Consultation Response Form

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Question 1 Do you think that the draft guidance covers the main health issues which impact on the lives of Refugees and Asylum Seekers?

Smoking was only mentioned once, and only in passing, yet this could be a significant contributor to health inequalities for the RAS group. Smoking is the largest contributor to premature death in Wales and inequalities in smoking prevalence is the single largest cause of health inequalities in Wales.

Question 2 Are there other health issues which should be included? If so, which and why? Please provide evidence.

ASH Wales recommends that smoking is considered to be a high priority for health professionals that are in contact with the RAS community. The latest statistics for Wales show that smoking prevalence is more than twice as high for the most deprived (28%) relative to the least deprived (13%) smokers in Wales, and this inequality has barely changed in the last decade. Smoking prevalence is even higher for individuals with a mental illness, where prevalence stands at (36%) compared to the population average of 19% and has not fallen for men over many years, despite overall prevalence falling. As discussed in the consultation document, given that the RAS community are likely to be at risk of higher rates of mental health issues and are at a greater risk of poverty, their chances of subsequently smoking after arriving in Wales may be quite high. This point is alluded to in this report and this report, yet more data may be needed to verify this.

A variety of reports also suggest that smoking prevalence may be higher among some refugees and asylum seekers, especially smoking cigarettes and shisha, or water pipes. Cigarette smoking is found to be higher among Eastern European

migrants[1], yet the Middle East faces a rise in the use of tobacco products and is also seeing a surge in waterpipe smoking, which is now a public health challenge in the UK.[23] In addition, some studies suggest male Iranian and Vietnamese refugees have increased odds of tobacco use.[4]

This NICE equality impact assessment form states that is likely that smoking prevalence is higher among certain national/ethnic groups among the RAS population:

'Refugees and asylum seekers: Asylum seekers and refugees are not a homogeneous group of people but it seems likely that smoking rates will be relatively high among certain national and/or ethnic groups. There are also likely to be barriers to refugees and asylum seekers accessing cessation support: these include inadequate information, particularly for new migrants unfamiliar with health care systems in England, insufficient support in interpreting and translating for people with limited English fluency, and confusion around entitlement to some types of services particularly among migrants with insecure immigration status'.

Given that Wales does measure smoking prevalence for the RAS group, it is hard to find any figures for Wales. Yet it may be important for governments to collect data in order to monitor this, in order to better inform decisions to allocate smoking cessation resources.

Smoking is a financial burden to a poor individual's finances and may push a RAS individual into poverty, making this issue particualrly important for the RAS group who are also at a greater risk of poverty.

Question 3 Will the key actions help support the implementation of the guidance? Do they cover the right issues? If not, please provide evidence.

More could be done to protect the RAS groups with initially high smoking prevalence rates, or reduce the risk that they start smoking after settling in Wales.This could involve immediate referral to 'help me quit' NHS stop smoking services on arrival if an individual does smoke, which are found to triple the liklehood of an individual scusseffully quitting. There would also need to be an understanding that the RAS

[1] The Migration Observatory (2014). Health of migrants in the UK: what do we know? Retrieved from http://www.migrationobservatory.ox.ac.uk/resources/briefings/health-of-migrants-inthe-uk-what-do-we-know/

[2] Jawad, M. (2016). Differences in tobacco smoking prevalence and frequency between adolescent Palestine refugee and non-refugee populations in Jordan, Lebanon, Syria, and the West Bank: cross-sectional analysis of the Global Youth Tobacco Survey. Retrieved from https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0087-4 50

[3] Public Health England (2017). Waterpipe smoking (shisha) in England: The public health challenge. Retrieved from www.adph.org.uk/wp-content/.../03/PHE-ADPH-Shisha-ReportFebruary-2017-.pdf

[4] The Migration Observatory (2014). Health of migrants in the UK: what do we know? Retrieved from http://www.migrationobservatory.ox.ac.uk/resources/briefings/health-of-migrants-inthe-uk-what-do-we-know/

community may smoke waterpipes and shisha rather than conventional cigarettes, and smoking cessation service employees should be trained to accommodate for this.

In addition, the individuals GP should be aware that the RAS community are at risk of becoming a smoker if they don’t already smoke, due to life stresses as well as the potential to replicate the health behaviours of individuals in their social circle. The GP should be encouraged to discuss the risks of smoking to health, finance and the importance of not starting and stay vigilant to any changes in smoing behaviour.

Question 4 Is the Care Pathway at annex 1 appropriate in delivering the healthcare services to RAS? If not, please provide evidence?

Question 5 We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them: