Department of Health

Practice track report for the degree of MSc Global and Public Health Policy

Understanding experiences of refugees with accessing and using healthcare services in Swindon and Bath and North East Somerset.

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My Voice Matters is ensuring the voice of people with diverse lived experiences and backgrounds are heard.

We are proud to be able to give the opportunity for seldom heard voices to be heard by providers and wider organisations in their own words.

This report was written by Dr Aanchal Rana as a practice track report for the degree of MSc Global and Public Health Policy at the University of Bath.

We offered her access to our team and engagement pathways to support her delivering this piece of work. All opinions and findings are her own

Executive Summary

In the countries where the refugees and asylum seekers are resettled, they frequently have trouble getting access to health care. On their exile trip, the migrants experience challenges and obstacles. When they go to the newest country, they suffer greatly to find jobs, housing, basic necessities, and health care.

This adds up and has an impact on their health—both emotional and physical. Our research centred on how immigrants used healthcare services in Bath and North East Somerset (B&NES) and Swindon and the barriers they faced getting access to healthcare in the UK.

Participants in the qualitative study included refugees (those who had been in the UK for two years or fewer), employees of the NHS and GP offices, and representatives of voluntary sector organizations.

The participants were given a consent form, participant information sheet, and flyers, and each one of them was given detailed information about the project. For individuals who conducted interviews via Microsoft Teams, the forms were provided to them through email. the refugee participants were personally questioned at a hotel, community café, English language course, and food pantry.

Total number of 16 refugees, 4 from NHS and GP surgeries, 5 from voluntary sector organisations and 2 from Local Authorities who worked with NHS participated in the study. Thematic analysis was used to examine the data collected from the interviews. The author began by carefully reviewing the interviews in order to become familiar with the facts. Nvivo software was then used to methodically code the material.

The new codes were generated first and the themes were identified such as language barrier, mental health, dental care, delayed appointments and accessibility.

All of those interviewed emphasized that the language barrier and miscommunication made it difficult for migrants to schedule appointments and comprehend hospital regulations. Although refugees usually don't talk about their struggles with their bad mental health state out of fear of stigma and being judged by others, mental and dental health are the primary healthcare demands for them.

However, it was clear that they required assistance with their mental health. They struggled with delayed appointments and lengthy wait lists since they were used to receiving healthcare services and being familiar with the rules of the healthcare system in their home country.

Many of them were not aware of the waitlists and NHS processes, which are the same for everyone who uses the NHS. However, they had a perception of not being prioritised over UK citizens because of their refugee status.

The refugees expressed concern about their expulsion from the hotels where they are being housed by the UK government as well as about lengthier waitlists for accommodation. They were not able to obtain permanent housing due to a lack of employment and resources. Living in motels and cramped quarters with their family made them more anxious. Due to such issues it was impacting their mental health which lead to poor physical condition as well. Perhaps by offering practical assistance

with registration, scheduling appointments, and attending services, as well as by hiring interpreters with enough funding by the Government, the challenges that refugees and asylum seekers face in accessing and using general practice services may be alleviated.

Local governments and non-profit organizations must offer refugees educational programs on how to access healthcare services. They must also inform them of their rights under the NHS and the free services they are entitled to, which will improve their ability to access services. It is intended that the challenges that refugees and other immigrants face would be addressed, and that healthcare accessibility will be enhanced and healthcare inequities will be minimized for them.

List of Abbreviations used

Abbreviation	Meaning
UN	United Nations
UNHCR	United Nations High Commission for Refugees
DOTW	Doctors of the World
GP	General Practitioner
NHS	National Health Service
UKRS	United Kingdom Resettlement Scheme
ACRS	Afghan Citizens Resettlement Scheme
A&E	Accident and Emergency
LMICS	Lower and Middle income countries
UNWRA	United Nations Relief and Works Agency
B&NES	Bath and North East Somerset

Introduction

The definition of a Refugee is someone who:

"Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it - United Nations. (United Nations, 2021).

According to data by United Nations, at the end of 2021, there were 89.3 million persons who had been forcefully moved worldwide (United Nations,2021). Of those, 27.1 million were refugees, with half of them being minors (21.3 million under the purview of UNHCR (united nations high commission for Refugees) and 5.8 million in Palestine under UNRWA (United nations relief and works agency) (United Nations,2021).
There were also 4.6 million asylum seekers, 53.2 million persons who were internally displaced, and 4.4 million Venezuelans who were relocated overseas. (United Nations,2021). Millions of individuals also lack a nationality and are denied access to fundamental freedoms including education, healthcare, work, and mobility (United Nations,2021).

In the UK as of November 2022, there were 5,483 stateless people, 127,421 outstanding asylum claims, and 231,597 refugees, according to UNHCR figures (UNHCR, 2023). A significant rise from the previous year was caused by the war in Ukraine (UNHCR, 2023). Four out of five refugees worldwide choose to remain in the area that caused their displacement, therefore developing nations often take in these refugees (UNHCR, 2023).

With 3.7 million, Turkey is now the country hosting the most refugees, followed by Colombia with 1.7 million (UNHCR, 2023).

However, Refugees in the UK are subject to the resettlement procedure, which involves moving refugees from a nation where they first applied for asylum to a third state that has agreed to accept them. This country is frequently in the same area as the refugee's place of origin (UNHCR, 2023). For refugees whose life, liberty, health, or human rights are in danger in their place of asylum or for whom transferring to another nation is their last chance of being reunited with their family, it is also a game-changing, long-lasting solution. (UNHCR, 2023).

The Mandate Scheme, the UK Resettlement Scheme (UKRS), the Community Sponsorship Scheme, and the Afghan Citizens Resettlement Scheme (ACRS) are all options for refugees to relocate to the United Kingdom. In the year that ended in September 2022, resettlement programs provided protection to 1,391 individuals. This represents 25% of the 2019 resettlement population (UNHCR, 2023).

It has been noticed that, in limbo, undocumented immigrants are at risk of detention and deportation, being exploited on the job, working in precarious positions, including prostitution, modern slavery, and having limited or no access to essential services like healthcare (Bragg and Feldmann,2011). Health requirements for asylum seekers and refugees can be complicated. These might be affected by encounters preceding leaving their nation of origin, during travel or after appearance in the UK. Comprehensive and individual-focused care is fundamental for help flexibility and assist them with adjusting to life in the UK (Pitalla R and Jacob W, 2023).

Common health challenges include:

- Untreated communicable infections
- Poorly controlled chronic conditions
- Maternity care
- Mental wellness and expert help needs.
- War-related injuries. (Pitalla R and Jacob W, 2023)

Healthcare access can be characterized as the level of fit among patients and the medical care system (Asif and Kienzer, 2022). Public and specialized healthcare for refugees, asylum seekers, and undocumented migrants is extremely difficult to come by in the UK, according to reports. This has a direct connection to the so-called "hostile environment" regulations that Theresa May, the previous home secretary, enacted in 2012. These laws limit 'illegal' immigrants from receiving essential services, which compels them to leave the nation willingly. These laws cover the social, welfare, benefit, and healthcare systems. (Webber, 2019). The Charges to Overseas Visitors Regulations 2015 and 2017 Amendments where one-way hostile environment regulations were implemented in the National Health Service (NHS). (PatientsNotPassports, 2020; Worthing and other, 2021). This mandated charging foreign visitors for secondary care, including those denied asylum and those without regularized immigration status. Treatment is denied to those who are unable to pay up front unless it is deemed "urgent" or "immediately necessary" (Giacco et al.,2014 and Worthing et al 2021).

