

Q27 What do you know about following services available outside daytime hours?

Number (% within gender)		What do you know about this out of hours service?			Total
		Not heard of it	Heard, don't know how to contact	Heard, and know how to contact	
Q27a GP	Male	51 (68%)	11 (15%)	13 (17%)	**70**
	Female	50 (49%)	20 (20%)	32 (31%)	**96**
Q27c Hospital A&E	Male	33 (45%)	13 (18%)	27 (37%)	**73**
	Female	28 (29%)	22 (23%)	47 (48%)	**97**
Q27d NHS Direct 111 telephone	Male	46 (61%)	12 (16%)	18 (24%)	**76**
	Female	29 (29%)	26 (26%)	45 (45%)	**100**
Q27f Pregnancy delivery suite	Male	41 (57%)	18 (25%)	13 (18%)	**72**
	Female	52 (53%)	11 (11%)	36 (36%)	**99**

Gender did not affect knowledge about pharmacists or 999 ambulances. Women knew more about GPs out of hours (trend chi-squared with 1 df = 6.46; p = 0.011), hospital Emergency Departments (trend chi-squared with 1 df = 4.06, p=0.044), NHS Direct (trend chi-squared with 1 df = 15.4; p < 0.001), and delivery suites (trend chi-squared with 1 df = 9.33, p = 0.002).

Final administrative question

Q29 Did you complete this with the help of a researcher or support worker?

Though 45 (55%) of 82 men and 52 (46%) of 112 women had help with questionnaires, these proportions do not differ significantly (chi-squared with 1 df = 1.35; p = 0.245).

Appendix 6: Focus Group Topic Guide

HEAR
Asylum Seekers and Refugees

Aim

To understand the effect of health service experiences on the health (physical and mental) and well-being of adult asylum seekers and refugees in Wales

Objectives for Focus group

a) Explore awareness of services

b) Explore positive experience of services and what helps

c) Explore what could be done differently to improve experiences

d) Explore expectations for support and care

e) Explore ways communication between patients and services could be improved

1. Introductory vignettes

Here are a few scenarios – things which could happen to people like us. Can you tell me what you think?

a. *Husband/wife has a painful eye. It is very red and watering and vision is blurred*

- Changed circumstances: evening

[**Prompts to aid discussion**: What should they do?

When should they do something else/ extra/ different?

Should he/she contact anyone? Why?

What will happen if he/she doesn't do anything?

Are there any reasons why they may not do anything?

Is this what you would do if you were the person in this story?]

b. ***Sister aged 18 years is always tired, very sad, mostly stays at home, lost interest in things she used to like. She's been like this for a month***

- Changed circumstances: She's been like this for 3 months

[**Prompts to aid discussion**: What should she do?

Should she contact anyone? Why?

What will happen if she doesn't do anything?

Are there any reasons why she may not do anything?

When should she do something else/extra/different?

Is this what you would do if you were the person in this story?]

c. Child has been up all night with a fever and cough which they have had for 24 hours

- Changed circumstances: child's temperature/cough has lasted more than a week

[**Prompts to aid discussion**: What should the parent do?

Should the parent contact anyone? Why?

What will happen if the parent doesn't do anything?

Are there any reasons why the parent may not do anything?

When should the parent do something else/ extra/ different?

Is this what you would do if you were the parent of the child in this story?]

2. <u>General questions</u>

a. Would you like to tell us about your own particular experience of using healthcare services?
   - What worked well, what didn't
   - What about other services (GP, secondary care, opticians, dentist, pharmacists, health assessment)

b. Is there anything that made it easier for you to access any of these services that you have used?
   - Advice (Welcome to Wales, information leaflet, family, neighbours, charity, response from healthcare staff)
   - Support (family, neighbours, charity, healthcare staff)
   - Websites
   - Transport
   - Cultural knowledge

c. Thinking about the GP service in particular:
   - Did you know how to register with the service (or was this in place already)?
   - Have you sought advice from the doctor/nurse/HV?
   - What helped you access this service (welcoming service, support from HV, charity)?
   - What was difficult about this service (travel, communication, making appointment, staff attitude)?

d. What do you do to help you stay well (emotionally and physically)?
   - Explore resilience (hobbies, family, religion)

Thank you.

