People Seeking Asylum, Refugees and People Refused Asylum

JSNA Profile

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Nottingham City Council – Produced 31/05/2024.
Public.health@nottinghamcity.gov.uk

Key Health Needs – Evidence Summary

Communicable Diseases

There is evidence that prevalence of certain communicable diseases is greater amongst people seeking asylum, refugees and people refused asylum in the UK (Crawshaw et al, 2018). It should be noted that the evidence is often poor due to the lack of data that is routinely collected. However, it is known that this population often travel from and through countries with higher prevalence of certain communicable diseases that are rare in the UK and are more likely to reflect the prevalence rates from their countries of origin.

Notably, large proportions of this population are from countries where Hepatitis B, Tuberculosis (TB) and HIV are far more prevalent than in the UK (Cinardo, et al., 2022) (Eiset & Wejse, 2017). People leaving their home countries can also face cramped living conditions, breaks in treatment, lack of clean water and exposure to infectious diseases during the journey which can enhance the exposure to communicable diseases (WHO, 2018).

Reduced levels of Immunisation

Research suggests that immunisation status is generally lower in this population. Vaccinations are often incomplete, and this population are unlikely to have records to demonstrate their vaccination status. A large study of refugees bound for the UK between 2018-2019 found that there was a significant lack of vaccination coverage for 13 key vaccine preventable diseases and that generally where there was some coverage, it was very rarely in line with the level of coverage that would be given in the UK (Deal et al, 2022).

Mental Health

Studies have found that Post Traumatic Stress Disorder (PTSD) amongst this population is diagnosed at a higher rate than the host population (Priebe, Giacco, & El-Nagib, 2017) (WHO, 2018). In their countries of origin, people seeking asylum and refugees can experience a significant range of risk factors for PTSD including persecution and armed conflicts. Exposure to conflict may range from witnessing destruction and death directly to having a number of traumatic experiences, including torture or combat involvement. Some individuals from refugee populations have also faced economic hardship, including a lack of food, water, shelter and other basic needs and resources. A 2005 systematic review found that the prevalence of PTSD ranged between 9% and 17% for people seeking asylum and refugees in Europe against host population rates of 1-3% (Fazel , Wheeler, & Danesh, 2005). A 2020 systematic review including studies from 15 countries found that 31.46% of people seeking asylum and refugees were diagnosed with PTSD (Blackmore et al, 2020).

There Is also evidence that self-reported mental health of people seeking asylum is poor (Due, Green, & Ziersch, 2020) (Jones, et al., 2022) (Moore, Burgess, & Catona, 2022). There is evidence of high levels of stress and mental distress related to the asylum-seeking process. Key factors contributing to this are uncertainty about the asylum application, loneliness, isolation and feelings of powerlessness and lack of social integration (Fish & Fakoussa, 2018) (Jones, et al., 2022).

Literature also shows recognition that concepts of mental health differ culturally, and that the presentation of mental health need is likely to show significant variation. People seeking asylum and refugee patients may present with somatic symptoms, such as headaches, chest pain, back pain, and abdominal symptoms. (Knights, Munir, Ahmed, & Hargreaves, 2022). 'Mental health' is also highly stigmatized in many parts of the world, and this is likely to have an impact on the health-seeking behaviour of people seeking asylum and refugees (WHO, 2018).

Maternal health

Women seeking asylum and refugee women have been highlighted as facing several additional challenges throughout pregnancy. It is notable that poor outcomes in pregnancy are faced more generally by certain groups in the UK with the 2022 MBRRACE report finding that between 2018-2020 Black women were 3.7x more likely to die than white women (34 women per 100,000 giving birth) and Asian women were 1.8x more likely to die than white women (16 women per 100,000 giving birth) (Knight, et al., 2022).

Research has identified that people seeking asylum generally access maternal care later, do not take recommended levels of folic acid, receive reduced ante natal care, experience heightened levels of stress and have increased postnatal length of stay with insufficient discharge planning for mothers and infants with increased social needs (Jones et al., 2022) (Sturrock et al., 2021).

Female Genital Mutilation

Female genital mutilation/cutting (FGM/C) is defined by the World Health Organization (WHO) as, 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'. The practice of FGM is illegal in the UK but remains prevalent in many parts of the world. There are multiple physical and psychosocial factors that accompany FGM/C, including infections, heavy bleeding, menstrual difficulties, sexual impairment, and Post Traumatic Stress Disorder. Depending on what type of FGM/C has occurred there will also be different interventions required during the intrapartum period to facilitate childbirth (Turner & Tancred , 2023).

People seeking asylum, refugees and people refused asylum have been identified as being at a particular risk of having experienced FGM, primarily because many individuals from this population come from countries with some of the highest rates of FGM, such as Eritrea, Sudan and Somalia which have prevalence rates amongst 15 and 49 year old women of 83%, 87% and 99% respectively (Turner & Tancred, 2023). People seeking asylum, refugees and people refused asylum have been identified as facing additional barriers to receiving appropriate care for FGM/C such as having lower health literacy levels and lack of support networks.

Sexual and Gender Based Violence

There is evidence that people seeking asylum, refugees and people refused asylum experience Sexual and Gender Based Violence (SGBV) at higher rates than the general population. Risks of SGBV are highlighted at different stages throughout the migration and asylum process including: pre displacement, during conflict, throughout the migration journey and once in the receiving country. Many survivors of SGBV have reported SGBV at multiple points along their journeys (Pertek, et al., 2021). SGBV can be experienced by anyone seeking asylum or any refugee. However, it is believed that this is overwhelmingly experienced by women.