To begin filling up this knowledge gap, case managers from DOTW UK participated in qualitative sessions, and documents from FOI requests were examined with a focus on how refugees, asylum seekers, and unauthorized travellers obtain, organize, and use medical treatment. (Asif and Kienzer, 2022). The data reveals how discriminatory tactics can lead to actions that prevent outcasts, those seeking asylum, and undocumented

migrants from accessing essential NHS services, leading to adverse effects on these networks' physical and emotional wellbeing (Asif and Kienzer, 2022).
Access to healthcare is made more difficult by discriminatory laws such as pricing constraints and language and communication hurdles. It has been challenging for refugees, asylum seekers, and illegal migrants to get quality healthcare in the United Kingdom since healthcare entitlement does not always imply healthcare eligibility (Asif and Kienzer, 2022).

In England, for instance, entitlements to healthcare services and groups can vary. According to the Government of the United Kingdom (Gov.UK, 2019), all primary care, including GP and nurse consultations, is free for everyone. (Asif and Kienzer, 2022). Access to A&E, family planning services, diagnosis and treatment of infectious and sexually transmitted diseases, and treatment of conditions brought on by torture, human trafficking, domestic violence, and female genital mutilation are among the other free services (Asif and Kienzer, 2022).

Due to the fact that the right to healthcare for all people in the UK is not fully guaranteed, difficulties in obtaining and receiving healthcare are exacerbated further. According to DOTW UK's (2016) study, despite being entitled, four out of every five patients seen at their London clinic are denied GP registration. Despite NHS England guidelines clearly stating that GP practices are not required to ask for proof of identification from patients wishing to register, health seekers were unable to provide documents such as IDs and visas (GOV.UK, 2019). This is a legacy of the now-outdated policy that was implemented in 2017, when the Home Office issued its "access to NHS patient records policy," which made it possible to view patient home addresses and GP information (Papageorgiou et al., 2020) (Asif and Kienzer, 2022).

To address this issue of being unable to or having difficulty accessing healthcare services and NHS by refugees and asylum seekers, there are many statutory body working to address their problems and help them in the best possible way.

Who is Healthwatch?

Healthwatch is an independent body that represents the patient. Under the Health and Social Care Act of 2012(Healthwatch, 2021). Healthwatch was established to advocate for the needs, experiences, and concerns of people who use health and social care services (Healthwatch, 2021).

Healthwatch was established to advocate for the needs, experiences, and concerns of people who use health and social care services(Healthwatch, 2021).It exists on a public and nearby level, pursuing a similar objective of empowering individuals to have a voice about their well-being and social consideration frameworks(Healthwatch, 2021). Healthwatch England and local Healthwatch cooperate to share data, and expertise and figure out how to further improve health and social care services in England (Healthwatch, 2021). They represent individuals who independently utilise health and social care services (Healthwatch, 2021). They make sure that providers of services put patient care first (Healthwatch, 2021). By comprehending the requirements, experiences, and concerns of people who use health and social care services, their sole object is to advocate on their behalf. Likewise, they put a ton of emphasis on addressing individuals' stresses and worries over the services they currently (Healthwatch 2021)

Healthwatch also works with a lot of voluntary sector organisation in B&NES and Swindon who works voluntarily for refugees, asylum seekers and vulnerable population.

Why did Healthwatch Suggest this research topic?

Healthwatch started this research project for refugees. As we consistently hear that refugee experience issues getting to health and social consideration yet have no reasonable comprehension of what the issues are this piece of work will assist with figuring out this. Anecdotal evidence suggests that newcomers to the UK access healthcare in a manner distinct from the expected "norm," such as going to A&E expecting to be sent to see a GP (as is typical in China). It is making artificial pinch points in the NHS due to lack of communication and understanding.

The aims of this research project

To understand how health care services in Swindon and Bath and North East Somerset are meeting the needs and expectations of refugees who are new to the UK.

- To understand the health care needs of refugees in Swindon and Bath and North East Somerset.
- To understand what works and what doesn't work for refugees when engaging with health care services in Swindon and Bath and North East Somerset.
- To explore ways to improve how health care services could meet the needs and expectations of refugees, for example, in terms of better communicating how healthcare services work.

Methodology

A qualitative data collection method was used to understand the healthcare needs and policies for the refugees. According to Al-Busaidi (2008), qualitative research has the potential to generate a wealth of data based on the perspectives of the people who took part in the study. This makes it possible to generate novel concepts and insights that can then be applied to further studies of recurring themes*(Asif and Kienzer, 2022).* Therefore, for our research Qualitative approach was used for a more comprehensive understanding of the healthcare needs and policies of the refugees.

Bath and North East Somerset and Swindon are the two UK locations where the study was carried out.

The study was conducted throughout the months of June and July 2023. Although the data collecting deadline was July 15, it had to be postponed to July 30,2023 due to the absence of numerous NHS personnel.

People who worked with refugees in the voluntary sector, the NHS, GP offices, and among refugees themselves were interviewed. Employees from Healthwatch Swindon and Bath assisted and cooperated with me while I carried out the study independently.

We visited several community cafés, libraries, food pantries, English language courses, offices of voluntary sector organizations, hotels, and hospitals before we could get to know people and form connections with them. I met with the employees on many occasions via Microsoft Teams in order to establish a connection and inform them of my research. They received a participant information sheet via email so they could learn more about the study and decide whether to freely participate in it. Through the Healthwatch project managers in Bath and Swindon, I was able to establish contact with members of the NHS and volunteers from voluntary sector organizations.

Prior to conducting the interview, the consent form and Participation information page were provided to each of them through email, and a day and time were chosen by email. The participant provided the completed consent form through email on the day of the interview and was then given a 25–30-minutes interview.

All NHS personnel and medical offices were interviewed on Microsoft teams, and several voluntary sector organisation staff were interviewed as well. A local authority from each of Bath and Swindon who collaborates with the NHS and participates in the refugee arrival program consented to give me an interview toward the conclusion of data collecting. Hence, I interviewed them on Microsoft Teams as well. I was invited to the Harbour project office, in Swindon which is a voluntary sector organisation working for refugees and asylum seekers. I made a visit alongside the Healthwatch Swindon project director, to see and study the issues and meet with them face to face and get more experiences and some insights about their living conditions.
At the Delta Hotel by Marriott in Swindon, interviews with the Afghani refugees were done in person. The Delta Hotel, run by the Swindon Borough Council, is where the Afghani refugees in Swindon reside. The Swindon Borough Council volunteers and employees set up a place where I could conduct the refugee interviews with little to no hindrance.

I prepared a few flyers in Pashto and Dari, the regional dialects of Afghanistan so that people could understand the findings in an understandable and brief way. Many of them spoke decent English, but a few of them needed some help with the translation. A lady refugee who worked as a doctor was able to assist them and let them know about the review and for the rest, I used Google translate on my phone.

The participant information sheet was given out to every single one of them and I had to explain the content. Subsequent to acquiring suitable information about the research and

making an informed decision, they signed the consent form and gave the interview. Each participant's interview lasted approximately 25 to 30 minutes.

A member of the Healthwatch team joined me in order to establish connections with the Ukrainian community in Bath. We visited a church in Bath where Bath Welcome Refugees, a voluntary sector organisation that deals with displaced persons in Bath, was holding a charity event. We proceeded to English language courses to meet more Ukrainians after getting to know a few individuals there, and I had the opportunity to interview three Ukrainian refugees there. For the Ukrainians to better understand the study effort, a few flyers in the language were prepared. Two Ukrainian refugee women who volunteered to take part in the study were handed a consent form and participant information sheet. The interview was conducted face-to-face in a little church chamber.
Additionally, I got the chance to go to an Oasis Church food bank in Bath, where I made some connections, spoke with refugees about my project, and interviewed three Ukrainian refugees.

The interviews were numbered R1 to R16 for refugees, V1 to V5 for voluntary sector organisation staff members, N1 to N4 for NHS staff and L1 and L2 for local authority members.

Ethics

Ethical approval was obtained in the beginning of the study from the ethics committee at the University of Bath, United Kingdom and the ethics approval code is **RANA-2023-REACH.**

Data Analysis

The data derived from the interviews were analysed using thematic analysis. To become familiar with the data, I began by closely reading the interviews. The material was then coded systematically with NVivo V.1.7.1 software (NVivo qualitative data analysis Software; QSR International, V.1.7.1, 2020)

The new codes were generated first and the themes were identified such as Language barrier, Mental health, Dental care, Housing, Delayed appointments and Accessibility.

The study sample consisted of 16 refugee participants (men and women), 5 people from voluntary sector organisations, 4 from NHS and GP surgeries and 2 from local authorities who works with the NHS. All the participants are from different demographic characteristics.

Table 2: The table describes groups and number of participants in the study.

Sr no	Participant groups	No. of participants
1	Refugees (Living in UK for 2 or < 2 years)	16
2	NHS & GP surgery	4
3	Voluntary sector organisation	5
4	Local authorities working with NHS	2

Identified themes:

Five major key themes identified from data analysis are: Language barrier, Mental health, Dental health, Delayed appointments, Health and Housing and lastly Accessibility.

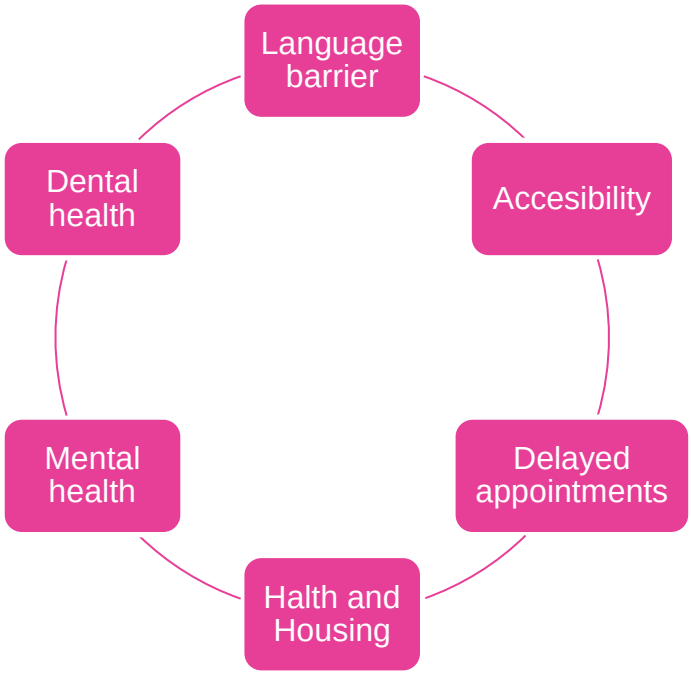

Figure 1: The model illustrating the identified themes of the research.

Language Barrier

Literature demonstrated correspondence to be a significant medical care need for refugees and asylum seekers, as effective resettlement and mental prosperity rely on language proficiency (Pollard and Howard , 2021).The literature also showed need for more effective spread and correspondence of data by the Workspace and medical care providers (Pollard and Howard , 2021).

Migrants portrayed disarray over NHS designs and how to get to medical services or organize appointments.

Asylum seekers and refugees frequently have less information about the healthcare framework as they might have less access to get information ahead of time than those moving for employment purpose. (Pollard and Howard , 2021)

All the interviewees including refugees, NHS staff, and voluntary sector staff enhanced on language barriers and communication difficulties while making an appointment either the GP Surgery or at the hospital. They also described the quality of interpreters and insufficiency with those due to lacking dialects and being too mainstream. The people from voluntary sector organisations also may have mentioned it could be due to issues with funding.

Most common health issues are Trauma-related mental health issues, it's very traumatic because many women have shared that they have been raped during their journey to UK. Adds, mental health cannot be translated in any other language that's why it's pretty intense. (v1)

First and foremost is a language barrier that's why they don't understand the protocols and procedures for registering with the GP or any hospital. Also, different countries have different healthcare services, so it takes a little time for them to understand things. (v4)

Some of the refugees mentioned about availability of online translation services at the GP offices in Swindon, but it did not quite help them understand the procedures. Therefore, language barrier is a big hurdle accessing healthcare of refugees.

Delayed appointments

According to the data by NHS , the maximum waiting time for non-urgent, consultant-lead treatments is 18 weeks from the day your arrangement is reserved through the NHS e-Referral service, or when the hospital or administration receives your reference letter (NHS.UK,2023) However, all of the refugees in the interviews referenced that there is a significant delay waitlist and they have been getting late appointments at the doctor's office or even to see the expert specialist at the emergency clinics. The Ukrainian displaced people in Bath expressed that , they have been flying back to their country for fundamental medical services due to the long waiting list here at the NHS.

> I haven't been to the hospital yet as my friends keep on talking about the long wait list here at the hospital for any kind of surgery and I have just been once for a fever, and that too it took me 7 days to see a doctor. Therefore, I have been going to Ukraine every 3-4 months for my dental treatment and the thyroid problems. I am aware of the difficult situation in Ukraine due to war but we can't help it, it's better to go back to Ukraine for the treatment than dying here with pain for months. (r13)

Mental health

The refugees often perceived that the they are going through psychological distress due to separation from their homes, families and loved ones. They have been trying overcoming current living situations as they have been living in a single room in one hotel with limited food access and amenities. They don't have access to any luxury, they don't have extra money to spend on their hobbies or interest like they use to in their own countries.

The refugee participants are also dealing with a lot of trauma related stress and post traumatic mental health distress. As they fled from their own country, leaving their

homes and loved ones behind and settling themselves in a foreign land with cultural difference. The refugees remarked on cultural differences and their hardships in absorbing in the new environment in the new country.

> We have applied for permanent housing here in Swindon, it's almost been more than a year haven't heard anything. I am so stressed out, worrying about my mother and siblings. I am the eldest child in my family and I don't know if we will ever get proper house, food and facilities. The landlords here don't trust us for anything, maybe we are refugees that is why some of us are not getting houses and jobs. We don't have enough money and we might get kicked out of hotel sometime this year. So my life is a chaos right now. I am so stressed out and I haven't slept since a year I feel. I don't get sleep at nights. Looking at my ill mother and my younger siblings, nobody says a word but deep down every one is stressed. I am waiting for a better tomorrow. (r8)

It has also been seen that in many lower- and middle-income countries, talking about mental health is considered as a taboo and stigma. In numerous LMICs where there might be less protections executed for people with disabilities, many individuals with psychological illnesses are the subject of abuses, extreme poverty and social rejection, making emotional wellness shame a general medical problem as well as human rights issue (Naslund and Dang, 2021). There is additionally frequently restricted need for stigma reduction techniques in LMICs, and these endeavours are commonly under-supported, underfunded and under-studied. (Naslund and Dang, 2021)

In an interview with a female Afghan refugee about her mental health, she said:

> *Yes, I feel I want to talk to someone about my mental health but I am not sure whom do I talk to or approach. I guess, I am a bit hesitant towards talking about it. I am also shy and I feel*

that people here in my family or at the hotel might judge me if I talk to someone about my mental health.

We are safe in this country; we are waiting for permanent accommodations and also right to work so I feel life will be stable in future. Hence, I feel my mental health might get better as well. (r8)

> *I am happy that we are here and we are safe but I have depression, I am battling with it since more than a year now but I am not seeking any help because it's not normal for us. We don't talk about it to anyone. Most of the Ukrainian women here I know have depression and anxiety issues after the war but nobody talks about it. (r12)*

Dental Health

In accordance with accessible literature, language has been recognized as a typical barrier to dental care. Limited and discriminatory access to dental services among asylum seekers and refugees can propagate poor oral well-being and worsen inequalities. O'Donnell et al., observed that access to dental care for refuge searchers was more troublesome and the experience more negative as compared to medical care (O'Donnell et al., 2007). In spite of the fact that access to NHS dentistry has become progressively challenging for the general population, taking into account the intensifying difficulties of the vulnerable populace in getting access to care and the greater burden of illness, guaranteeing impartial access to healthcare services is imperative (Paisi,M et al.,2022).

In the interviews with the refugees, when asked about dental health they mentioned:

I need some help with my dental treatment, I have a dislodged crown in my oral cavity and it's really bothering me. It's been more than a month and I still haven't gotten a dentist's appointment. And I can barely eat now. (r3)

I am having troubles accessing a dental appointment, I have even asked the organisation who's looking after us here in the hotel to do something about my appointment, but haven't heard from them either. Accessing dentists is a task in UK. (r9)

While visiting with other Ukrainian refugees at the food pantry and English language classes in Bath who did not want to participate in the study. At the point when gotten some information about their dental arrangements, they looked very disappointed and frustrated about the dental registration framework with NHS and referenced that getting dental specialists' appointments is more troublesome than getting to medical services in UK. Some of them flew back to Ukraine for their dental treatment since it was getting exceptionally burdening here.

Health and Housing

According to the study's analysis, it was discovered that housing difficulties were brought up by every participant who was a refugee. They fear being evicted from the hotels the UK government is now paying for or the host family they are living with since they have been on the waiting list for homes for many months to years. And this is having a significant psychological influence on them. The housing situation that the immigrant families are experiencing is having an impact on their emotional and

physical wellbeing. They worry that since they are refugees, they won't be given housing and that others don't trust them.

When speaking with a member of voluntary sector organisation staff member and a refugee participant, they mentioned:

> *Health and housing is a big issue for refugees. Refugees have been living with the host families in Bath, mostly Ukrainians, and they have to relocate or move to a different house after a year, which leads to change in GP practice* (v2)

> *We have applied for permanent housing here in Swindon, it's almost been more than a year haven't heard anything. I am so stressed out, worrying about my mother and siblings. I am the eldest child in my family and I don't know if we will ever get proper house, food and facilities. (r8)*

Therefore, as housing and health go hand in hand, better housing will result in happiness and excellent physical and mental health for the immigrants.

Accessibility

Refugees have reportedly complained about waiting times for appointments, inadequate translation services at doctor's offices, and other obstacles to obtaining healthcare in the UK, according to data analysis. They spoke on how, in comparison to the UK, healthcare services are simpler, quicker, and less expensive in their home countries.

> I have been going to Ukraine every 3-4 months for my dental treatment and the thyroid problems. I am aware of the difficult situation in Ukraine due to war but we can't help it, it's better to go back to Ukraine for the treatment than dying here with pain for months. (r12)

> I think in Ukraine its much simpler also its not expensive at all. I would prefer getting treated in Ukraine. At times even to get a doctor's appointment is a task because of improper translator services on site.(r11)

> Healthcare in our country was faster, quicker and much cheaper. We can go to a doctor's office or walk in to a hospital at any time of the day and we are sure that we will get the treatment immediately, unlike here. (r5)

Accurate language interpreting is really needed for better understanding of the refugees about their problems and healthcare providers to be ready to access by refugees, according to interviews with NHS staff, voluntary sector organizations, and local authorities. With the use of interpreters, certain persons who have trouble making appointments might be helped. In addition, delayed appointments could be handled with the aid of translator services by giving them details and explaining with the issues of long waitlists to avoid any confusion with the involvement of more authorities and the addition of adequate staff at the hospitals and GP offices.

Discussion

The findings of this study shows that the refugees go through number of challenges and barriers to accessing health care services in UK. The refugees, NHS staff and voluntary sector organisation staff mentioned about the hardships that the refugees go through just to integrate themselves in a foreign country with cultural differences and they try really hard to integrate in the western culture. The participants talk about language as one of the key barriers for the refugees to access health care and other services which leads to lack of information and knowledge about the healthcare system protocols. The refugees also discuss lengthier wait times at the doctor's office and how they feel discriminated against in comparison to other citizens of the nation because of their refugee status. Additionally, they talked about how their mental health is being negatively impacted by housing issues and how disturbing it is to worry about being kicked out of hotels. They are also suffering with a great degree of post-traumatic stress disorder and trauma-related stress. They left their homes and loved ones behind as they departed their own nation, relocating to a distant country with a different culture. The migrants face difficulties they had adjusting to their new surroundings and the cultural differences in their new nation.

Healthcare needs for refugees in Bath and Swindon

In the interviews, the refugees top healthcare concerns were mental and dental health, and the challenges they had in getting the care they needed were language problems, long waiting periods and limited accessibility.

Although many asylum seekers and refugees can read and write in English, some may not be as proficient (Pollard and Howard, 2021). Numerous migrants originated from nations with poor literacy rates, especially among women, and trauma can occasionally impair learning ability (Pollard and Howard,2021). To overcome the issue of language barrier, there are translator services available at the GP offices and the hospitals, however it was

found that the translator services were not very effective as it lacked dialects and due to which their symptoms couldn't be diagnosed accurately and they had a hard time understanding the NHS protocols. Language barriers and a lack of interpreters at NHS clinics made explaining medical issues and recommended treatments challenging, if not impossible. Such obstacles have a negative influence on refugees' health in many Western host countries. (Asif and Kienzler, 2022). For instance, Hocking (2021) reports that immigrants in Australia said that inaccessible and unaffordable healthcare caused minor or chronic health concerns to worsen over time, forcing later, more expensive and specialized treatment Asif, and Kienzler, 2022)

In this study, it was also found that accessing healthcare services by the refugees was also hindered by delayed appointments and longer waitlists. Research has shown that ethnic minority people have reported poorer medical service encounters when contrasted with White English individuals (NHS digital). The lack of accessible information, language boundaries, poor information about administrations and longer waits for appointments for ethnic minority people can all add to their access to health and social care (NHS digital) Although, according to the data by NHS, the maximum waiting time for non-urgent, consultant-lead treatments is 18 weeks from the day your arrangement is reserved through the NHS e-Referral service, or when the hospital or administration receives your reference letter (NHS.UK)

In a paper by university of Oxford, it has been analysed that in the period immediately following the 2004 EU enlargement, waiting times increased in places where native internal migrants moved in, and that immigration increased the average waiting time for outpatients living in impoverished areas outside of London (Giuntella, O et al.,2018). Their data implied that both the decreased mobility of local inhabitants in these regions and the increased morbidity seen among immigrants migrating into more disadvantaged areas may be used to explain the short-term rise in outpatient waiting times in poor areas in response to immigration (Giuntella, O et al.,2018). Another major

factor contributing to the NHS's lengthier waitlists and backlog is the country's growing frequency of physicians' strikes. If the doctor's strikes don't end, it's also anticipated that the NHS waiting list would reach 8 million this winter (The Guardian, 2023).

It has been discovered via conversations with refugees that the migrants believe the NHS is underserving them because of their exile status and that this is why their appointments are delayed. They believe that the NHS does not give them priority over citizens of the UK. It is entirely incorrect, though. Given their poor mental health and the amount of stress they are already under, which is merely their incorrect view. The refugees believe that UK citizens are given precedence by the NHS. When you look at the facts and figures on the NHS website itself, that is totally false because everyone is on the same waitlist. Hence, it's just a miscommunication and a wrong perception on their part.

Participants in the research also discuss how their mental health suffered after moving to the UK. Their poor mental health can be attributed to a number of issues, some of which were noted in the interviews, including post-immigration difficulties, cultural integration, family loss, being away from home and loved ones, being in hotels, not having enough money or accommodation and many others.

It has been seen that multiple traumatic events that affect their mental and physical health are possible for refugees (Paudyal, P et al.,2021). These terrible events may occur while they are travelling to or from their native country or as they go through the asylum procedure (Paudyal, P et al.,2021). Civil dispute is frequently linked to pre-immigration issues such as physical harm, near-death experiences, witnessing murder, grieving (such as the painful loss of loved ones), imprisonment, and torture (Paudyal, P et al.,2021). Others have more traumatic incidents both on their way to exile and throughout the settlement process (Paudyal, P et al.,2021). According to available data, post-immigration stressors like racial discrimination, difficult socioeconomic living conditions, institutional housing, a lack of language skills, and a lack of social support are harmful to refugees'

mental health and may last for years or even decades after they have been resettled in a new environment (Paudyal, P et al.,2021).

Further studies have revealed that on practically all health and wellbeing metrics, asylum seekers and refugees do worse than the UK population (O'Donnell et al.,2007). This demographic has been linked to symptoms of anxiety, depression, post-traumatic stress disorder (PTSD), and agoraphobia. It has been claimed that up to two-thirds of refugees living in the UK experience anxiety or despair (Paudyal, P et al.,2021). One of the main barriers to migrants seeking mental health care is stigma. It has been noted that talking about mental health and getting help are taboo subjects. It is uncommon for refugees and asylum seekers to address mental health problems or seek help. They experience humiliation and judgment. The women refugees who participated in the interviews spoke about getting therapy for their stress and anxiety problems but stated they were concerned about being judged by others. Understanding that the refugees have a perspective of mental illness and psychosocial well-being that is profoundly founded in established social, cultural, and religious traditions is vital for mental health experts and healthcare providers (Paudyal P et al.,2021). The participants demonstrated a generally strong understanding of the UK National Health Service, including how to navigate appointments and acquire medications, despite the challenges mentioned above(Paudyal P et al.,2021).

As we know Housing is a significant social determinant of health, as is widely established, but less is known about how housing experiences affect health and wellbeing for those with a history of being a refugee or seeking asylum. One of these factors is housing, and a growing body of research shows that housing significantly affects general well-being as well as particular mental and physical health outcomes including respiratory ailments and depression (Ziersch, A et al., 2017). Additionally, research shows a complicated link between housing and health, with implications for both individual health outcomes and

population-level health inequities, and that effects are likely to be both direct and indirect(Ziersch, A et al.,2017)

In research in Australia with refugees and asylum seekers, it was analysed that issues with housing lead to a negative impact on their mental health (Ziersch, A et al.,2017). Participants emphasized that one of the keys to achieving good health outcomes was residing in neighbourhoods where one could establish strong social ties(Ziersch, A et al.,2017).Participants in the study also reported that they had encountered discrimination in their neighbourhoods, most notably in the form of neighbourly discrimination that had adverse effects on their mental health, which is consistent with a large body of research linking discrimination to ill health(Ziersch, A et al.,2017).

When questioned about health-related difficulties in our study, several of the refugees brought up housing, how difficult it is for them to find a home, and how this has a detrimental influence on their physical and mental health. Participants focused on housing inequalities since they had trouble finding employment and landlords did not trust them because of their background and affordability was also an issue for them due to lack of employment and high cost of living. In this regard, the government or the local authorities to ensure housing for the migrants and the health outcomes would be improved by changing policy to provide home security and reduce mobilities for refugees and asylum seekers (Ziersch, A et al.,2017).

To go to safety, asylum seekers and refugees sometimes travel great distances in dangerous migration routes. (Paisi M et al.,2022). This population has a heavy burden of oral illnesses and unmet treatment requirements. Among refugees and asylum seekers, periodontal and dental problems are very common (Paisi M et al.,2022). ASRs frequently need emergency dental care when they first arrive in the host nation, and after that, they usually only go to the dentist when they have a dental issue, such tooth pain (Keoba M et al.,2016) .Only a small percentage of refugees and asylum seekers

have access to dental treatment. Access to oral healthcare is mostly determined by the host nation's healthcare policies (Keoba M et al.,2016). For example, in Sweden and Finland, both refugees and asylum seekers who have been given permanent residence status are eligible to receive government-funded dental treatment (Keoba M et al., 2016). In contrast, dentists in England are not obligated to request proof of identification, proof of residency, or proof of immigration status from anyone requesting to become NHS patients, as stated by the NHS, and any immigrant is able to receive a few oral health care services in England (Gov.UK, 2021). However, the participants in our study emphasised on difficulties with dental appointments and the dental treatments being expensive which they can't afford at this stage. The suggestions for improving access to dental care for refugees could be ensuring alternative commissioning agreements, increased public funding for dental care, and finding more effective methods to serve vulnerable populations are all part of achieving equal access to dental and oral health services (Paisi M et al.,2022).

Refugees frequently encounter obstacles while trying to receive even basic medical care. Therefore, there is a pressing need for improved services and collaboration between health experts and appropriate government agencies so that such gaps may be recognized and filled (Healthcare for refugees, 2021). In our study, the participants mentioned about the gaps and inaccessibility to appropriate health care services. It was also emphasized that there are gaps between these things and it has to be bridged for refugees to make healthcare easier and better. According to the NHS, everyone who registers with a GP as an NHS patient or uses NHS services temporarily is eligible for free GP and nurse consultations in primary care, treatment from a GP, and other primary care services (NHS entitlements, 2023). Someone who has been in the region for more than 24 hours but less than three months is considered a temporary patient (NHS entitlements, 2023). The UK's healthcare system is built on residential care for secondary care services (NHS entitlements, 2023). This implies that in order to be

eligible for free healthcare, you must be a resident of the UK who is legally settled there (NHS entitlements, 2023).

