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Extended Research Article

Opportunities and practices supporting responsive health care for forced migrants: lessons from transnational practice and a mixed-methods systematic review

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Scientific summary

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Scientific summary

Background

During 2022, a record 103 million people were forcibly displaced inside or across borders worldwide. In the UK, although numbers are low in relation to other comparable economies, in the 12 months to September 2022, 85,902 people sought asylum, 143,377 people were awaiting an initial decision, 17,378 people received refugee or alternative forms of humanitarian protection, 213,307 Ukrainian refugees were granted visas under the Ukraine Family and Ukraine Sponsorship schemes, and an estimated half a million undocumented migrants were living in the UK.

For those seeking and receiving asylum, a complex set of interconnecting adversities, before, during and after arrival in receiving countries produce significant risks to poor health. Beginning with the original persecution or exposure to war and violence that typically drive displacement, adversities include risks of trafficking, precarity and trauma throughout the displacement journey, isolation and difficult experiences adapting to a new dominant culture, and the prevailing attitudes and structures in transit and receiving countries. These factors are often paid limited attention in the settlement context, despite heavy evidence that compared with native-born populations, forced migrants typically face a greater risk of diverse and comorbid health conditions, including infectious, cardiovascular and chronic respiratory diseases, cancers, and diabetes, and an increased risk of developing poor mental health.

Postmigration stressors are complex and intersecting, and when it comes to navigating and negotiating access to health care in settlement or receiving country contexts, studies increasingly highlight poor experiences and substantial barriers. This aligns with broader evidence that public systems rely heavily on individual agency, provide best for those with minimal needs and are in a position to shape, frame and reproduce inequalities. While international human rights law provides us with an ethical framework in which to recognise rights to health care and to the social and material conditions for good health, health and care practices are often neither sufficiently responsive nor adequately equipped to ensure quality care for forced-migrant communities.

Aims and objectives

This project aimed to integrate evidence and knowledge about interventions and practices that support responsive health care and improved health agency for forced migrants across different healthcare moments of opportunity. We considered three key questions:

1. What are the healthcare moments of opportunity for forced-migrant communities?
2. What practices and models could be used in these moments of opportunity to support responsive health care and improved health for forced-migrant communities?
3. How can these practices and models be integrated into UK health and civil society systems?

Our objectives were to undertake:

1. Stakeholder engagement and dialogue to support: (1) the identification of existing and potential moments of opportunity; and (2) community and service priorities in (responsive) health care for forced-migrant communities.
2. A systematic search, data extraction and quality appraisal of published peer-reviewed and 'grey' literature.
3. Identification of and the collection of data from, existing international examples (case studies) of services taking active measures in improving access to care for forced migrants.
4. A synthesis of findings through attention to the capabilities framework and a further process of engagement and dialogue between and with important stakeholders resulting in a guiding framework that provides a set of core principles and considerations in the delivery of a responsive system of health care for forced-migrant communities.

Approach 1. Workshops and stakeholder engagement

We held two cross-community workshops with adult forced migrants who had been in the UK for between 3 months and 4 years. We conducted many individual conversations and one online group conversation with stakeholders from health, social care, voluntary, faith, and local authority groups and services. We documented key concerns, priorities and ideas for health care for forced-migrant communities. This intelligence helped to inform our systematic review, the qualitative data collection and understanding of local issues.