Whilst in the UK women can face particular risks when they face risks of having "No Recourse to Public Funds" (NRPF) including when immigration status and access to financial support is dependent on that a spouse and where asylum applications have been refused with no further access to appeal (Dudia, 2020) (Pertek, et al., 2021).

Child Health

Evidence suggests that both accompanied and unaccompanied asylum-seeking children face additional health risks. Despite being a heterogenous population, research has shown that asylum seeking and refugee children can face a range of additional health risks, in particular on entry to a country. A 2019 systematic review of 53 studies including the health records of 223037 asylum seeking and refugee children across 9 high income reception countries showed that this population exhibit high estimated prevalence rates for anaemia (14%), haemoglobinopathies (4%), chronic hepatitis B (3%), latent tuberculosis infection (11%) and vitamin D deficiency (45%) on entry in reception countries. The review found that one third of refugee children had a form of intestinal infection and found that on arrival children faced nutritional problems ranging from wasting and stunting to obesity (Baauw, et al., 2019).

A 2022 study of asylum-seeking children accessing a UK clinic in the North of England found that over two years, 80 children accessed this service. With the most frequent diagnoses (total n = 104) being anaemia (n = 17), neurodevelopmental (n = 12), respiratory (n = 12) and mental health (n = 9) conditions. Mild–moderate stunting (23%), overweight and obesity (41%), stunting with obesity (9%) and micronutrient deficiencies (vitamin D (66%), vitamin A (40%) and manifest (14%) or latent (25%) iron deficiency anaemia) were highly prevalent. 62% of children had experienced psychological trauma, and 39% had abnormal results in psychosocial wellbeing screening. 21% of children required secondary or tertiary care, 8% mental health referrals, and 47% were followed up in a specialist clinic (Harkensee & Andrew, 2021).

Unaccompanied Asylum-Seeking Children

Recent UK research into the health needs of Unaccompanied Asylum Seeking Children has shown that in this population there is significantly higher prevalence of infectious diseases, mental health needs and experiences of physical and sexual abuse (Armitage , et al., 2022) (Cardoso Pinto, Seery, & Foster, 2022).

Oral health is also an identified risk for this population (Davies Hayton & Oates , 2019).

Oral Health

Oral health problems are common in people seeking asylum and refugees. Oral health has been reported to be one of the most common health needs of this population. While the number of studies is relatively small, poor oral health outcomes have also been recorded amongst this population, with barriers to accessing dental care, changes to diet, prioritisation of other factors during the resettlement process and only accessing dental services with in pain being noted as key causes (Zinah & Al-Ibrahim, 2021).

Globally it is believed that people seeking asylum and refugees experience higher rates of caries and periodontal disease (Keboa, Hiles, & Macdonald, 2016) UK research has shown that Unaccompanied Asylum Seeking Children present with tooth decay at higher rates than the national average (Fennell-Wells & Yusuf, 2020) and that self- reported oral health amongst this population is poor (Paisi, et al., 2022).

Future Need

Predicting future trends in relation to people seeking asylum, refugees and people refused asylum is challenging. The government has expressed its aim of making it more challenging for people to enter the country via small boat crossings and is also pursuing arrangements to make it more challenging for people to make valid claims for Asylum if they have travelled through a "safe third country".

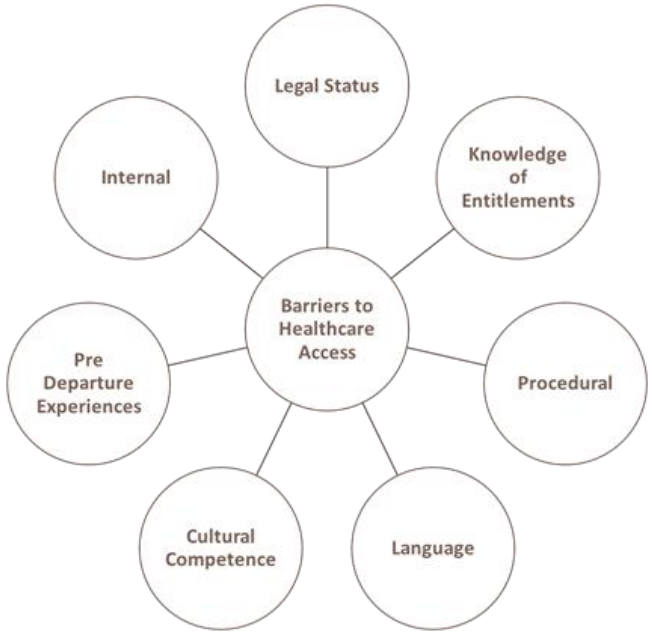
However, the numbers of people displaced globally through conflict and disaster is rising and that it is highly likely that new migration patterns will emerge in coming years. Evidence shows that the number of people being displaced due to climate and weather-related disasters is likely to become the prime reason for displacement. The World Health Organisation reports (2022) that in 2020, of the 40.5 million newly internally displaced people across the world, 76% (30.7 million) were forced to move by climate and weather-related disasters. In comparison, 24% (9.8 million) were displaced by conflict and violence.

In the future it is likely that health needs of this population will become increasingly influenced by exposure to climate and weather-related disasters as well as exposure to conflict.

Barriers to Healthcare Access

In the UK theoretically, individual entitlements to healthcare are the only thing which determines who can access health care and what services are provided. In reality a number of specific factors impact health-care access in the case of people seeking asylum, refugees and people seeking asylum. There is a large volume of qualitative literature that focuses on the barriers faced by this population to accessing healthcare.

A 2020 systematic review analysing 38 studies summarises the types of barriers facing this population as:



(El-Gamal & Hanefeld, 2020)