Contrastingly, even when translating is necessary to comprehend their medical issues, they are often denied access to primary care, such as GP registration, as well as interpreting services from GPs, dentists, and even hospitals. (Healthcare for refugees, 2021). The Covid-19 outbreak brought to light these and other problems that the migrants encounter when seeking medical care(Healthcare for refugees, 2021).

It has been seen that because of confusion over their eligibility for NHS treatment, refugees and asylum seekers are occasionally wrongfully refused or charged for secondary care. According to a member poll, 55% of doctors who treat refugees and asylum seekers were regularly or occasionally unsure of their right to medical treatment. Unfortunately, because there is misunderstanding over who is entitled to care, many women avoid using maternity facilities out of fear of being penalized or turned away (BMA, 2022).

The variety of the research population and the complexity of the data must be acknowledged (Kang C et al., 2019). The participants' cultural origins, migratory paths, and health requirements varied widely (Kang C et al., 2019). This intricacy mixed with refugees and asylum seekers multiple social marginalization in the UK as well as the challenges of the asylum system (Kang C et al., 2019). For instance, asylum seekers and refugees get a weekly allowance from the government which is so less and are unable to purchase basic necessities (Kang C et al., 2019). Despite the fact that access to basic healthcare is free and they are put up in hotels, the participant stories show how poverty might serve as a secondary barrier (Kang C et al., 2019). Due to the expense, using public transportation to appointments is impractical, they are forced to eat the food that they are provided at the hotels because they can't afford to eat outside food of their choice. They have got a limited and restricted life here in the UK.

Refugees and migrants have significant healthcare obstacles, and their worse health outcomes are demonstrated by their struggles getting access to care, obtaining unequal medical treatment, and getting appropriate continuity of care (Hadgkiss and Renzaho,2014). The quality of healthcare has a significant impact on health outcomes, the degree to which medical treatment is equitable, timely, safe, effective, and personalized is referred to as its quality (Iqbal P et al., 2022). The primary care of the host nation is frequently the initial point of patient access to medical treatment (Iqbal P et al., 2022). In order to address disparities, high-quality primary care is essential (Iqbal P et al., 2022). It is a difficult challenge to support good healthcare delivery for refugees, asylum seekers, and their families (Iqbal P et al., 2022). The WHO specifies that in order to realize the aim of providing refugees and migrants with universal health coverage, multidisciplinary and intersectoral work must be done to advance the delivery of health care (WHO, 2023).

Recommendations

The UK government has to put the most needy and disadvantaged members of society first in order to provide healthcare that is more sympathetic and equitable for everybody (Asif and Kienzer, 2022). Policymakers, service providers and stakeholders would need to acknowledge, affirm, and address the precarious circumstances and needs of refugees, asylum seekers, and undocumented migrants in order for there to be an empathic health system (Jeffrey, 2016; Stone, 2019) . Concretely, this entails addressing the social and economic determinants of health, as well as providing meaningful and culturally competent treatment and social support (Asif and Kienzer, 2022). It also calls for addressing the underlying root causes of poor health, such as discriminatory laws, racism, and exclusion (Asif and Kienzer, 2022).

The healthcare professionals and GP offices must be sufficiently staffed and sourced along with trained interpreters and translating services in a timely manner which can guide them appropriately without any miscommunication and cultural understanding.

High-quality translators and interpreters who are proficient in a variety of regional languages and dialects are highly recommended in these circumstances so that the vulnerable population may easily and confidently utilize the healthcare system. Additionally, it would be fantastic if the web site's content was available in languages other than English.

To overcome the issues with longer waiting times at the doctor’s office. For appointments with refugees and asylum seekers, health professionals should make sure enough time is set aside to allow for cultural understanding, conversation, and the development of trust (Robertshaw, L et al.,2017).

To overcome the accessibility and affordability, the NHS, other authorities like Healthwatch and voluntary sector organisations should ensure that the refugee should

be informed about patient transportation services and travel reimbursement programs.

In order to eliminate financial barriers to calling a health service, NHS England should collaborate with Ofcom and telecoms firms to ensure that hospital and GP phone numbers are included in the freephone service (Healthwatch, UK, 2023).

The voluntary sector organisations mentioned about providing practical help to the migrants with registration and appointments at the doctor's office. Perhaps by offering practical assistance with registration, scheduling appointments, and attending services, as well as by hiring interpreters with enough funding, the challenges that refugees and asylum seekers face in accessing and using general practice services may be alleviated.

To close the gap, local governments and non-profit organizations must offer refugees educational programs on how to access healthcare services. They must also inform them of their rights under the NHS and the free services they are entitled to, which will improve their ability to access services.

Strengths and limitations of the study:

The study has a number of strengths:

1. This qualitative research on refugees' access to healthcare in Bath and Swindon is the first of its type.

2. Because we had volunteers from four distinct groups, we gained a deeper understanding of the issue.

3. Also, because the questions were open-ended, the participants who were refugees used the chance to talk about their struggles in general along with healthcare.

The limitations are:

1. The sample size was small, and we had anticipated seeing more participants who were refugees and more participation from NHS and GP surgeries.

2. The majority of the refugees at the English language courses and cafés were reluctant to complete the consent form because they believed that their identities would be disclosed.

3. Since some of the refugees couldn't express themselves in English, there were moments when language was a barrier during the interviews with the refugees.

4. Participants who had been refugees for less than two years in the UK met the inclusion criteria.

5. Three months is a short period for conducting a study on such an important topic.

Conclusions

The results of our study indicate both positive and negative encounters with healthcare services for refugees in the UK. Local government officials, medical experts, and members of the voluntary sector organizations all have opinions on how well-off immigrants are when it comes to getting healthcare.

The individuals who were refugees, however, cited a number of obstacles to using NHS services, including language problems, inaccessibility, delayed appointments, and others, which is also causing a huge impact on their mental health. They have had a great deal of hardship throughout their exile, and being separated from their loved ones and home is putting them through a tremendous amount of emotional strain.

They are experiencing housing problems since they don't have a set place to live and have been on the housing waiting list for a very long time. Due to their lack of social life and work opportunities, they lack strong desires. In order to improve healthcare accessibility for migrants and refugees and take care of their basic needs, interventions must be designed by policymakers with the participation of necessary stakeholders. This starts by focusing on barriers like communication, affordability, housing issues, and many others.

The healthcare professionals who provide services to the refugees also go through a number of challenges in terms of everything. And as we know putting out best practices involves enough funding, proper organisational skills, staff and employee training and dissipation of appropriate knowledge and when dealing with refugees and asylum seekers, more should be done to provide humanistic and compassionate treatment, and healthcare systems should help healthcare providers in this endeavour.

It is hoped that the difficulties that refugees and other immigrants face both on their exile trip and once they have arrived in a new country will be addressed and that healthcare accessibility will be improved and healthcare disparities would be minimized for them. The experiences of other healthcare professionals in providing treatment for refugees and asylum seekers should be examined in primary qualitative research.

The results of our study may have an impact on how refugees and asylum seekers are handled. Refugees and other migrants can receive better care and live in better conditions in all directions.

Other healthcare providers including dentists, pharmacists, midwives, and asylum seekers might be part of future studies. Additionally, carry out larger-scale investigations and include additional authorities to obtain a more comprehensive understanding of the issues.