Approach 2. Systematic review

Methods

We conducted a mixed-methods convergent integrated systematic review. We included experimental and observational studies, qualitative studies and primary mixed-method studies allowing us to draw on the strength of the different constituent research approaches to produce a broad conceptualisation of evidence, deemed especially useful in the case of complex interventions or complex systems. We included studies conducted in any country and in any language. We included studies with two types of participant: (1) adults or children who are forced migrants; and (2) participants who are relevant to a healthcare 'moment of opportunity' for a forced migrant; this included any worker (voluntary or paid, professional or lay) who could play an instrumental role in supporting healthcare access and healthcare experiences. We included studies that aimed to deliver responsive health care for forced migrants. We included studies only where this aim was clearly captured within the stated aims and objectives of the study (not intervention). We included studies regardless of outcome measures, but considered outcomes based on three criteria, namely whether they reported a direct measure of access (e.g. quality of communication, acceptability or appropriateness), a proxy measure of access (e.g. knowledge gain from a practice improvement training programme, such as on cultural awareness as reported by workers) or no measure of access (e.g. a clinical/psychosocial measure only). We searched the American Psychological Association PsycINFO (OVID Technologies 1967–), EMBASE (OVID), the Cochrane Central Register of Controlled Trials, Cumulative Index to Nursing and Allied Health Literature (EBSCO Publishing 1994–), MEDLINE (Ovid Technologies Inc. 1996–), applying no restrictions on language or publication status, from inception to 28 February 2022. This was supplemented by a grey literature search of relevant material, and forward and backward citation searches. We assessed methodological quality using the study design-specific tools from the Joanna Briggs Institute and developed an additional assessment tool to allow the explicit consideration of appropriateness of interventions for cross-cultural settings. We 'qualitised' relevant quantitative data by translating these findings into textual descriptions. These findings were pooled with the textual summaries of qualitative findings and examined and categorised through a framework synthesis approach to data analysis. We conducted a thematic synthesis of intervention and practice designs, in what we saw as their critical features as they related to aspects of access.

Results

A total 108 studies were selected for inclusion. Most (72) were judged to be of high quality. Forced-migrant participants were drawn from most continents of the world. Most interventions related to mental health. There was substantial heterogeneity in the design of interventions and practices, the health and institutional contexts of interventions, the participant groups and reported outcomes. Outcomes fell into a number of distinct domains, including acceptability, awareness and health agency. Direct measures of access were reported in 64 studies, proxy measures in 48, and 15 studies reported no measure of access. Consistent with our focus on responsive care, we sought within the descriptions of the interventions or service practices to identify any actions that might foster a responsiveness to the needs and contexts of the study population. We identified that programmes of care were overwhelmingly informed by multiple knowledges and perspectives (collaboration, published evidence, experts). The majority of studies also described practices that had recognised language and communication, displacement (and settlement) experiences, potential disconnects between the cultural traditions, values and expectations of arriving and local societies, the broader systems in which participants or services were located, and a set of resource practices and mechanisms for reaching people, namely engaging with, and seeking representation from, communities. We further identified six domains of impact of interventions: (1) the benefit from and creation of community, including linkages with formal (health) services; (2) the formation of networks of care that included traditional and non-traditional healthcare providers; (3) proactive engagement, including conducting care in familiar spaces; (4) considered communication, particularly relating to the benefits of bilingual workers; (5) informed providers and attitudes that saw improved knowledge and compassion; and (6) a right to knowledge that identified the importance of respecting the need of new arrivals for information, knowledge and confidence in local systems, including normalising and understanding the impacts of experiences of war.

Approach 3. Case study enquiry

Methods

Maintaining our broad view of evidence we concurrently identified examples of relevant interventions and models of care in current practice, globally, that were taking active steps to improve access to care for forced migrants. We intentionally sought variability through different contexts, characteristics and models of care. We used case study methodology to understand possibilities and practices in responsive care and located these within the different local knowledges, experiences, skills and attributes of workers alongside the experiences of those engaging in services. We also took into account the broader institutional and political contexts in which this all takes place. We conducted semistructured interviews with providers, collaborators and service users, face to face or remotely, and one to one or as part of a small group interview. For UK settings, we made site visits and conducted short-term observation of clinics, where appropriate, and provider settings. Visits and observations served to broaden our understanding of the local contexts, providing the opportunity to acquire the tacit knowledge that can be drawn from observing workers' personal qualities, the range of interactions taking place within any given space, the informal reflexive perceptions and insights between participants and researchers, bringing a vital aspect to our enquiry. We reviewed service information and evaluations where available. Qualitative evidence, including field notes and documents, was combined in a broad thematic analysis.

