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*The European Journal of Public Health*, Vol. 30, No. 6, 1157–1163

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doi:10.1093/eurpub/ckaa135 Advance Access published on 25 August 2020

## Assessing health systems' preparedness for providing care for refugees, asylum seekers and migrants: a scoping review

Ewa Kocot <sup>1</sup>, Anna Szetela<sup>2</sup>

1 Health Economics and Social Security Department, Institute of Public Health, Faculty of Health Sciences, Jagiellonian University Medical College, Krakow, Poland

2 Health Policy and Management Department, Institute of Public Health, Faculty of Health Sciences, Jagiellonian University Medical College, Krakow, Poland

**Correspondence:** Ewa Kocot, Health Economics and Social Security Department, Institute of Public Health, Faculty of Health Sciences, Jagiellonian University Medical College, Grzegórzecka 20 Str., 31-531 Krakow, Poland, Tel: +48-607-627-368, e-mail: [ewa.kocot@uj.edu.pl](mailto:ewa.kocot@uj.edu.pl)

**Background:** Health care systems and care professionals often face the challenge of providing adequate health care for migrant groups. The objective of this study is to answer the question of whether and how meeting the special health system requirements regarding refugees (R), asylum seekers (AS) and migrants (M) (RASM) is checked and evaluated. **Methods:** A scoping review was used as a methodology of the research, with four electronic databases, websites of relevant organizations and European projects searched, using a strictly defined search strategy. Finally, 66 studies were included in the analysis. **Results:** The included studies presented assessment of different types, aspects and facilities of health care, as well as various methods of analysis. In the vast majority of the studies ( $n = 52$ , 78%) interviews or questionnaires were used to collect data. The studies were mostly declared to be qualitative. The main issues assessed in the studies can be categorized into three groups: (i) legal aspects, (ii) before receiving health care and (iii) during health care usage. **Conclusions:** RASM inflow is a big challenge for health care system in many countries. The first step to guarantee adequate health care for RASM is assessing how the system is functioning. This makes it possible to find gaps, indicate the directions of activities needed and monitor progress. Further work on the development of a comprehensive tool, checked in terms of validity and reliability assessment, and enabling examination of many aspects of health care for RASM should be carried out.

## Introduction

The refugees (R), asylum seekers (AS) and migrants (M) group (RASM) can differ in many respects from a local population (e.g. in terms of culture, experiences and beliefs, but also health care entitlements and health needs as well) and can be very diverse within

itself. It may translate into different, specific health care-related needs. For this reason, health care systems and care professionals often face the challenge of providing adequate health care for migrant groups. Special requirements can apply to different phases and dimensions of the health care process; these may occur at the stage of access to care, when services are provided, or during the following

treatment process and so on. Therefore, health systems facing a problem with migrant inflow should be especially prepared for providing health care for these vulnerable groups.

The special system requirements, the health care needs of migrants and the barriers to access to care are recognized quite well in the literature.<sup>1–11</sup> Although there are diverse and context-specific health system responses to large-scale migration in a given region,<sup>2</sup> general approaches on migrant-friendly interventions include, e.g. language support, intercultural mediation, health information and promotion, trainings for health professionals, promoting intersectoral actions and partnership.

Assessing the special preparedness of health care in the RASM health area is very important, as the identification of the gaps and problems that may emerge is the first step to ensure RASM health security, which affects not only their health, but may affect the health of the entire populations as well.

This review has tried to answer the question of whether and how meeting the special health system requirements regarding RASM is checked and evaluated. This includes assessment of the entire health care system and its elements, such as specific kinds of care (e.g. maternal, psychiatric care), specific facilities (e.g. hospitals) and specific aspects of care (e.g. the cultural competency of providers). The review examined the evaluation scopes and methods used in practice. The detailed research question was: What methods of RASM health care evaluation (if any) were used and what were the characteristics of these studies (country, scope, etc.).

## Methods

A scoping review was used as a methodology of the research. This review was conducted based on the scoping review methodological approach outlined by Peters et al.<sup>12</sup>

### Search parameters

Four electronic databases were searched: MEDLINE via Ovid, Scopus, Embase and The Cochrane Library. To identify additional literature to include, reference lists of studies were also searched. Grey and policy literature were searched manually on websites of the relevant organizations (WHO and their Regional Offices, International Organization for Migration and UN Refugee Agency) and European projects focussing on migrants' health. The database searches were conducted on 29 May 2019, internet websites of organizations and projects were screened in June 2019. No limits concerning publication dates were set. The information about the search terms is included in the [Supplementary data S1](#).

