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The Documented Impact on the Health and Welfare of Asylum Seekers Housed in Refugee Camps and Institutions: A Literature Review

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Introduction

In September 2020, the Home Office began to use two former Ministry of Defence sites (Napier, Kent and Penally, Pembrokeshire) as a form of 'contingency' initial accommodation to house asylum seekers arriving to the UK.

The Home Office has maintained that the use of this type of contingency accommodation has been adopted in response to pressures placed on the existing asylum estate by the arrivals of small boats across the English Channel, as well as the national lockdown implemented in response to the Covid-19 pandemic. However, prior to the onset of the pandemic, there has been a significant backlog in the processing of asylum applications by the Home Office since 2018. This is likely to be an important factor in determining the number of people accommodated in asylum accommodation.

Humanitarian charities, legal bodies, the Welsh Assembly and healthcare professionals have called for the closure of barracks accommodation for asylum seekers, citing its unsuitability as housing for individuals with potential vulnerabilities often present in asylum seeker and refugee populations, as will be discussed in this report. There have

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been numerous press reports of overcrowding, poor access to healthcare and legal representation in both sites, as well as concerns that residents are isolated from communities and third sector support. An outbreak of Covid-19 at Napier barracks in January 2021 saw at least 197 confirmed cases among a population of 380. A detailed analysis of the impact of Covid-19 on asylum seeking populations it outside the scope of this report, because the developing academic evidence-base on this subject is not yet in the public domain.

HM Inspectorate of Prisons (HMIP) and the Independent Chief Inspector of Borders and Immigration (ICIBI) carried out a joint inspection of both camps and highlighted concerns around the unsuitability of these sites as contingency accommodation for asylum seekers.[1] Following publication of the initial findings of this inspection, as well as mounting pressure from third sector organisations, legal challenges and a groundswell of public concern, the Home Office announced that Penally barracks would close completely in March 2021, while Napier barracks would continue to be used.[2]

We have undertaken the literature review that forms this report in response to the use of institutional contingency accommodation settings in the asylum estate, in order to to summarise current knowledge on the potential impacts that contingency accommodation (such as that provided at Penally and Napier barracks) can have on the mental and physical health of asylum seekers.

The purpose of this report, is to examine how the specific features of contingency accommodation affect the mental and physical health of asylum seekers. This report will consider both the deterioration of pre-existing health conditions and the risk of people developing new sequelae as a result of living in these types of facilities. The report examines existing literature around camp accommodation for refugees, as well as the mental health conditions that refugees are likely to experience both in relation to their pre-migration experiences, as well as their experiences in camp accommodation.

The authors of the report recognise the interconnected nature of physical and mental health and the impossibility and undesirability of separating the two when planning healthcare pathways and providing care. However, due to the search process involved in the literature review this report looks separately at the literature on mental and physical health below. This report explores the impact of housing people seeking asylum in

contingency, institutional, non-community and/or camp settings and for shorthand refers to people living in ‘camps’.

Methods

Two literature searches were conducted to examine the documented impact on the mental and physical health and welfare of people housed in contingent accommodation, such as refugee camps and institutional environments. Two further searches were conducted to identify literature on specific mental and physical health needs of refugees and asylum seekers and what risk factors exist to predict psychopathology. Both peer reviewed papers and grey literature were included from the past 10 years.

Databases Used:

· ASSIA (Applied Social Sciences Index and Abstracts)
· Global Health
· Medline
· PsycInfo · Social Care Online

For each of the databases above, the below search was used (with changes to database specific subject headings where necessary):

1. ((refugee* or displaced person* or migrant* or asylum seek*) adj3 (camp* or institution* or settlement*)).ti,ab.
2. (refugees/ or migrants/) and (camp* or institution* or settlement*).ti,ab.
3. 1 or 2
4. (welfare or health or wellbeing).ti,ab.
5. health/
6. health care/
7. exp mental health/
8. 4 or 5 or 6 or 7
9. (impact* or consequence* or outcome*).ti,ab.
10. 3 and 8 and 9

Note: search terms followed by / denote use of a database subject heading; terms followed by ti,ab denote keyword searches in title and abstracts.

Other sources used:
· King's Fund Library database
· Mednar

· OpenGrey
· NICE Evidence
· TRIP database

For the above sources, the below search was used: (refugee* or "displaced person*" or migrant* or "asylum seek*") and (camp* or institution*) and (welfare or health or wellbeing)

and (impact* or consequence* or outcome*)

Mental health conditions experienced by asylum seekers and refugees and pre migration factors thought to contribute to these

Research over twenty years demonstrates consistently higher prevalence of mental health disorders and psychological distress among refugees and asylum seekers.[3] Their greater risk of developing a mental health condition reflects the unique and complex challenges they face.

Research indicates that asylum seekers are five times more likely to have mental health needs than the general population and over 61% will experience serious mental distress. The data also shows that, despite this high prevalence, they are less likely than the general population to receive mental health support.[4]

A systematic review examining the prevalence of serious mental disorder in 7000 refugees resettled in Western countries observed the existence of Post-Traumatic Stress Disorder (PTSD), major depression, psychotic illness and generalized anxiety disorder to varying degrees in this population. Overall, refugees were approximately ten times more likely to experience post-traumatic stress disorder than age-matched general populations in those countries.[5]

PTSD is the most frequently recognized mental health disorder among refugees given the traumatic backgrounds many have experienced. However the prevalence of other mental health conditions is also markedly increased.

A survey carried out in a Syrian refugee camp in 2017 demonstrated a prevalence of major depressive disorder of 44%[6]. The risk identified was higher for women than men and increased with time spent in the asylum process. An epidemiological survey conducted in

refugee camps in Greece showed that between 73% and 100% of the refugees interviewed suffered from anxiety disorder.[7]

A systematic review of mental health outcomes for refugee youth residing in refugee camps reported a prevalence of mental health disorders as high as 87%. It concluded

across the studies reviewed that there is a consistent finding of maladjustment problems for adolescents and young adults living in camps.[8]

As well as experiencing elevated rates of mental health disorders, co-occurrence of disorders is also widely reported. PTSD and depression can co-exist is as many as two thirds of cases and may overlap with substance misuse (for example as a form of self treatment).`[9]

It should however be noted that most studies did not estimate prevalence based on definitive diagnostic assessments but used screening questionnaires to identify probable cases as rapidly as possible. Indeed, some host countries have developed screening guidelines for this purpose so identified cases can be referred for further care.[10]

Factors predicting prevalence of mental health conditions

The increased vulnerability to mental health problems that refugees and asylum seekers face is linked to pre-migration experiences as well as their experiences on their asylum journeys and their post-migration circumstances.

Refugees may be fleeing from natural disasters, war, conflict, violence and torture. They may have faced persecution on the basis of their race, political views, tribal affiliations, religious beliefs or sexuality. They may bear the physical and emotional consequences of this violence and trauma.

Furthermore, refugees face potentially traumatizing experiences on their journeys. In 2020. more than 1400 people drowned crossing the Mediterranean sea on inflatable rafts and dinghies.[11] Many refugees face financial exploitation and violence at the hands of traffickers and smugglers during their journeys. In Libya for example, criminal networks,

militia groups, government officials, and private employers exploited migrants, refugees, and asylum-seekers in sex and labour trafficking.[12]

Pre-migration traumatic events and post-migration stressors were both positively associated with PTSD and serious mental illness.[13] Among potential predisposing factors for psychological health problems in immigrants and refugees, the Canadian Task Force

on Mental Health Issues (1998) lists: separation from family and community; an unwelcoming host community; prolonged or severe suffering prior to exile; being elderly or adolescent; lacking knowledge of the host language; and loss of socio-economic status.[14]

A study which focused on the association of mental health problems with prior torture and trauma, found rates of 30.6%, while another systematic review of psychiatric disorders in refugees and internally displaced people affected by armed conflicts showed rates of PTSD between 3% and 88%, of depression between 5% and 80%, and of anxiety between 1% to 81%.[15]

The very wide variations both within and between the studies can likely be explained by differing sampling and other methodological factors. Overall however, the studies demonstrate that rates of all common mental health disorders are considerably higher among refugees than that of the general population.[15]

Among pre-migration traumatic events, the loss of loved ones was found to be a significant predictor for post-traumatic stress disorder and depression among Syrian refugees living in Turkish refugee camps.[16] A very recent paper identified in the search examined systematic human rights violations, traumatic events, daily stressors and mental health of Rohingya refugees in Bangladesh. Regression models showed that trauma history and human rights violations significantly predicted PTSD and emotional distress whilst in the camps.[17]

What are the predictors or new incidence or deterioration (environment)

"The mental health of these populations is determined as much by their circumstances in the host country as by traumas preceding migration".[3]

Worldwide, most refugees are accommodated in varying types of contingency accommodation, such as refugee camps. It is often the case that such accommodation,

despite being designed as a temporary respite, can remain a key component of the provision made for the refugee population for far longer than intended. For example, the Za'atari refugee camp in Jordan, which was established in 2012 as temporary provision to house Syrian refugees fleeing conflict, is now classed as the fourth largest city in Jordan.

This paper has already explored the challenges to mental health that displaced populations face such as separation from family, erosion of social support, experiences of violence and persecution. Life in refugee camps can compound this adversity by challenging the cultural and social norms that governed life in their communities prior to becoming refugees. For example, day to day life in the camp can involve the restriction on movement, food insecurity, uncertainty about their future and uncomfortable living conditions.

It has been borne out in this review of the existing literature that housing refugees in contingency accommodation such as refugee camps negatively affects their mental wellbeing. The mental health disorders already present as a result of pre-migration vulnerabilities are often exacerbated by the environmental stresses of living in an institutional or camp setting.

There is considerable research evidence to suggest that conditions related to exile may be as powerful as events prior to flight relative to refugees' mental state.[3]

A study published in 2018 examined the mental health of refugees in Greek refugee camps and explored the narratives of social suffering following the EU border closures that year. It demonstrated that the living conditions in the camps both generate and increase psychosocial distress. The refugees in the camps experienced uncertainty about their future and disruption in their day-to-day lives as well as the loss of social networks which negatively impacted on their mental health. As quoted previously in this paper, the

study demonstrated a high prevalence of anxiety disorder (between 73% and 100%). Refugees reported that the camp environment, specifically the passivity of life in the camp aggravated feelings of meaninglessness and powerlessness. The uncertainty about their future, the lack of control over their lives and futures cause symptoms of depression and anxiety. Furthermore, the camp environment prevented interactions with the surrounding Greek society, which compounded feelings of isolation and being unwelcome.[7]

A cross-sectional study published in 2017 examined the mental consequences of persecution, war and other forms of pre-migration trauma experienced by the Rohingya refugees of Myanmar as the resided in refugee camps in southeastern Bangladesh. Results revealed high levels of PTSD, depression and somatic symptoms. The study also explored the impact of life in this contingency accommodation on the mental health of the refugees. It demonstrated that the environmental stressors associated with camp living such as problems with food, restricted movement and concerns regarding safety were the cause of depressive symptoms amongst the participants. Regression analysis indicated that while there was a direct effect of exposure to trauma and mental health outcomes, the environmental stresses of living in contingency camp accommodation partially mediated this relationship. The study concluded that the daily stresses of camp life play a vital role in the mental health outcomes of populations affected by violence, trauma and statelessness.[17]

Similar findings were demonstrated in a mixed-method study examining the prevalence and cause of mental health disorders amongst Rohingya refugees in a refugee camp in Bangladesh. It demonstrated that up to 20.46% of the camp residents were experiencing "serious mental health issues". In addition to this, ethnographic enquiries cast light on the daily stresses of living in the refugee camp such as socio-spatial confinement, the break up of families and lack of social cohesion as well we uncertainty about their future as significant predictors of the residents' mental health outcomes.[18]

This review identified two further studies examining the mental health of Congolese refugees living in refugee camps in neighbouring countries. All these studies found that conditions in the camps such as poverty, loss of connectedness from society and lack of hope for the future to be some of the predictors for suicidal ideation and attempt.

One of these studies used qualitative methods to foreground the impact of conditions in refugee camps on mental health, as well as highlighted the socio-political and economic context of refugees' lives. Participants in the study cited a lack of access to basic needs such as food, shelter, healthcare associated with life in the camp when discussing the impediments to positive mental wellbeing. This study concluded that the pervasive adversity caused by life in a refugee camp worsened mental health outcomes.[19] These themes were also explored in a qualitative study exploring daily life in a refugee camp in Molé, Northern Democratic Republic of Congo. The interviews with participants revealed that camp living conditions were associated with feelings of sadness, hopelessness,

uncertainty about the future and deep psychological distress.[20]

A study investigating the prevalence and predictors of post-traumatic stress and depression symptoms among Syrian refugees in a camp in Turkey found rates of PTSD as high as 83.4%. The main predictors of PTSD being female sex, previous mental health problems, a history of torture and loss of a loved one. It also demonstrated that participants being unsatisfied with camp conditions (feeling unsafe, feeling unhappy with the food, social and religious needs being unmet) were predictors of poor mental health.[16]

This qualitative study of semi-structured interviews with Syrian refugees in Turkish camps discussed pre-migration and post-migration difficulties that impact on the mental health and psychosocial wellbeing of refugees. The study examined camp conditions and their impact on the mental health of the residents. Features of the camp such as insufficient assistance and shelter, shared facilities such as toilets and showers, lack of privacy, insufficient access to healthcare all led to an objective deterioration in the participants' mental health. The camp in question had specific rules including a curfew, rigidity of entrance hours as well as regulations for visitors. The camp employed CCTV and required residents to show identity cards and freedom of movement to and from the camp was restricted. Some participants in the study described the camp to be "like a prison".[20]

The study concluded that these features associated with life in the camp, when experienced after significant pre-migration trauma, lead to worse mental health outcomes. The study explained that even if safety is restored after premigration trauma, a wide range of reminders within a camp environment can easily and involuntarily trigger trauma responses.

Influence of length of stay in contingency accommodation on mental health

A systematic review examining post-migratory risk factors and asylum seekers' mental health identified six articles that investigated the association between the length of stay in contingency accommodation such as asylum centres and mental health. Three of the articles included found an association between prolonged length of stay in contingency accommodation and poorer mental health outcomes. These outcomes were measured in terms of increased risk of mental distress, increased referrals for mental disorders and a poorer self-described quality of life. The other three studies found no significant association between length of stay and poorer mental health. However, the review

concluded that overall there was a positive association between length of stay in contingency accommodation and poorer mental health outcomes, and highlighted the stronger methodical soundness of the studies that observed the association.[21] All these studies were 'cross-sectional' and we did not find studies looking prospectively and longitudinally at change in mental health for people placed in contingency accommodation.

A study published in 2018 examined how Syrian adolescent and young adult refugees cope during their stay in refugee camps. The research explored how the "personal human capital" of these adolescent and young adults helped them to cope with life in the camps by gathering data from 110 adolescents aged between 13 and 18 in the camp. It explored the effect of pre-migration traumas and the impact on psychological distress experienced by the Syrian young people participating in the study. The study also evaluated the situational and socio-demographic factors that contributed to mental and psychological problems. Of the socio-demographic factors observed in this study, it was concluded that length of time spent in the refugee camp was the most significant predictor of the presence and severity of reported symptoms of mental distress. The results showed that the longer a person stays in a refugee camp, the more they are likely to report severe psychological problems and symptoms of post-traumatic stress. The study concluded that once an adolescent or young adult has fled from a war, they tend to display initial resilience by summoning their recovery capital to cope with a new situation and life in a refugee camp. However, as adolescents or young adults continue to live in the camp for long periods of time, they become less resilient, less hopeful and more psychologically unwell.[22]

A study cited in an earlier part of this paper explored the relationship between previous traumatic experiences and mental health outcomes of Rohingya refugees living in a Bangladeshi refugee camp. This paper indicated that daily stressors encountered in Bangladesh did not significantly predict PTSD scores. This contradicts the findings of other studies of Rohingya refugees in contingent accommodation. The authors hypothesised that their divergent findings may be explained by the relatively recent arrival of the majority of refugees in this study compared to the previous study, which included refugees who had been residing in the camp for several years. The authors suggested that the participants in their study who had spent relatively little time in the camp, and therefore had less time to recover from their traumatic experiences in Myanmar, and so these factors continued to loom large in their experiences of mental distress. It was predicted by the authors that the daily stressors of camp life would play a larger role in psychological distress and poorer mental health outcomes once the participants remained in the camp

for a longer period of time.[18]

Conclusions and recommendations on mental health literature

The review of the literature outlined above has elucidated key factors for consideration when reviewing the provision of contingency accommodation for asylum seekers and refugees. There is a substantial body of evidence to show that refugees are inherently more vulnerable to developing mental health disorders due to pre-migration factors causing them to leave their home countries as well as the hazards that they face during their perilous journeys towards their destination. What this review has illuminated, however, is that contingency accommodation is itself associated with poorer mental health outcomes. The features of this type of accommodation likely to contribute to worse mental health outcomes include isolation from communities, perceptions of being unwelcome, shared facilities, lack of privacy and freedom to move within and without all lead to symptoms of psychological distress. The length of stay in camp accommodation has also been demonstrated to lead to objective deteriorations in mental health. Given this mounting body of evidence, this report encourages the housing of asylum seekers in communities rather than contingency accommodation, recognising the inherent set of vulnerabilities that refugees possess.