- Do you have anything further you want to tell us or have any questions about your experience or the healthcare service in Wales
- Do you have recommendations to improve the service or care that you've received

Appendix 7: Health Professional Interview Schedule

Aim

As part of the HEAR study, we will conduct telephone interviews with NHS health practitioners and care providers to explore their experience of providing care for asylum seekers and refugees and how they perceive it affects the care of patients.

Objectives

To explore NHS staff views on:

1. the scope of health provision and changing roles
2. process and experience of delivering care to asylum seekers and refugees including problems and benefits of providing care
3. training received and how prepared they feel in providing and addressing the care needs of asylum seekers and refugees in primary and secondary care
4. Their perceptions on the patients' experience of care
5. Health service encounter
    a. Communication
    b. Cultural understanding (medication, access to health)
    c. Continuity of care
    d. Time
    e. Trusting relationships
    f. Health and social conditions
6. Health system
    a. Linking in with other services; organisation and integration
    b. Professional support
    c. Resources and capacity
    d. Training and guidance

Draft topic guide

1. Please you describe your professional role.
2. How often do you provide care for AS&R's in your line of work?
    a. How would you know if someone was an AS or refugee?
    b. How and why did you get involved with working with AS&R's?
    c. How did this work/role come about? Is there specific funding available for this work?
    d. Do you share the work load with any other colleague(s)?
    e. How long have you been working this way?
3. Thinking about a recent contact can you describe how you responded to a patient who was an AS or refugee in your current role.
    a. Refer to a particular situation
    b. Assessment of the patient
    c. Health problems

4. Which services do you often liaise with or refer patients to?
    a. GP
    b. Secondary care
    c. Social care services
    d. AS&R specialist services

5. Are there any issues you would like to talk about in terms of working with other health professional or social care professionals?

6. How do you think the patients respond to the care you provide?
    a. What is it that you do that works well for the patient?
    b. How willing are they to agree to your diagnosis/prescription?
    c. How do you manage their expectations?
    d. How long do you support patients?

6. Thinking more generally about the care you provide;
    a. Do you feel that you are confident in your understanding of the patients' particular needs and entitlements?
    b. Do you feel you have had the necessary training and resources to care for AS&R patients?
    c. Was the training sufficient?
    d. Was the training long enough/too long?
    e. How prepared did you feel after completing the training?
    f. How long was it after the training before you were caring for AS&Rs?
    g. Was there anything else you would like to see included/done differently in the training?

7. How does the care that you provide to AS&Rs differ compared to the general population?
    i) Time
    ii) Resources

8. How do you think a health professional's role should develop in the future to provide appropriate care for this patient group?
    a) Do other health professionals share your views?
    b) How do their opinions influence you?

9. Are there any specific issues you would like to raise about caring for this patient group?
    i) cultural barriers/understanding (care, medication)
    ii) practical/access issues
    ii) communication
    iii) risk involved with caring for this patient group
    iv) health or social care issues

10. Is there anything else you would like to add?

Appendix 8: Resources highlighted by people seeking sanctuary or professionals

1. Websites: One practitioner mentioned using the Islington Council website for advice on supporting people who have no recourse to public funds to understand health and care entitlements. One volunteer worker mentioned accessing heath information on pregnancy and child care in Arabic for a mother.

   http://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/PresentDetail?Open&s=Starting_Solids

2. Information booklets: A paramedic mentioned using a Multi-lingual emergency phrase book. The booklet is available to all emergency service workers in England and covers 41 languages and includes the 21 most used triage phrases.

   https://www.nhsconfed.org//media/Confederation/Files/Publications/Documents/MEP-A5-3009-web.pdf

   Life in the UK book was also mentioned by a support worker as a resource to explain services in Wales.

3. Access cards: In Neath Port Talbot the local Black Minority Ethnic Community Association working with services has developed an Access Card which shows the reader that the person presenting the card requires an interpreter. At present the card is being publicised across health and local authority run services and services are encouraged to have in place procedures offering language interpretation to all those who present the card.

   www.wales.nhs.uk/sitesplus/863/opendoc/321734

   In another area a community organisation had provided cards with NHS 111 and 999 numbers so that people were aware of where to call if they needed advice or had an emergency.

   In West Wales an English tutor in an English as a second language (ESOL) class has developed a prompt card with a number of short key phrases to use in a healthcare settings and to access services.

4. Maps and images: There were instances where maps and images were used to overcome the language barriers. Visual cues enabled asylum seekers and refugees to navigate the landscape to locate clinics and GP surgeries and hospitals. In one area the Health Assessment Team mentioned that the use of maps and images had dramatically reduced missed appointments. Opticians were also able to use pictures to undertake eye examinations and were not reliant on a person's ability to read letters. However, these resources can be difficult to keep-up-date, as voluntary sector services due to funding and capacity.

In Table 3 we illustrate innovative ways health service providers have tried to address the needs of people seeking sanctuary either by modifying practice or introducing new procedures.

Table 3: Innovative ways of working and examples of good practice

1. Funding through a new contract between a Health Board and selected dental practices provides longer appointments and access to interpretation through Language Line for patients referred by the local Health Assessment Team	2. A community dental service provided basic dental treatment to patients referred by the Asylum Seeker nurse. Once treatment was complete, the patients were encouraged to register with a local practice for NHS check-ups and future care
3. Weekly drop in sessions, facilitated by the British Red Cross and volunteers and attended by specialist health visitors, for AS&Rs to discuss health concerns for themselves and family members. Staff could also write prescriptions for minor ailments.	4. Specialist asylum seeker services proactively provide support including; a nurse to attend GP appointments with patients; transport to appointments; liaison with third sector services; referral to services such as mental health.
5. Specialist GP working within the Health Assessment Team provided longer appointments to explore individual health and psycho-social issues; flexible arrangement, able to do blood tests and x-rays on the same day; access to interpretation including wider social issues and legal matters.	6. Specialist midwife for vulnerable adults who is caring for asylum seeker and refugee women attending maternity appointments at a local hospital. Referrals made by the Health Assessment Team. 7. Social workers assigned by local authority to support Syrian refugees in collaboration with volunteers.
8. Innovations by primary and secondary care providers in response to high numbers of asylum seekers and refugees in their area: -Proactively arranging language support -Processing travel payments for asylum seekers and refugees -Close communication with local asylum seeker and refugee support services, usually a nurse -Training for GP reception staff by shadowing the AS&R nurse -Receptionist checking immunisation	9. List of GP and dental practices willing to take asylum seekers and refugees, drawn up by the Health Board and shared with primary care providers 10. Opticians going out doing outreach work informing asylum seekers and refugees about the service and its eligibility; accessibility to both children and adults; clearing up misconceptions about what the service was for, some people thought opticians meant 'options.'

records of asylum seekers and refugees registered at a GP practice -Flagging translation needs when an asylum seeker and refugee patient makes a GP appointment -GP cluster employs AS&R health worker to support patients understanding of the service, explain healthcare processes, making appointments, access to travel expenses, identifies vulnerabilities such as trauma etc.	11. Monthly health and well-being meetings, held by a voluntary group, for third sector and specialist asylum seeker services to meet and discuss care and management of patients.
12. Third sector and community volunteers supporting asylum seekers and refugees in improving their well-being and mental health through engagement (counselling, gardening, art, sports, drop ins)	13. Three monthly meetings with health service providers and Health assessment team