### Selection process

An assessment of the studies eligibility was done by two authors of this review independently. In the case of the conflicting eligibility decisions an external consultant, familiar with health care system assessment topic, was asked to give an additional opinion. In all these cases, consensus was finally reached.

The selection of studies was performed using the following inclusion criteria: (i) the analysis was related to health care for R, AS and/or M as a separate group or groups, (ii) location of the analyzed type/setting of health care was defined and (iii) the assessment was clearly stated. Studies were excluded if the assessment concerned: migrants' health or health behaviours that were independent of the organization/the functioning of health care; specific disease management; temporary projects or programmes; intervention effectiveness and theoretical strategies. The studies included were those available in English.

The bibliographic programme Mendeley was used for the records management, including duplicates removing. A total of 5396 records were found after the search in electronic databases and websites. After duplicate elimination 4716 record abstracts were screened

and 124 of them assessed as potentially eligible. Finally, after full-text analysis 66 items were included in the review. The search and selection process is presented in the flow diagram ([figure 1](#)). In accordance with the adopted methodological approach, the studies meeting the selection criteria were included regardless of their quality.<sup>12</sup>

### Data analysis

Data were extracted from the included studies by the two authors of this review according to an Excel form containing the following fields: (i) author; (ii) publication data (title, year of publication, journal); (iii) aims of study; (iv) country and year of study; (v) study population, sample size (if applicable); (vi) methodology; (vii) key findings and conclusions and (viii) study limitations.

## Results

### Characteristics of the included studies

Despite the fact that no publication year limit was established, there were no studies published before 2003. The studies were published as follows: 3 items before 2005, 9 in the years 2005–09, 21 in the years 2010–14 and 33 in the years 2015–19. The highest amount of included studies were dated 2015 ( $n = 14$ ; 21% of total), no publications were found from 2005 and 2006. The detailed numbers can be found in the [Supplementary data S2](#).

Among the reviewed studies, 59 were published in international journals, 6 were joint reports issued in cooperation with the WHO<sup>13–18</sup> and one was the report delivered as a result of a European project.<sup>19</sup>

The subject of the studies was health care for RASM in countries located on five continents: Europe ( $n = 28$ ), Australia/Oceania ( $n = 16$ ), North America ( $n = 11$ ), Asia ( $n = 7$ ) and Africa ( $n = 4$ ). Taking into account the country of study, the highest amounts concerned Australia ( $n = 10$ ), the USA ( $n = 7$ ) and Spain ( $n = 6$ ).

With regard to the type or aspect of care or facilities, 32 publications (48% of the total) concerned health care in general, without any narrowing. The next most numerous groups were studies on primary care ( $n = 12$ ) and maternal/reproductive/sexual health care ( $n = 7$ ). The subjects of all included research are presented in [table 1](#).

In half of the analyzed research, the study population is not determined by nationality and/or gender ( $n = 33$ ). A specific nationality (or nationalities) was an inclusion criterion in 27 studies (41%). Eight studies concern a group of women (12% of the total).

### Methodology used for assessment

In the vast majority of the studies ( $n = 53$ , 80%) interviews or questionnaires were used to collect data. In the case of 21 publications, there was a second method applied in addition to the interview (questionnaire): focus groups, observations, discussion at meetings with stakeholders or document analysis. Nine studies are based entirely on focus groups and one is a case study of a migrant family. In three studies, only a procedure without human participants was adopted (documents reviews). In 40% ( $n = 27$ ) of the studies, RASM groups were exclusively involved in the interview/questionnaire or focus group discussion. In nearly the same number of cases ( $n = 24$ , 37%), only other groups related to the providing RASM health care were involved: health care providers, other medical, managerial or administrative staff and various kinds of experts (government and local authorities, employees of refugee service organizations and facilities and interpreters). In 10 studies (15%), the opinions of both: RASM and other groups were analyzed ([table 2](#)).

The authors of three studies introduced comparators to the study: in parallel to the opinion of RASM, the opinion of the host population was examined.<sup>60,63,68</sup>

The studies were mostly declared to be qualitative. Only one-third of the research used a quantitative approach in addition to the

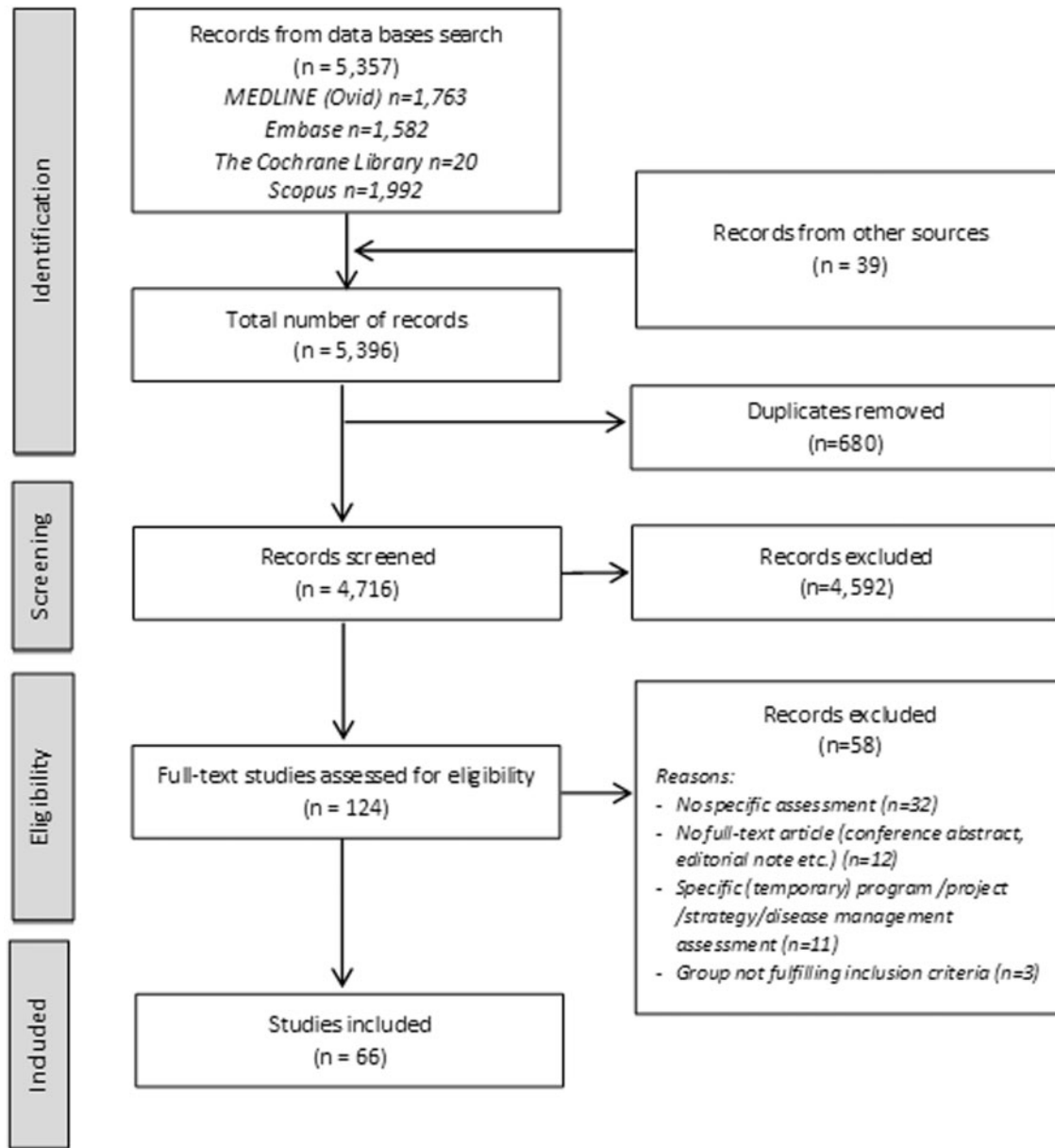


Figure 1 Flow diagram of data search and selection

Table 1 Type, aspect or facilities of care taken into account in the studies

Type of care/facilities	N <sup>a</sup>	References
Health care in general	32	[13–44]
Primary care	12	[45–56]
Maternal/reproductive/sexual health care	7	[57–63]
Mental/behavioural health care	4	[64–67]
Hospital care	3	[68–70]
Palliative/long-term care	3	[71–73]
Medicines therapy	3	[47, 74, 75]
Health visitors care	1	[76]
Secondary care	1	[48]
Hospital cancer care	1	[77]
Communicable diseases health care	1	[78]

a: The sum is not equal to the number of publications as some of them included more than one type of care.

qualitative (22 out of 66), some of them to a very limited extent. In the vast majority of publications, information regarding interview/

questionnaire validation, a pilot study or a reference to other previously used methods was not included (49 out of 66). Only two authors clearly detailed the validation/pilot study of the used tools,<sup>49,56</sup> some research was part of bigger surveys or used a special tool created as a part of the given organization's (WHO) or project's activities,<sup>13–19,30,32,40,56,60</sup> three papers included some reference to previously existing models/concepts.<sup>21,55,76</sup>

Eleven authors did not specify how many people participated in the conducted interviews, focus groups or questionnaires or information was only partial (e.g. the number of interviewees were indicated, but it was not known how many participants took part in the additionally conducted focus groups).<sup>35,39,70</sup> The number of the study participants (if applicable and whose number is known) varied considerably, from six<sup>58,59</sup> to almost 600<sup>52</sup> (in one case,<sup>60</sup> there were over 1000 interview participants, but the vast majority of this large group constituted the host population as the comparator): 39% of studies had <30 persons involved, 31% had ≥30, but <100 and the same (31%) had >100. In the three studies with the biggest number of participants, data were gathered using broader surveys, related to other subjects also.<sup>30,40,56,60</sup>

**Table 2** Data gathering method used in included study

	Study participants	N	References
Data gathering method			
Interviews/questionnaires	(1)	15	[23–30, 49, 59, 60, 68, 72, 75, 77]
	(2)	12	[32–34, 51, 52, 61, 66, 67, 69, 73, 76, 78]
	(1) + (2)	4	[31, 48, 50, 65]
Focus groups	(1)	6	[21, 22, 45, 47, 64, 74]
	(2)	2	[46, 58]
	(1) + (2)	1	[57]
Document analysis	N/A	3	[42–44]
Case study	Migrant family	1	[71]
Mixed methods			
Interviews/questionnaires + focus groups	(1)	6	[35–38, 53, 70]
	(2)	2	[40, 41]
	(1) + (2)	3	[39, 62, 63]
Interviews/questionnaires + meetings	(2)	7	[13–19]
Interviews/questionnaires + observations	(2)	1	[55]
	(1) + (2)	2	[54, 56]
Interviews/questionnaires + document analysis	(2)	1	[20]

(1), RASM; (2), health care providers/other medical, managerial or administrative staff/experts.

**Table 3** Topics of questions used in questionnaires and interviews

General question category	Group of people questioned	
	RASM <sup>a</sup>	Health care providers or other professionals connected with health care <sup>b</sup>
Entitlement to health care	<ul style="list-style-type: none"> <li>Health insurance status</li> </ul>	<ul style="list-style-type: none"> <li>Assessment of the legislation situation and barriers</li> </ul>
Health status, health care needs	<ul style="list-style-type: none"> <li>Health conditions before migration and now</li> <li>Health needs of RASM (in general or in a specific area)</li> </ul>	<ul style="list-style-type: none"> <li>Priority in RASM health needs</li> </ul>
Use of health care	<ul style="list-style-type: none"> <li>Present or past use of services (in general or specific)</li> </ul>	<ul style="list-style-type: none"> <li>Extent of RASM health care use compared with non-migrants [73]</li> </ul>
Access to health care	<ul style="list-style-type: none"> <li>Satisfaction with health care access</li> <li>Barriers of access to HC*** (in general or to a specific kind)</li> </ul>	<ul style="list-style-type: none"> <li>Assessment of access of RASM to HC (in general or specific services/settings)</li> <li>Barriers to access to health care</li> <li>Facilitators of access to health care</li> <li>Needs and proposals to improve access to health care</li> </ul>
Access to and quality of information	<ul style="list-style-type: none"> <li>Sources of information</li> <li>Knowledge about the health care system</li> <li>Possession of information concerning health care access possibilities</li> <li>Provision and understanding a diagnosis, treatment process, doctor instructions, how to use medicine</li> <li>Attitude to information—more or less of it is needed?</li> </ul>	<ul style="list-style-type: none"> <li>Perception of understanding the health system by RASM</li> </ul>
Quality of care, satisfaction with health care	<ul style="list-style-type: none"> <li>Perception of the overall quality of health care provided to RASM</li> <li>Culturally specific issues during treatment</li> <li>Perception of differences in health care for RASM and for the host population</li> <li>Perception of continuity of care, transitions between services</li> <li>Health care services/health system satisfaction, getting appropriate treatment</li> </ul>	<ul style="list-style-type: none"> <li>Capacity to provide support for RASM</li> <li>Needs regarding RASM support (e.g. interpreters/translators)</li> <li>Barriers and challenges providers face in providing care</li> <li>Providers' facilitators and needs to provide adequate health care to RASM (support, strategies, trainings, education)</li> <li>Perception of transition between service processes</li> </ul>

a: Studies used for the table preparation: [26, 27, 29, 30, 36, 37, 48, 53, 54, 56, 59, 60, 62, 68, 72, 75, 77].

b: Studies used for the table preparation: [13–18, 20, 33, 34, 41, 48, 51, 52, 54, 61–63, 65, 67, 69, 73, 78].

### Characteristic of questionnaires and interviews

In total, there were 15 questionnaires and 41 interviews identified as methods of study (in three cases both). In 60% of the questionnaires ( $n=9$ ) and 37% of the interviews ( $n=15$ ), the participants group consists of only migrants; in 40% of the questionnaires and 51% of the interviews, only of health professionals and additionally 12% of

interviews was conducted on both groups (RASM and health professionals).

Only six authors made available a complete list of strict questions used in their study. Usually authors described, with a varying levels of detail, groups of questions they asked, sorting them by a main subject. Sometimes only chosen questions were cited. In general, according to the nature of the method, more developed information

about the asked questions is provided in studies which declared use of a questionnaire than in those using the interview method. However, in some interviews authors detailed question topics (or even specific questions) in quite a lot of detail, although they were the basis for further discussion.

The questions used in the questionnaires and interviews could be generally categorized as presented in table 3. Most of the research included, as a first part, questions about the socio-demographic and sometimes economic characteristic of the participants. These kinds of questions were not included in table 3, as they are not specific to the analyzed subject.

Looking at the questions, there were no significant differences between studies on various types of care, various RASM groups, or countries. Only one slight difference was observed: the direct questions to professionals regarding received or needed support that facilitate care provision to RASM (like special cultural competency trainings, education, etc.) occur less frequently in the studies about health care in general—in this group they were found only in the reports based on the WHO methodology and in the research conducted by Jewson *et al.*<sup>13–18,33</sup> These types of questions were more often asked in the research on more narrowly defined health care (primary care, maternal care, etc.).<sup>52,61,63,69,73</sup>

### Main categories of issues assessed

The methods used in the included publications enabled assessment of various aspects of health care for RASM, which could be categorized into three main groups (depending on the stage of providing health care process): (i) RASM health care entitlements and their legal aspects; (ii) issues occurring before actually obtaining health care and (iii) issues occurring during the use of health care.

The legal aspects of delivering health care for RASM are assessed in relation to the complexity of the legal and administrative procedures which have to be executed to guarantee access to care.

The issues before receiving health care services, that have been mainly assessed, referred to access to adequate information (in languages understandable by RASM) concerning health care system organization and rules, entitlements or the places where health care can be received. The other aspects under evaluation in this group were possibilities of arranging appointments or reaching health care facilities, and the occurrence of financial barriers preventing access to health care.

Among the issues related to the usage of health care, the most frequently assessed were: adjustment of health care to special RASM needs, beliefs and practices; different aspects of health staff skills for working in a cross-cultural environment; adequacy of health care services for RASM financing and organization and providing relevant information about diagnosis, the treatment process and doctors' orders.

## Discussion

The influx of migrants which started in Europe in 2015 resulted in an increasing number of publications related to health care system responses not only in European countries. Although a lot was known about the health status and needs of RASM groups in different countries before 2015, the massive influx of migrants in some transit and/or destination countries in Europe resulted in a focus on the more global perspective.

The importance of validity and reliability testing in research is widely confirmed and cannot be ignored.<sup>79–83</sup> The vast majority of studies included in this review were qualitative research, based on interviews, questionnaires or focus groups, but only in few of them was the validation issue mentioned<sup>49,56</sup> (excluding studies based on the method developed for larger projects or surveys). The sampling method declared was mainly non-random, but purposive, the samples were often of a small size and were limited to specific geographic areas or communities. Additionally, RASM only speaking their

own language, and not that of the host country population, were excluded from many studies, as interviews, questionnaires or focus groups were conducted in the language of a given country. The linguistic barriers and intercultural challenges—being one of the most common indicated obstacles for host–newcomer communication—may have influenced the findings of the studies. All this has caused problems with generalization; results were not statistically representative, but rather indicative.

In most studies, only one side's opinion was taken into account: RASM or health care professionals/experts. The question appears to what extent assessments based on a unilateral opinion can be credible? They can give some overall insight into a given group impression and perception of health care functioning, but using such a kind of assessment as an indication of the direction of the actions needed to improve the health care system must be done with caution. A good example can be found in the Cheng *et al.*<sup>55</sup> study: migrants negatively assessed the long waiting time for services, but according to the staff opinion, the migrants' behaviour is very often the reason for it. Thus, the migrants' opinion can indicate the need for organizational changes, but according to the staff evaluation, educational activities aimed at migrants should rather be taken. Negative assessment of some aspects of health care can be also influenced by socio-economic conditions not related directly to health care (e.g. problems with transport). The RASM group is often very diverse and the perception and assessment of health care functioning can be strongly dependent on migrants' situation (migration reasons, legal status, duration of stay and country of origin), education level (language proficiency and health literacy) and many other factors, as can be seen in the research of Småland Goth and Berg.<sup>49</sup> Goetz *et al.*<sup>56</sup> noted that experience actually affected expectations regarding health care more than the GP performance. Health care can be also assessed by RASM in comparison to health care in their country of origin. As a result, it is difficult to formulate one unambiguous, reliable evaluation of the given health care system (or elements of it) only using RASM opinion. To get a reliable assessment, looking at different points of view is advisable.

Problems emerging in health care may be unrelated to patients' backgrounds as migrants.<sup>72</sup> This does not mean that the system functioning should be assessed positively, but that the negative points were not related to migrants' position. Therefore, a judgement with the host population as the comparator is a good solution. Some studies used this method<sup>60,63,68</sup> and it enabled assessment of whether the issues identified were not more global problems of health care in the given country.

In fact, only two more extensive methods of assessment were found: one, developed by WHO Europe<sup>84</sup> and the second, as a part of the SH-CAPAC project<sup>19,85</sup> (both dated 2016). As the assessment of health system preparedness and capacity to manage the RASM influx requires a specific approach, the WHO method was developed to support health authorities in optimizing health care for RASM. Improving the health system is not possible without previous evaluation of the strengths and weaknesses of a given current situation. The WHO toolkit was piloted in 11 European countries, but there is an example of its use outside the WHO activities as well (in Malaysia).<sup>32</sup> Within SH-CAPAC, with its general objective to 'support Member States [of the European Union] under particular migratory pressure in their response to health-related challenges' (p. 14),<sup>85</sup> the assessments of the health care responses to the migrant influx were proposed and applied in six European countries/regions. Mapping the legal framework of the health response in 12 European countries and then conducting detailed assessment in six countries/regions was an opportunity to discuss and propose a common approach to the challenges occurring in the transit and destination countries. The practical dimension of both instruments, by WHO Europe and the SH-CAPAC project, is reflected in their further outcomes, such as giving a framework for coordination mechanisms in the countries, proposing public health response to the RASM influx, building strategies at different levels of the health system



and, generally, building a migrant-sensitive health care delivery model. These initiatives are big steps in the development of assessment methods, giving important lessons for future work in this area.

The first step to guarantee adequate health care for RASM is assessing how the system is functioning. This makes it possible to find gaps, indicate the directions of activities needed, and monitor progress. Further work should be carried out on the development of a comprehensive assessment tool, checked in terms of validity and reliability, which enables examination of many aspects of health care for RASM from different points of view. However, the specifics of health system in a given country should be always taken into account.

## Supplementary data

Supplementary data are available at *EURPUB* online.

*Conflicts of interest:* None declared.

### Key points

- RASM inflow is a big challenge for health care system in many countries.
- The first step to guarantee adequate health care for RASM is assessing how the system is functioning.
- The assessment of the health system for RASM functioning and finding the gaps can indicate the directions of the public health policy activities needed and monitor progress.
- Further work on the development of a comprehensive assessment tool should be carried out.

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 The European Journal of Public Health, Vol. 30, No. 6, 1163–1168

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 doi:10.1093/eurpub/ckaa138 Advance Access published on 25 August 2020

## Prevalence of torture and trauma history among immigrants in primary care in Denmark: do general practitioners ask?

Liv Stubbe Ostergaard <sup>1</sup>, Helle Wallach-Kildemoes<sup>2</sup>, Marie H. Thøgersen<sup>3</sup>, Ulrik B. Dragsted<sup>4</sup>, Annemette Oxholm<sup>4</sup>, Ole Hartling<sup>4</sup>, Marie Norredam<sup>1</sup>

- 1 Department of Public Health, Faculty of Health and Medical Sciences, University of Copenhagen, Danish Research Center on Migration, Ethnicity and Health, Section of Health Services Research, Copenhagen, Denmark  
 2 Department of Pharmacy, Faculty of Health and Medical Sciences, University of Copenhagen, Section for Social and Clinical Pharmacy, Copenhagen, Denmark  
 3 Department of Rehabilitation, Dignity – Danish Institute Against Torture, København, Denmark  
 4 Amnesty International Danish Medical Group, Amnesty International Denmark, The Medical Group, Copenhagen, Denmark

**Correspondence:** Liv Stubbe Ostergaard, University of Copenhagen, Øster Farimagsgade 5, DK-1014 Copenhagen, Denmark, Tel: +45 61 27 8703, e-mail: Lstubbe@sund.ku.dk

**Background:** Torture survivors typically present with varied and complex symptoms, which may challenge assessment by general practitioners (GPs). This study explored the prevalence of torture and trauma history among immigrants born in non-Western countries presenting to GPs in Denmark and the extent to which GPs ask this population about torture or trauma history. **Methods:** Based on a self-reported questionnaire among non-western immigrant patients, we used bivariate analyses to determine the prevalence of torture and trauma history and the proportion of patients being asked by their GP about this. Data were analysed using multivariate logistic regression. **Results:** From 46 GP clinics, 300 questionnaires were finalized by immigrant patients. Twenty-eight percent of the patients had a history of torture. Of these, significantly more were men (70%) than women (29%). About half of the torture survivors (55%) had been asked by their GP about torture history. The odds ratio (OR, 95% confidence interval) for being asked about torture history by the GP was 1.28 (0.46–3.53) among women compared with men. Compared with Southeast Europe, OR for being a torture survivor among male immigrants from Middle East-North African region and South and East Asia was 1.83 (0.81–4.15) and 0.25 (0.08–0.82), respectively. **Conclusions:** Our results suggest that torture and trauma are widespread among immigrants presenting to GPs. In our study, the GPs had managed to detect half of the torture survivors. A more systematic approach to detection in General Practice is advisable, and more knowledge on how and when to ask is needed.

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## Introduction

Amnesty International reported in 2015 that 122 countries tortured or ill-treated people,<sup>1</sup> despite attempts to ban torture and ill treatment, such as the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT).<sup>2</sup> Therefore, parts of the immigrants coming to Europe will have experienced torture or other forms of traumatic events in their country of origin or during their flight. Estimates on the overall prevalence of torture among immigrants and refugees range from 5% to 35%.<sup>3</sup> In Denmark, a study of health status and prevalence of traumatization among newly arrived asylum-seekers showed that 45% had been exposed to torture and almost two-thirds of these met the criteria for post-traumatic stress disorder

(PTSD).<sup>4,5</sup> Physical and mental consequences of trauma and torture have a high impact on the ability to live a healthy life, form social relationships and have an occupational functioning in society.<sup>6</sup> Early detection of torture or trauma history can therefore be crucial to limit symptoms as depression, anxiety, self-medication and enable individuals to contribute to the host society.<sup>7–9</sup>

In Denmark, the healthcare system is tax-based and everyone who has been granted a residence permit has free access to the healthcare system, including most examinations and treatments. General practitioners (GPs) are often the first point of access to wider health care provision and can play an important role in early detection of torture and trauma survivors. However, survivors of torture typically present with varied and complex symptoms<sup>10</sup> and GPs may be treating torture survivors without recognizing it, and