While contingency accommodation continues to be in use (despite the harm outlined above), people may be screened to identify those with existing or developing mental

health conditions. Treatment may not be effective or fully effective while the person remains in a camp environment. Screening questionnaires of this nature are widely used and have been adopted by many of the qualitative studies included in this report. Canada has adopted the use of the Refugee Health Screener-15 to identify and evaluate those in need of mental health support, as well as a combination of screening tools for PTSD, depression, anxiety and alcohol misuse. These screening tools are not intended to diagnose mental health conditions, but to identify and evaluate those in need of referral for specialist assessment and care. The stated aim of the use of such screening tools is that early identification of those at risk may assist refugees in living more productive and healthier lives following their legal protection.[10]

As it stands, no such screening tools are used by the UK Home Office during the intake of newly arrived asylum seekers. Decisions on placing people in detention, initial/contingent accommodation or dispersal accommodation are currently taken without any appropriate refugee health screening or needs assessment. Given the body of

evidence laid out in this report that associates the placement of vulnerable asylum seekers in such accommodation with harm to mental health and welfare, the adoption of a screening system such as that of Canada, may at a minimum, identify those in need of further mental health care and help prevent further psychological distress. Such a process would also help ensure a needs-led response could be taken to promote recovery from trauma and reduce the risk that people would be placed in accommodation that would be harmful to health.

Physical health, asylum seeking and refugee populations

Throughout the journey that a person seeking asylum experiences there are factors that put them at high risk of physical health issues. Initial factors include poor medical infrastructure, reduced or absent vaccination programs, epidemiology of infectious diseases in their country of origin and lack of food security. For survivors of persecution there may be experiences of torture or abuse. During migration, the lack of access to medical care and adequate nutrition may be intensified or repeated and there is also the risk of further violent trauma, torture and exploitation. On arrival in the host country preceding physical concerns are not always adequately screened for and addressed, people are housed in overcrowded accommodation with poor sanitation and may have limited ongoing access to healthcare. There is also a complicated interaction between

mental and physical health; poor mental health and trauma suffered during migration can lead to poor self-care and minimisation of physical health symptoms. These migratory factors do not take into account that asylum seekers and refugees also suffer from a high percentage of non-communicable diseases and these are often overlooked in the emergency setting.

Impact on infectious diseases

Greenaway and Castelli published an expert review of infectious diseases throughout the migration process for forced and economic migrants. Increased delays of administration within Europe has led to prolonged stays for asylum seekers in overcrowded camps with poor sanitation. This, in turn, leads to increased rates of communicable diseases with a high number of outbreaks. The most common conditions seen in primary care at this stage were respiratory, gastrointestinal and skin infections. In some camps outbreaks have included vaccine preventable diseases such as measles and varicella.[9]

Within Europe, the Island of Lesvos has become one of the sites receiving the largest

influx of asylum seekers crossing the sea from Turkey. Hermans et al[10] looked at Camp Moria refugee camp and Caritas hotel (hotel accommodation for vulnerable asylum seekers) on Lesvos. They performed a dynamic cohort study using details from medical consultations over a 6 week period. In keeping with the review by Greenaway et al they found the most common presenting complaint out of the 1026 patient visits recorded was upper respiratory tract infections (26% of consultations). They proposed the environment within the camp was favourable to the spread of contagious diseases due to overcrowding and poor sanitation. Young single men were housed in tents with multiple other men and family tents were housing as many as 24. There were also no vaccination programs at the time of the study, and despite no vaccine-preventable outbreaks being recorded during the study period, the combination of this with the housing conditions clearly puts this population at undue risk of harm.

With regards to outbreaks, a prospective observational study was undertaken by Rojek et al looking at 13 different refugee camps in Greece in 2017 to monitor the data collected during medical consultations. They were specifically looking at the information that would be required to provoke an alert using the WHO outbreak surveillance, investigation and response guidelines for humanitarian settings.[11] They found that consultations did not

contain the information required that would be valuable to an outbreak team or create an alert about a potential outbreak. It is a cause for concern that appropriate outbreak surveillance is not being used in a population that are known to be more vulnerable to infectious disease outbreaks as a direct result of the close conditions they are being accommodated in.