Healthwatch has been working for many years to make the lives of refugees and migrants simpler, to meet their basic requirements, to increase their knowledge and confidence, and to enable them to lead more secure and happy lives in all facets. It is hoped that the findings of this study will aid in their comprehension of the issues and struggles that refugee face when staying in hotels and host homes and will allow them to once more make a difference in their lives.

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I want to thank all the refugees, NHS employees and workers at GP offices, as well as staff from voluntary sector organisation from Bath and Swindon who volunteered to take part in the interviews for this study. I also want to express my gratitude to Ann Marie Scott, Sue Poole, Josephine and Amrit for giving me the chance to work with Healthwatch on such an important issue and for sharing their perspectives and last but not the least, my supervisor, Dr. Alexandra Ziemann, who offered a valuable advice and supported me throughout my course and my research.

References

1. Asif, Z. and Kienzler, H., 2022. Structural barriers to refugee, asylum seeker and undocumented migrant healthcare access. Perceptions of Doctors of the World caseworkers in the UK [Online]. *SSM - Mental Health* [Online], 2(1), p.100088. Available from: https://doi.org/10.1016/j.ssmmh.2022.100088.
2. Bawden, A. and Duncan, P., 2023. Record 7.6 million people in England waiting for NHS treatment [Online]. *The Guardian* [Online], 10 August. Available from: https://www.theguardian.com/society/2023/aug/10/people-england-waiting-for-nhs-treatment#:~:text=A%20record%207.6%20million%20people [Accessed 14 September 2023].
3. BMA, 2022. *Overcoming barriers to refugees and asylum seekers accessing care - Refugee and asylum seeker patient health toolkit - BMA* [Online]. *The British Medical Association is the trade union and professional body for doctors in the UK.* Available from: https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit/overcoming-barriers-to-refugees-and-asylum-seekers-accessing-care.
4. Bragg, R. and Feldman, R., 2011. 'An Increasingly Uncomfortable Environment': Access to Health Care for Documented and Undocumented Migrants in the UK [Online]. *Migration and Social Protection* [Online], pp.143–163. Available from: https://doi.org/10.1057/9780230306554_6.
5. Button, D., Salhab, A., Skinner, J., Yule, A. and Medien, K., n.d. *Patients not passports* [Online]. *New Economics Foundation*. Available from: https://neweconomics.org/2020/10/patients-not-passports [Accessed 14 September 2023].
6. Giacco, D., Matanov, A. and Priebe, S., 2014. Providing mental healthcare to immigrants [Online]. *Current Opinion in Psychiatry* [Online], 27(4), pp.282–288. Available from: https://doi.org/10.1097/yco.0000000000000065 [Accessed 16 September 2019].

7. Giuntella, O., Nicodemo, C. and Vargas-Silva, C., 2018. The Effects of Immigration on NHS Waiting Times [Online]. *Journal of Health Economics* [Online], 58(58), pp.123–143. Available from: https://doi.org/10.1016/j.jhealeco.2018.02.001.
8. Hadgkiss, E.J. and Renzaho, A.M.N., 2014. The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature [Online]. *Australian Health Review* [Online], 38(2), p.142. Available from: https://doi.org/10.1071/ah13113 [Accessed 13 September 2019].
9. healthwatchbathnes.co.uk, n.d. *What we do | Healthwatch Bathnes* [Online]. Available from: https://healthwatchbathnes.co.uk/what-we-do [Accessed 14 September 2023].
10. Jeffrey, D., 2016. Empathy, sympathy and compassion in healthcare: Is there a problem? Is there a difference? Does it matter? [Online]. *Journal of the Royal Society of Medicine* [Online], 109(12), pp.446–452. Available from: https://doi.org/10.1177/0141076816680120.
11. Kang, C., Tomkow, L. and Farrington, R., 2019. Access to primary health care for asylum seekers and refugees: a qualitative study of service user experiences in the UK [Online]. *British Journal of General Practice* [Online], 69(685), pp.e537–e545. Available from: https://doi.org/10.3399/bjgp19x701309 [Accessed 18 October 2019].
12. Keboa, M.T., Hiles, N. and Macdonald, M.E., 2016. The oral health of refugees and asylum seekers: a scoping review [Online]. *Globalization and Health* [Online], 12(1). Available from: https://doi.org/10.1186/s12992-016-0200-x [Accessed 11 November 2019].
13. May 2023, N.-3., n.d. *Our position on the cost of living crisis* [Online]. *www.healthwatch.co.uk*. Available from: https://www.healthwatch.co.uk/news/2023-05-30/our-position-cost-living-crisis [Accessed 14 September 2023].
14. Naslund, J.A. and Deng, D., 2021. Addressing mental health stigma in low-income and middle-income countries: A new frontier for digital mental health [Online]. *Ethics, Medicine and Public*

Health [Online], 19, p.100719. Available from: https://doi.org/10.1016/j.jemep.2021.100719 [Accessed 29 September 2021].

15. NHS Digital, n.d. *Ethnicity* [Online]. Available from: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/ethnicity.
16. O'Donnell, C.A., Higgins, M., Chauhan, R. and Mullen, K., 2007. 'They think we're OK and we know we're not'. A qualitative study of asylum seekers' access, knowledge and views to health care in the UK [Online]. *BMC Health Services Research* [Online], 7(1). Available from: https://doi.org/10.1186/1472-6963-7-75 [Accessed 18 November 2020].
17. P. Iqbal, M., Walpola, R., Harris-Roxas, B., Li, J., Mears, S., Hall, J. and Harrison, R., 2021. Improving primary health care quality for refugees and asylum seekers: A systematic review of interventional approaches [Online]. *Health Expectations* [Online], 25(5). Available from: https://doi.org/10.1111/hex.13365.
18. Paisi, M., Baines, R., Wheat, H., Doughty, J., Kaddour, S., Radford, P.J., Stylianou, E., Shawe, J. and Witton, R., 2022. Factors affecting oral health care for asylum seekers and refugees in England: a qualitative study of key stakeholders' perspectives and experiences [Online]. *British Dental Journal* [Online], pp.1–7. Available from: https://doi.org/10.1038/s41415-022-4340-5 [Accessed 26 June 2022].
19. Papageorgiou, V., Wharton-Smith, A., Campos-Matos, I. and Ward, H., 2020. Patient data-sharing for immigration enforcement: a qualitative study of healthcare providers in England [Online]. *BMJ Open* [Online], 10(2), p.e033202. Available from: https://doi.org/10.1136/bmjopen-2019-033202 [Accessed 3 January 2021].
20. Paudyal, P., Tattan, M. and Cooper, M.J.F., 2021. Qualitative study on mental health and well-being of Syrian refugees and their coping mechanisms towards integration in the UK [Online]. *BMJ*

Open [Online], 11(8), p.e046065. Available from: https://doi.org/10.1136/bmjopen-2020-046065 [Accessed 20 September 2021].