Results

Five sites were identified from a 'long list' of more than 80. Three were in the UK: (1) a non-clinical outreach advocacy, education and support service helping to improve access to state healthcare systems; (2) a community-based, holistic health screening and care planning service; and (3) an inclusion health general practitioner and well-being service that includes holistic health screening. One was in Belgium (a stepped-care mental health service taking a human rights, transcultural and community approach to mental health care) and one in Victoria, Australia (a nurse-led service providing holistic health assessments and care co-ordination for patients with complex needs). Our exploration of these services provides a resource of contrasting services that each demonstrates what is possible in the health care of forced migrants. Taken together, however, the services show a willingness to innovate and work outside existing structures, a complementary 'micro-flexibility' in their interactions with patients and clients, and the creation of safe spaces to encourage trust in providers. A further subset of active behaviours was identified: engaging in intercultural exchange (navigating with humility, interest and reflexivity different perceptions); facilitating the connection of people within their cultural sphere (faith, nationality, experiences, language, gender); a focus on the individual; and a reflexive attitude to the individual and their broader circumstances.

Synthesis of findings

We synthesised the three approaches to our study with attention to Nussbaum and Sen's capabilities framework and ideas of health justice, as discussed by Venkatapuram (Venkatapuram S. *Health Justice: As Argument from the Capabilities Approach*. Cambridge: Polity Press; 2011), to a 'capability to be healthy'. We developed a tentative set of responsive principles, which we explored through four stakeholder 'conversations'. We saw this as a further form of evidence synthesis that could help to 'transform' and root the research findings through the exchange of reflections, ideas, insights and evidence in the context of the social, cultural and structural realities in which contributors were located. Overall, we found that environments that enable good health and enable people to live lives of meaning are of vital importance. We identified responsive healthcare spaces as spaces in which flexibility and reflexivity is nurtured, in which communication is prioritised and where there is a radical commitment to intercultural exchange that begins from a place of humility and that uses shared communities as spaces of trust and conduits to broader societal bridges and formal care. We found that these elements are supported by a 'linked-up-ness' between a range of unlikely collaborators and a deep commitment to interprofessionality and interconnectivity between public, community and

private players and services. For those in protracted asylum and immigration system contexts particularly, we have identified a systems battle that is in constant tension with services driving a community of care. While we found that these systems are permeable, the combination of dehumanising immigration regimes, implicit or active exclusion from state structures, and lack of accountability as to where the responsibility for the health and well-being of refugees and people seeking asylum is located, constrains capabilities for health and is likely to waste human and material resources within healthcare systems as well.

Recommendations for future research

Our key research recommendations are as follows. At policy level, we suggest a rapid, cross-sector review of the health and health service implications of existing and proposed immigration practices and their implications in the short, medium and longer terms. For refugee communities, we suggest that there should be further exploration of the role and training of non-specialist peers in healthcare practice in a range of facilitative and delivery roles, including translation. For practitioners, we suggest that research is conducted to better understand: (1) how we motivate, engage and leverage alliance-building relationships across a broad constituency of caring practitioners; and (2) the models and possibilities for embedding intercultural exchange, competencies and reflexivities in both professional education and professional practice.

Conclusion

Our study poses important questions around local and national capacity to dismantle some of the structures, institutional behaviours and ideas that affirm the current experience of healthcare contexts for forced migrants. At the same time, we have shown that it is feasible within a range of organisational contexts for healthcare practice to do this. To our knowledge, it has not previously been recognised how broad a range of caring practitioners and agencies can, and should, through intentional and interconnected practice, contribute to the health care of forced migrants. Opening up healthcare systems to include other state actors, such as teachers and settlement workers, and a range of non-state actors, who should include religious and ethnic community leaders, is a key step in this process. We argue that community is and should be prioritised as a conduit for engagement in a range of healthcare provision, benefiting important social connections and bridging access to statutory care. Refugee patients and communities should be seen as partners in their care deserving of knowledge, skills and confidence in healthcare navigation and psychoeducation, particularly as it relates to normalising responses to war and settlement stressors. An appetite for a networked community of knowledgeable healthcare providers should be recognised and enabled through broad, reflexive and considered programmes of collaborative and informed practice.

Study registration

This study is registered as PROSPERO (CRD42021271464).

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