Alongside infectious diseases, Nellums et al[12] performed a systematic review of peer reviewed articles to ascertain the available data on antimicrobial resistance (AMR) within the migrant population of Europe, including asylum seekers and refugees being held in refugee camps. Their work found that asylum seekers and refugees were at high risk of developing AMR whilst being held in high-migrant settings such as camps and detention centres. Similarly with communicable diseases, this was attributed to overcrowding, poor sanitation and the conditions they may have been exposed to in transit. This work was reiterated in the review by Muller et al [13]who noted that antimicrobial choice in refugee camps is predominately based on availability rather than microorganism susceptibility. Additionally, there are limited resources available to allow for screening of AMR in field laboratories.

Within the current climate it is hard to ignore the ongoing global pandemic. As previously

mentioned, at the time of our search there was limited work published about the effects that contingent accommodation has on the spread of COVID-19 however, Truelove et al conducted a future modelling study to predict the potential impact the disease may have within refugee camps in Bangladesh. Their model predicted that it was highly likely large scale outbreaks would occur within the camps, that the number of people requiring hospitalization would exceed the available beds and that the rate of mortality would significantly rise.

They hypothesised that simple measures to prevent the spread of COVID, such as social distancing, contact tracing and quarantining would be extremely difficult in a high populous camp setting. Healthcare was already over capacity prior to the pandemic and expanding it to accommodate the increased need during a time of global disruption would be challenging. They noted that the population within the camp was relatively young and this may reduce the risk of severe disease but there is limited knowledge on how poor baseline health and acute nutritional deficiencies may affect disease severity. [14]

Impact on women's health

A large percentage of global refugees are females of reproductive age. They face a lack of provisions and education related to menstrual health [15].They also have challenges accessing contraception, safe abortion, antenatal, perinatal and postpartum care throughout their migration journey and within camps.[16]

Sexual and reproductive health services

Cignaccia et al conducted a qualitative and quantitative study looking at accommodation conditions and healthcare provisions for women's health within 8 refugees centres in Switzerland.[17] Within the 8 centres 61% of the refugees were females of reproductive age.

In terms of health care provision they found that there was poor transfer of information between caregivers, mainly due to patient confidentiality, and this was a barrier to good quality care. Asylum seekers were not given information about their choices surrounding healthcare and this reduced the number of services utilised. There were also logistical issues, such as the remote location of asylum centres, that prevented women from accessing services such as family planning centres and antenatal classes. They also noted that professionals often had poor cultural sensitivity and showed a lack of

appreciation for differing cultural beliefs. Interpreters are integral for good quality care and highly recommended for use in refugee healthcare. In some areas of Switzerland there was no access or provision for the use of an interpreter.

Maternal mortality and morbidity

Parmet et al wrote an article exploring maternal mortality in Rohingya refugee camps in Bangladesh using the three delays model; delays related to the decision to seek medical care, delays in the time taken to access care services and delays in the time taken for treatment to be received.[18]

They found that fear of engaging with authorities due to prior experiences and cultural beliefs were factors in the first delay. Some of those factors were quite unique to the Rohingya population due to the restrictive and discriminatory laws in place in Myanmar. Other cultural factors are more universal such as gender-inequality, restricted education

for women and cultural unwillingness to be seen in a mixed healthcare setting. These all contribute to delays in seeking healthcare around female-sensitive issues.

The second delay was attributed to the physical set-up of camp, type of terrain within the camp and locality of healthcare services.

The third delay within the healthcare setting was attributed to language barriers and negative discrimination of refugees by the local population and government.

This paper is region specific however it addresses themes around cultural sensitivity, physical access to health care and language barriers that are more broadly applicable to contingent accommodation and healthcare access.

Hynes et al looked at maternal mortality in UNHCR camps across 10 countries between 2008-2010. They found that in all locations bar 1, the maternal mortality ratio of refugees was lower than that of the host population.[19] The UNHCR's standard is that over 90% of women should receive antenatal care and in 2007 they started the maternal death review report. They note that the data should be interpreted with caution as there will likely be some underreporting of maternal deaths particularly in early pregnancy and home deliveries. Although it is interesting to note that positive changes can be made in the contingent camp setting, all the countries included in the studies were countries with high,

very high or extremely high maternal mortality ratios within the local population.[20]

Environmental health concerns

Environmental health services are critical to the health and wellbeing of forcibly displaced people. Poor environmental services such as water, sanitation and hygiene (WaSH) result in an increase in the spread of communicable diseases. Behnkel et al compiled a scoping literature review in 2020 to look at the environmental health conditions in the protracted stage of displacement.[21] Protracted stage of displacement was defined as over 2 years and the review included literature about informal settlements and camps.