21. Pollard, T. and Howard, N., 2021. Mental Healthcare for asylum-seekers and Refugees Residing in the United Kingdom: a Scoping Review of policies, barriers, and Enablers [Online]. *International Journal of Mental Health Systems* [Online], 15(1). Available from: https://doi.org/10.1186/s13033-021-00473-z.
22. Public Health England, 2014. *NHS entitlements: Migrant Health Guide* [Online]. *Gov.UK*. Available from: https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide.
23. Rajeshwari Pittala and W. James Jacob, 2023. The need for inclusion of integrated teaching on refugee and asylum seeker health in undergraduate medical curriculum [Online]. *Frontiers in Education* [Online], 8. Available from: https://doi.org/10.3389/feduc.2023.1033388 [Accessed 14 September 2023].
24. Refugee Council, 2021. *Healthcare for refugees: Where are the gaps and how do we help?* [Online]. *Refugee Council*. Available from: https://www.refugeecouncil.org.uk/latest/news/healthcare-for-refugees-where-are-the-gaps-and-how-do-we-help/.
25. Robertshaw, L., Dhesi, S. and Jones, L.L., 2017. 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 [Online]. *BMJ Open* [Online], 7(8), p.e015981. Available from: https://doi.org/10.1136/bmjopen-2017-015981 [Accessed 6 April 2019].
26. Stone, J., 2019. The importance of empathy in healthcare: Advancing humanism. *URL*, *1*, p.22.
27. United Nations, 2021. *Refugees* [Online]. *United Nations*. Available from: https://www.un.org/en/global-issues/refugees.

28. UNHCR,2023, Asylum in the UK, UNHCR, UK 2023 available from https://www.unhcr.org/uk/asylum-uk. (accessed on 3rd august 2023)
29. Webber, F., 2019. On the creation of the UK's 'hostile environment' [Online]. *Race & Class* [Online], 60(4), pp.76–87. Available from: https://doi.org/10.1177/0306396819825788.
30. Worthing, K., Galaso, M.M., Wright, J.K. and Potter, J., 2021. Patients or passports? The 'hostile environment' in the NHS [Online]. *Future Healthcare Journal* [Online], 8(1), pp.28–30. Available from: https://doi.org/10.7861/fhj.2021-0007.
31. www.who.int, n.d. *Promoting the health of refugees and migrants: global action plan, 2019–2023* [Online]. Available from: https://www.who.int/publications/i/item/WHA72-2019-REC-1.
32. Ziersch, A., Walsh, M., Due, C. and Duivesteyn, E., 2017. Exploring the Relationship between Housing and Health for Refugees and Asylum Seekers in South Australia: A Qualitative Study [Online]. *International Journal of Environmental Research and Public Health* [Online], 14(9), p.1036. Available from: https://doi.org/10.3390/ijerph14091036 [Accessed 12 October 2019].
33. n.d. *Model of oral healthcare for asylum seekers and refugees How to support access to NHS dentists Prepared in partnership with* [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1010952/MoC_Local_authority__2_.pdf.

Appendices

CONSENT FORM

Understanding experiences of refugees with accessing and using healthcare services in Swindon and Bath and North East Somerset.

Researcher: DR AANCHAL RANA , ar2825@bath.ac.uk
Supervisor: DR ALEXANDRA ZIEMANN, az620@bath.ac.uk

Please initial box if you agree with the statement

1.	I have been provided with information explaining what participation in this project involves.
2.	I have had an opportunity to ask questions and discuss this project.
3.	I have received satisfactory answers to all questions I have asked.
4.	I have received enough information about the project to make a decision about my participation.
5.	I understand that I am free to withdraw my consent to participate in the project at any time without having to give a reason for withdrawing.
6.	I understand that I am free to withdraw my data within two weeks of my participation.
7.	I understand the nature and purpose of the procedures involved in this project. These have been communicated to me on the information sheet accompanying this form.
8.	I understand and acknowledge that the investigation is designed to promote scientific knowledge and that the University of Bath and Healthwatch will use the data I provide only for the purpose(s) set out in the information sheet.
9.	I understand the data I provide will be treated as confidential, and that on completion of the project my name or other identifying information will not be disclosed in any presentation or publication of the research.

10. I understand that my consent to use the data I provide is conditional upon the University and Healthwatch complying with their duties and obligations under current data protection legislation. 11. I consent to my data being shared within the research team at the University and Healthwatch.	Participant's signature:
12. I hereby fully and freely consent to my participation in this project.	

_____ Date: _____

Participant name in BLOCK Letters: _____

Researcher's signature: _____ Date: _____

Researcher name in BLOCK Letters: _____

If you have any concerns or complaints related to your participation in this project please direct them to the Chair of the Research Ethics Approval Committee for Health, health-ethics@bath.ac.uk.

PARTICIPANT INFORMATION SHEET

Understanding experiences of refugees with accessing and using healthcare services in Swindon and Bath and North East Somerset.

Name of Researcher:

Contact details of Researcher:

Name of Supervisor:

Contact details of Supervisor:

This information sheet forms part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please read this information sheet carefully and ask one of the researchers named above if you are not clear about any details of the project.

1. What is the purpose of the project?
2. Why have I been selected to take part?
3. Do I have to take part?
4. What will I be asked to do?
5. Are there reasons why I should not take part?
6. What are the possible benefits of taking part?
7. What are the possible disadvantages and risks of taking part?
8. Will my participation involve any discomfort or embarrassment?
9. Who will have access to the information that I provide?
10. What will happen to the data collected and results of the project?

11. Who has reviewed the project?

12. How can I withdraw from the project?

13. University of Bath privacy notice

14. What happens if there is a problem?

15. If I require further information, who should I contact and how?

QUESTIONNAIRE FORM FOR REFUGEES

- Date: [dd-mm-yyyy] _____
- Location of interview: _____
- Age(in years): _____
- Gender:_____
- Tell me about yourself. Where did you come from?
- Tell me about your experiences with the healthcare system in (Swindon/Bath)?
    - What healthcare do you need? (infectious/communicable diseases, immunizations/vaccinations, dental/oral health, mental health, maternity/women's health)
    - How is healthcare in the UK different from your country? (access to GP, hospital care)
    - What worked well using healthcare in the UK? (access to GP, hospital care)
    - What problems were you facing? (access to GP, hospital care)
    - What kind of support did you get with using healthcare in the UK? (communication/information)
- What would help you to overcome the problems you were facing? (communication/information?)
- Anything else you would like to tell us about?

QUESTIONNAIRE FORM FOR VOLUNTARY SECTOR STAFF

- Date: [dd-mm-yyyy] _____
- Location of interview: _____
- What is your role at (name voluntary sector organisation)?
- How many refugees do you see in a week?
- What are the common health care needs for the refugees? (communicable diseases, immunisations, oral health, mental health, maternity/women's health)
- What are the challenges for refugees engaging with the NHS? (access to GP/hospital care)
- How do you support refugees engaging with the NHS? (communication/information)
- In what ways could engagement of refugees with the NHS be improved? (communication/information)
- Anything else you would like to tell us about?

QUESTIONNAIRE FORM FOR NHS STAFF

- Date: [dd-mm-yyyy] _____
- Location of interview: _____
- What is your role at the (GP practice/hospital)?
- How many refugees do you see in a week?
- What are the common health care needs of the refugees? (communicable diseases, immunisations, oral health, mental health, maternity/women's health)
- What are the challenges for refugees engaging with the NHS? (access to GP/hospital care)
- How do you manage those challenges and how do you support refugees engaging with the NHS? (communication/information)
- In what ways could engagement of refugees with the NHS be improved? (communication/information)
- Anything else you would like to tell us about?

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