They conclude that environmental health conditions in protracted camps are poor and have a detrimental effect on the spread of communicable diseases due to exposure to

pathogens and environmental hazards. These conditions lead to poor health and livelihood outcomes.

Accommodation for refugees and internally displaced people is normally set-up or framed as having been set-up in an emergency setting, but 80% of refugee crises last over 10 years and 40% over 20 years.[22]

Impact on oral health

Poor dental health is linked to a decline in mental and physical health.[23] Refugees are at higher risk of having dental issues due to underdeveloped and/or disrupted healthcare systems within their home countries, arduous migration journeys[24] and oral hygiene techniques that may not involve regular cleaning or use of oral adjuncts, such as floss and toothpicks.[25] They may also suffer oral injuries due to torture and mistreatment.

The UNHCR noted that acute dental problems were the third most common presenting complaint of Syrian refugees in camps in Jordan.[26] A study by Abu-Awwad et al[27] looked at the effects of dental health on quality of life for Syrian refugees in Jordan. They looked at the impact on psychological, physical and social quality of life and found a negative impact across the 3 domains.

Keboa et al[28] published a scoping literature review in 2016 on oral health of refugees and

found across 7 different studies that refugees suffered a higher level of oral disease burden when compared to the least privileged populations within the host country. They also noted that refugees within camps often had to settle for extractions over restorative measures due to lack of resources for preventative dentistry and access to finances.[29]

This literature highlights that poor oral health is seen at a higher prevalence within the refugee population, it has a detrimental effect on welfare and quality of life and there is often limited access to dental care within contingent accommodation, particularly for preventative dentistry.

Impact on ocular health

According to the WHO 2010 there are 285 million people worldwide who are visually impaired, with 90% of the cases of blindness being in developing countries and 75% of all cases of blindness being preventable.[30] Poor vision has negative effects on quality of life, social integration and employment.[31]

A systematic review conducted in 2019 by Bal et al[32] found a high level of preventable blindness and poor vision within the refugee population. These findings were also noted in a cross-sectional study by Gelaw et al[33] who looked at ocular morbidity within refugee camps in Southwest Ethiopia. The population did not normally have any access to eye care. Upon setting up an eye clinic they found the overall presence of blindness to be significantly higher than that of the local population.[34] The most common causes of blindness were cataracts, trachoma and glaucoma - all of which are preventable.

Conclusions and recommendations on physical health and welfare literature

The literature covered a wide variety of physical health topics within a number of geographical settings. The overarching themes were that 1) Refugees and asylum seekers have distinct healthcare needs in relation to pre-migration and migration factors 2) Inadequate sanitation and overcrowding within contingent accommodation increases the risk of poor physical health 3) Healthcare barriers exist within contingent settings due to language differences, cultural insensitivity and a lack of specialised services.

The literature search conducted provided limited information on chronic ailments and highlights a need for further research in this area. Many camps and reception centres set up as emergencies have now housed people for extended periods of time with healthcare service provision that focuses on acute concerns. This has the potential to leave chronic conditions and symptoms inadequately treated for long periods of time. This will have a huge and potentially life-limiting impact on the affected individuals.

There is a complex interface between pre and post migration factors that render asylum seekers and refugees vulnerable to poor health outcomes. Alongside pre-existing vulnerabilities to poor health, this literature review highlights that holding people in

unsanitary and overcrowded accommodation can, in itself, be detrimental to physical health.

To improve the physical health within this group there needs to be good health screening on arrival of general health, vaccination status and key diseases. This will provide an indication of what specialist services will be required by the population. There needs to be space for people to live and adequate sanitation facilities for people to be able to maintain good levels of hygiene as to not exacerbate and create physical health problems. Healthcare should be provided by professionals who are trained in this area to ensure they have knowledge of the important factors that impact a refugee's health. It is also of utmost importance to ensure that the refugee population is aware of the services on offer as well as ensuring they feel welcome and as though they will be understood, despite language and cultural differences, if they access care. An effort also needs to be made to ensure chronic symptoms and diseases are not neglected in the contingent setting.

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Endnotes

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